

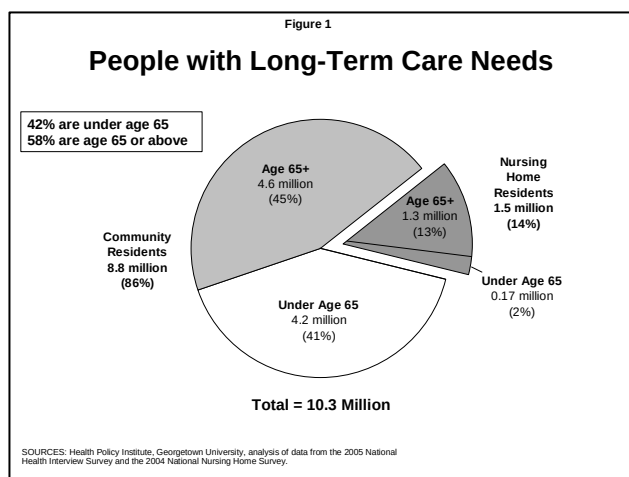
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Medicaid and Long-Term Care Services and Supports

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, or almost 5 percent of the total adult population, need long-term services and supports to assist them in life's daily activities (Figure 1). The majority of individuals who receive long-term care services are age 65 and above while 42 percent are under age 65. Long-term care includes 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.

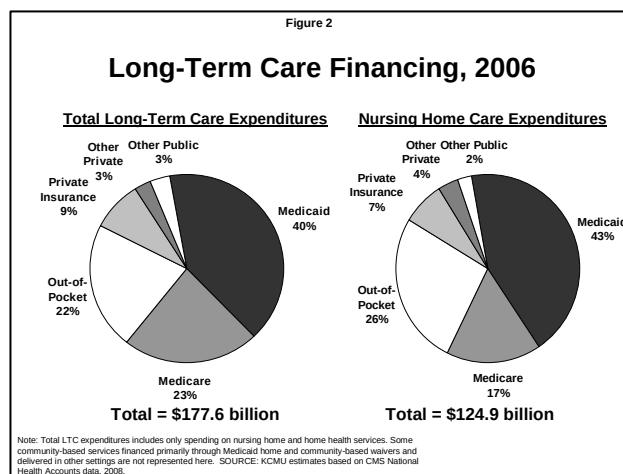


People with long-term care needs span all ages and often have substantial acute care needs. Children with intellectual disabilities such as mental retardation and development disabilities such as autism often need care throughout their lifetimes. Young adults with spinal cord and traumatic brain injuries 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?

Many people who need long-term care rely primarily on unpaid help from family and friends. Paying for long-term services is expensive and can quickly exhaust lifetime savings. Nursing home care averages \$70,000 per year, assisted living facilities average \$36,000 per year, and home health services average \$29 per hour. The cost of these services often exceeds individuals' ability to pay for their care. In 2006, nearly \$178 billion was spent on long-term services (Figure 2). Medicaid accounts for 40 percent of total long-term care spending. Medicare provides limited post-acute care through its skilled nursing facility benefit and its home health care benefit, accounting for slightly less than one-quarter of spending. Direct out-of-pocket care spending by individuals and families accounts for 22 percent of spending.



Who Qualifies for Medicaid Long-Term Care Services?

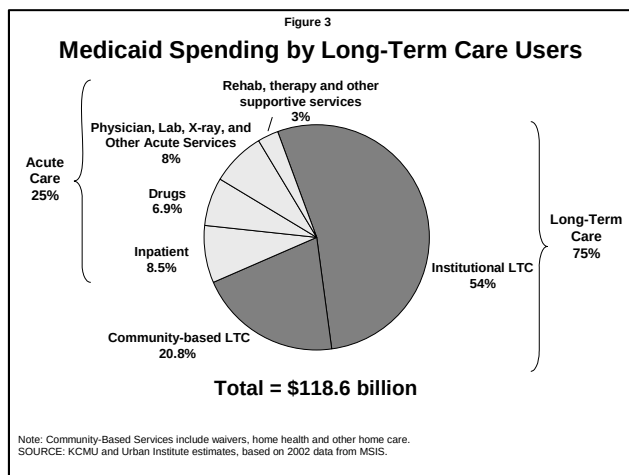
Medicaid is intended to assist low-income individuals and is not available to everyone who needs long-term services. Individuals must first meet financial qualifications for Medicaid coverage of long-term services and supports, in addition to meeting need criteria. For the elderly and people with disabilities with long-term care needs, these limits are often tied to the Supplemental Security Income (SSI) program – \$674 per month in 2009 – 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 (\$2,022 per month in 2009). 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.

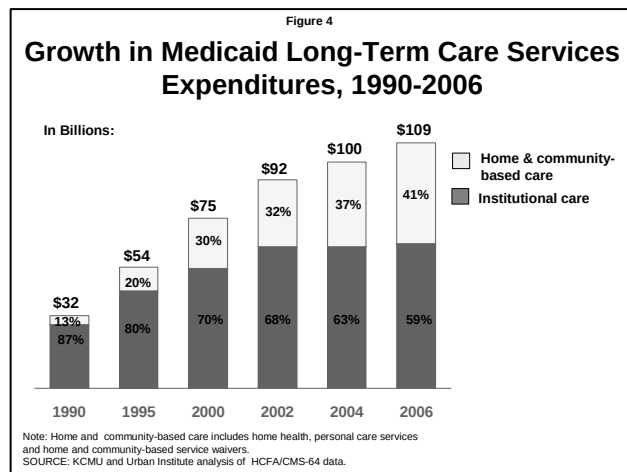
What Services Does Medicaid Provide for Long-Term Care Populations?

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. 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. 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).



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 (\$44.7 billion) of total Medicaid long-term care services spending, up from 13 percent in 1990 (Figure 4). Spending patterns for Medicaid home and community-based services vary widely among states although 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 – 331,689 individuals in 33 states in 2007 – an 18 percent increase over the previous year.



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

As the economic crisis deepens, states will be under increasing pressure to control overall costs in their Medicaid programs bringing new uncertainties for the provision of Medicaid home and community-based services. At the same time, the need for long-term care services that Medicaid addresses will likely grow in the coming years. For the foreseeable future, Medicaid will remain the major financing system for long-term care services and supports in our nation, and the program that addresses the needs of low-income Americans. The challenges for the financing, design, and provision of long-term care under the Medicaid program are how to align incentives to ensure access to needed services and provide cost-effective high quality services and supports to low-income Americans.

This fact sheet (#2186-06) is available on the Kaiser Family Foundation's website at www.kff.org.