

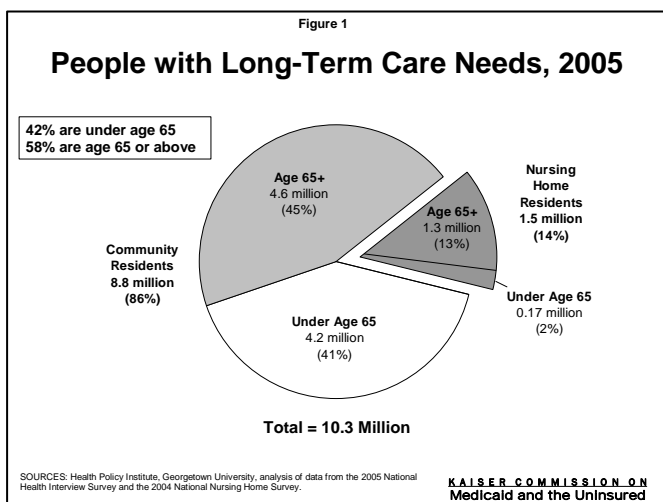
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Medicaid and Long-Term Care Services and Supports

Medicaid is the nation's major public health coverage program designed to address the acute and long-term care needs of millions of low-income Americans of all ages. Medicaid is the primary payer for long-term care covering a range of services including those needed by people to live independently in the community such as home health and personal care, as well as services provided in institutional settings such as nursing homes. Many of these critical services are not covered by Medicare or private insurance.

Who Needs Long-Term Care Services and Supports?

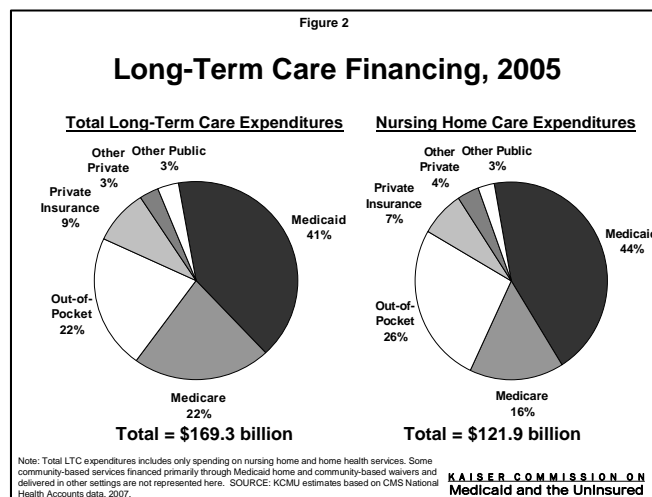
Over 10 million Americans need long-term care services and supports to assist them in life's daily activities (Figure 1). The majority of beneficiaries who receive long-term care services are age 65 and above while 42 percent are under age 65. Long-term care services include a range of services and supports that assist individuals with performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These range from providing assistance with eating, dressing, and toileting, to assisting with managing a home, preparing food, and medication management.



People with long-term care needs span all ages and often have substantial acute care needs. Children with intellectual disabilities such as mental retardation and development disabilities such as autism often need care throughout their lifetimes. Young adults with spinal cord and traumatic brain injuries and serious mental illness may need services for decades. Older people with Alzheimer's disease often need some long-term services due to decreasing mobility and cognitive functioning that comes with aging, and those with severely disabling chronic diseases such as diabetes and pulmonary disease need more extensive acute and long-term services as they age.

Who Pays for Long-Term Care Services?

Although many people who need long-term care rely primarily on unpaid help from family and friends, nearly \$170 billion was spent on long-term services in 2005 (Figure 2). Nursing home care is expensive averaging over \$70,000 per year and often exceeds individuals' ability to pay for their care. Medicaid accounts for 41 percent of total long-term care spending. Direct out-of-pocket care spending by individuals and families accounts for slightly less than one-quarter of spending. Medicare provides limited post-acute care through its skilled nursing facility benefit and its home health care benefit, accounting for 22 percent of spending.



Who Qualifies for Medicaid Long-Term Care Services?

Medicaid is intended to assist low-income individuals and is not available to everyone who needs long-term services. Individuals must first meet financial qualifications for Medicaid coverage of long-term services and supports, in addition to meeting need criteria. For the elderly and people with disabilities with long-term care needs, these limits are often tied to the Supplemental Security Income (SSI) program \$623 per month in 2007 – but states can, and often do set higher limits. Additionally, elderly and disabled individuals who qualify for Medicaid must have very few assets (\$2,000 for an individual and \$3,000 for a couple, in most states).

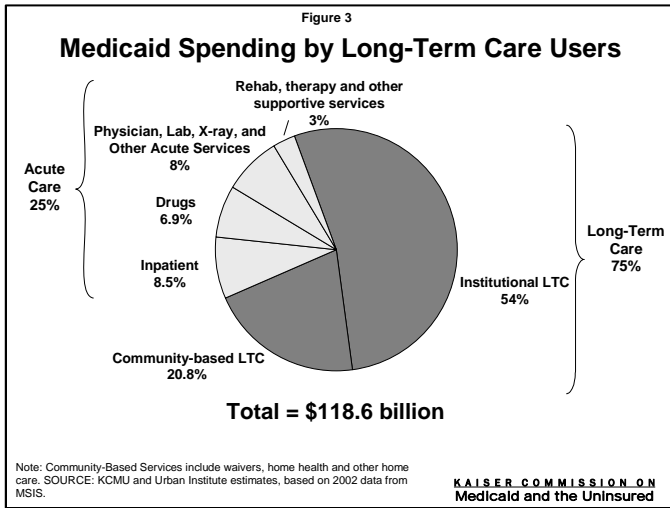
Medicaid is also the safety net for long-term care services for individuals who become impoverished as a consequence of disabling illness or injury. Thirty-six states, including DC, allow the "medically needy" – those with high medical bills – to spend down to a state-set eligibility standard, and because few people can afford the high cost of nursing home care, 38 states allow individuals needing nursing home care to qualify with income up to 300 percent of SSI (\$1,869 per month in 2007).

However, individuals who apply for Medicaid assistance with nursing home care are subject to a “look back” period of five years for asset transfers during which eligibility may be denied. This is intended to prevent those above the eligibility levels for Medicaid from giving away their resources in order to qualify rather than spending down to Medicaid eligibility. Medicaid coverage is excluded for individuals with home equity in excess of \$500,000 (or up to \$750,000 at state option).

To address the gaps in private coverage, many states provide a means for higher income individuals to buy-into Medicaid, such as the Ticket-to-Work option for individuals with disabilities to work and retain their health coverage and the Family Opportunity Act for disabled children with family income up to 300 percent of poverty.

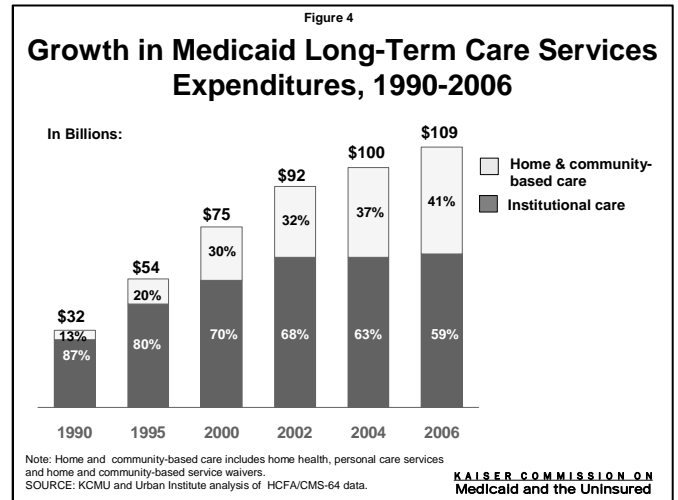
What Services Does Medicaid Provide for Long-Term Care Populations?

Over 3 million individuals, or 7 percent of the Medicaid population, rely on Medicaid long-term care services for a range of physical and mental health care needs. Among Medicaid long-term care users, 75 percent of spending went toward long-term services and supports, while the remaining 25 percent was devoted to acute care and other supportive services such as inpatient hospital, prescription drugs, physician, rehabilitative and therapy services (Figure 3). Over half of those who use Medicaid long-term care services are individuals age 65 and older, but 45 percent are disabled children and adults.



Medicaid covers a continuum of long-term care service settings from nursing homes to the community. While many prefer to remain in the community, some individuals with extensive needs require nursing home care. Spending on Medicaid home and community-based services has been growing. In 2006, spending on home and community-based care accounted for 41 percent (\$44.9 billion) of total Medicaid long-term care services spending, up from 13 percent in 1990 (Figure 4).

Demand for services in the community is growing as evidenced by the number of beneficiaries on waiting lists for home and community-based waiver services – 280,176 individuals in 31 states in 2006.



States are employing a wide range of approaches to balance their long-term care delivery systems in favor of community settings. Efforts to make Medicaid benefits more flexible and allow consumer involvement in determining and managing services are expanding across the states. Currently, 42 states allow some form of consumer direction of personal assistance services where the Medicaid beneficiary has greater control over hiring, scheduling and paying personal care attendants. Additionally, 31 states received Money Follows the Person Demonstration grants in 2007 that give states enhanced matching funds to transition Medicaid beneficiaries from institutional to community-based settings.

Outlook

For the foreseeable future, Medicaid will remain the major financing system for long-term care services and supports in our nation, and the only one addressing the needs of low-income Americans. Much of the policy discussion concerning Medicaid’s role as a provider of long-term care is driven by cost concerns, but as in other areas of health care, there is increasing focus on quality and indicators that can be used to evaluate quality of care across providers and settings. The needs for long-term care services that Medicaid addresses will not lessen in coming years; they will likely grow. The challenges for those who finance, design, and provide long-term care under the Medicaid program are to align incentives to ensure access to needed services, and provide cost-effective high quality services and supports to low-income Americans.

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