kaiser commission on MEDICAID FACTS

medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

June 2012

Medicaid and Long-Term Care Services and Supports

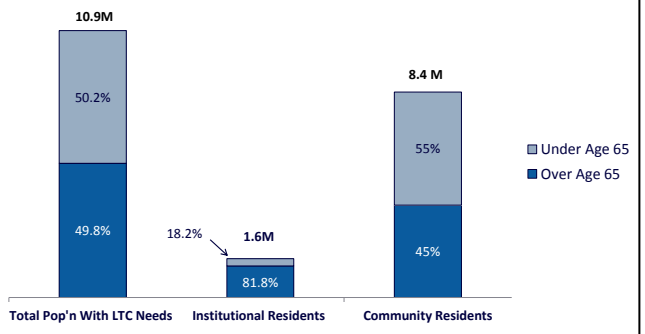
Medicaid is the nation's major public health coverage program designed to address the acute and long-term care needs of millions of low-income Americans of all ages. Medicaid is the primary payer for long-term services and supports (LTSS) covering a range of services including those needed by people 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. The Patient Protection and Affordable Care Act (ACA) creates a number of new opportunities for states to balance their long-term care delivery systems by expanding access to Medicaid home and community based services (HCBS) programs.

Who Needs Long-Term Care Services and Supports?

Over 10 million Americans need long-term services and supports to assist them in life's daily activities. About half of these individuals are over age 65 and half are people under age 65 with disabilities (Figure 1).

Figure 1

People With Long Term Care Needs



Source: Kaye et al. (2010) Long-Term Care: Who Gets It, Who Provides It, Who Pays, And How Much. *Health Affairs*, 29:1, 11-21.
Note: Data from 2007 American Community Survey (ACS) and the 2005 Survey of Income and Program Participation (SIPP)

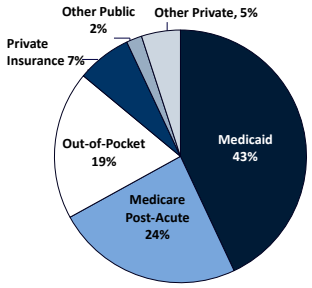
People with long-term services needs span all ages and often have substantial acute care needs also. Children with intellectual and developmental disabilities such as autism often need care throughout their lifetimes. Young adults with spinal cord and traumatic brain injuries and serious mental illness may need services for decades. Older people 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?

Paying for long-term services is expensive and can quickly exhaust lifetime savings. Nursing home care averages $74,800 per year, assisted living facilities average $39,500 per year, and home health services average $21 per hour. In 2009, $240 billion was spent on long-term services (Figure 2). Medicaid accounts for 43 percent of total long-term care spending. Medicare provides limited post-acute care accounting for slightly less than one-quarter of spending. Direct out-of-pocket care spending accounts for 19 percent of spending.

Figure 2

Medicaid is the primary payer for long-term care services



Total in 2009 = $240 billion

NOTE: Total LTC expenditures includes spending on nursing home, home health services, and home and community-based waiver services. All home and community-based waiver services are attributed to Medicaid. Total excludes residential care facilities for intellectually disabled, mental health, or substance abuse.
SOURCE: KCMU estimates based on CMS National Health Accounts data, 2009.

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 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 services needs, these limits are often tied to the Supplemental Security Income (SSI) program – $698 per month in 2012 – 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, though some states allow higher limits).

Medicaid is also the safety net for long-term care services for those who become impoverished as a result of disabling illness or injury. Thirty-four 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 people needing nursing home care to qualify with income up to 300

percent of SSI ($2,094 per month in 2012). 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 for Medicaid. Persons with substantial home equity are ineligible for Medicaid.

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, which allows 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.

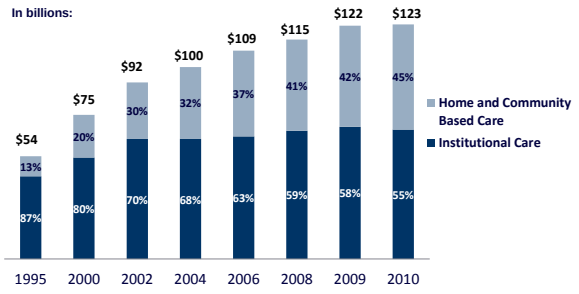
What Services Does Medicaid Provide for LTSS Populations?

Nearly 4 million individuals, or 6 percent of the Medicaid population, rely on Medicaid LTSS for a variety of physical and mental health care needs. Medicaid coverage of long-term care includes an array 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 and medication management.

Medicaid covers a continuum of long-term care service settings. While many prefer to remain in the community, some individuals with extensive needs require nursing home care. Spending on Medicaid HCBS has been growing. In 2010, spending on HCBS accounted for 45 percent ($54.9 billion) of total Medicaid long-term care services spending, up from 13 percent in 1995 (Figure 3). Comparitively, institutional spending has remained relatively flat and actually decreased slightly in 2010.

Figure 3

Growth in Medicaid Long-Term Care Services Expenditures, FFY 1995-2010



Note: Home and community-based care includes home health, personal care services and home and community-based service waivers. Institutional care includes intermediate care facilities for the intellectually disabled, nursing facilities, and mental health facilities.
SOURCE: KCMU and Urban Institute analysis of HCFA/CMS-64 data.

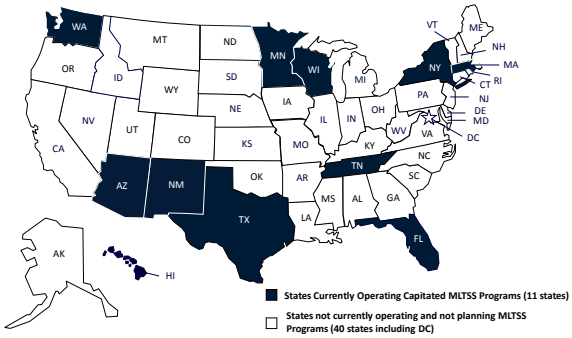
Spending patterns for Medicaid HCBS vary widely among states, with the percentage of LTSS expenditures going towards HCBS ranging from 16 percent in Mississippi to more than 90 percent in New Mexico. Despite HCBS spending growth there is still unmet need for services in the community. In 2010 there were 428,571 individuals in 39 states on waiting lists for Medicaid HCBS.

New Payment and Delivery Models (Managed LTSS)

There is increased interest among states in contracting with managed care plans to deliver services to LTSS populations rather than the traditional fee-for-service model. As of 2011 eleven states were operating capitated managed LTSS programs, with more planning to implement managed LTSS in the near future. Managed care carries the potential to improve care integration and better manage costs, but establishing a successful managed LTSS program is a complex process requiring thoughtful program design and initial investments of time and other resources, and state experience with managed LTSS is limited. Interest in managed LTSS has been fueled in part by federal initiatives which granted awards to states to design person-centered delivery and payment models to better coordinate care for people dually eligible for Medicare and Medicaid (dual eligibles).

Figure 4

States Currently Operating or Planning Medicaid Managed Long Term Services and Supports Programs, October 2011



SOURCE: L. Summer (October 2011). Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider. Kaiser Family Foundation.

Access and Quality

The quality of care in institutions has greatly improved in the past 20 years, but there are still concerns about facilities, standards and oversight, which is largely the responsibility of states. With regard to HCBS the issues are slightly different. Workforce training and pay, and questions of how to measure client satisfaction and the appropriateness of services are the primary HCBS quality concerns. Ensuring access to available services is also a challenge. Beneficiaries are often unaware of services or unable to access them.

Outlook

Medicaid continues to be the major financing system for long-term services and supports in our nation. Demand for services in the community remains high, and many states are grappling with concerns about the HCBS workforce and the availability of community resources to support people receiving HCBS. The ACA provides a number of incentives to states, in the form of increased federal matching payments, to increase the availability of HCBS. Concurrently, states are looking to managed care as a means of better integrating and coordinating care. As this population grows, states and the nation will be challenged to find new, more efficient ways of delivering quality LTSS in the most appropriate setting, while managing costs and respecting beneficiary autonomy.

This publication (#2186-09) is available on the Kaiser Family Foundation's website www.kff.org.