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Medicaid's Long-Term Care Beneficiaries: An Analysis of Spending Patterns

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Executive Summary

Medicaid accounts for 40% of all long-term care services delivered and almost half of all nursing home expenditures in the U.S., making Medicaid the nation's largest single payer of long-term care services. However, those who use long-term care services are among the most disabled and chronically ill of the Medicaid population. Long-term care users are a heterogeneous population whose spending and enrollment patterns vary widely across different types of service settings. These differences reflect a number of factors including use of long-term services and the balance between institutional and community-based care, how acute and other supportive services are used, and whether enrollees also have Medicare coverage. This paper provides an overview of Medicaid beneficiaries who receive long-term care services and their acute and long-term care expenditures in 2002. Analysis is based on data from the FFY 2002 Medicaid Statistical Information System (MSIS) Summary File.

Key Findings:

- **Medicaid long-term care users accounted for 7% of the Medicaid population in 2002 but over half (52%) of total Medicaid spending.** Three quarters of spending went toward long-term care, while the remaining 25% was devoted to acute care and other supportive services, such as inpatient hospital, prescription drugs, physician, rehabilitative and therapy services. Among Medicaid enrollees using long-term care services, just over half (55%) were elderly, 34% were individuals under age 65 classified as disabled, and 11% were adults and children who qualified for Medicaid based on income or other eligibility pathways.

- **One-third of elderly Medicaid enrollees used long-term care services, but they accounted for 86% of all Medicaid spending on the elderly.** Two thirds of these 1.9 million beneficiaries used institutional services, and their total spending averaged $38,780 per enrollee. Spending for the elderly who used community-based services was less than half this amount averaging $17,176. This compares to an average of $2,719 for the elderly with little or no long-term care spending.

- **Fifteen percent of beneficiaries classified as disabled used long-term care services, but they accounted for 58% of all Medicaid spending on the disabled.** Three quarters of these 1.2 million enrollees relied on community-based care, and had average total spending of $34,930. Per enrollee spending for the disabled using institutional care averaged $76,331. This compares to an average of $6,277 for those with little or no long-term care spending.

- **Dual eligibles accounted for two-thirds of Medicaid enrollees who used long-term services and a similar share of spending.** Medicaid plays an important role filling in gaps in Medicare, particularly for long-term care. Average spending on dual eligibles totaled $34,522, with 84% going toward long-term care services, 7% to prescription drugs, and the remaining 9% to other medical services. While drug coverage has now been shifted to Medicare, Medicaid continues to finance long-term care and other services for dual eligibles.

- **Overall, 406,226 children and 1.1 million adults under 65 used long-term care services.** Three quarters of children who used long-term care services qualified for Medicaid on the basis of income or an eligibility pathway other than disability. Disabled children had higher average spending for all services ($47,149) compared to children who qualified through other categories ($17,787). Adults who used long-term care services had higher average spending compared to children ($44,017 vs. $27,426) due to greater use of institutional care and higher spending on community-based long-term care services. In contrast to children, most adults who used long-term care services qualified for Medicaid on the basis of disability. Per enrollee spending on children and adults who had little or no long-term care spending was relatively low, averaging $1,621 and $3,097, respectively.

Policy Implications:

Medicaid enrollees who use long-term care services vary widely in their spending patterns and include heterogeneous populations with different needs for medical care and long-term services and supports. Enrollees under age 65 are more likely to use community-based long-term care services, while the elderly rely more heavily on institutional care. Medicaid enrollees who receive long-term care services in the community have lower overall per enrollee spending compared to their counterparts in institutional settings. That is not to say that enrollees residing in institutional settings would cost less if they were moved to the community, and for some portion of these residents, there may be no alternative to institutional care. A comprehensive long-term care system includes a continuum of service settings, but continued attention to serving individuals in the most appropriate setting should be a priority.

Children and adults in Medicaid who use long-term services are a unique population whose medical needs need to be assessed in light of recent DRA-related Medicaid changes. Most of these children are eligible for Medicaid through a route other than the disability classification, so reforms that place new restrictions on benefits for non-disabled children may place unique burdens on this population, either by limiting access to potentially critical services, or placing especially high cost-sharing burdens on families with long-term care needs for their children. Similar concerns are raised for the smaller number of adults who are not classified as disabled but who use long-term care services.

Finally, about one-third of all Medicaid dollars are spent on dual eligible beneficiaries who are eligible for Medicare and use Medicaid-financed acute and long-term care services. Prescription drug coverage has now been shifted from Medicaid to Medicare, but Medicaid spending for long-term care and other acute care services remains substantial. The relative roles of Medicaid and Medicare covering acute and long-term care services for dual eligibles warrants continued policy discussion.

Overview

Although long-term care accounts for less than 10% of all health care expenditures in the U.S., [1] these services account for 40% of all Medicaid spending, while the share of Medicaid spending accounted for by beneficiaries who use long-term care is even larger.[2] In turn, Medicaid accounts for 40% of all long-term care services delivered and almost half of all nursing home expenditures in the U.S., making Medicaid the nation's largest single payer of long-term care services.[3] While Medicaid primarily finances nursing home care, Medicaid spending on home and community-based care has doubled in the last decade,[4] and an increasing number are on waiting lists for Medicaid-financed community-based long-term care services.[5] These numbers indicate the significant role Medicaid plays in financing long-term care in the U.S., and the role that long-term care delivery plays in driving costs in Medicaid. Therefore, long-term care deserves consideration in any discussion about cost containment in Medicaid, and indeed, has become one of the focal points for this debate.

This paper provides an overview of Medicaid beneficiaries who receive long-term care services and their expenditures in 2002. We utilize person-level data to compare spending in Medicaid for populations who receive long-term care services provided in institutional settings to those who receive long-term care services in the community. We examine spending for both long-term care and acute care services in Medicaid. We also include differences in spending patterns between dual eligibles, those covered both by Medicaid and Medicare, and those solely covered by Medicaid. Because the elderly and non-elderly exhibit very different spending patterns, we examine these two populations separately.

Background

Long-term care encompasses a wide variety of delivery settings, service types, and payment mechanisms, but is commonly divided into two types—institutional and community-based. Institutional long-term care refers to services provided in nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), or institutions for individuals with mental disease. All states must provide nursing facility care as part of the state Medicaid package for individuals with very severe physical disabilities, although each state determines its own criteria for nursing home admission. States also vary in the extent to which individuals with mental retardation and mental disease are served by Medicaid rather than state funding streams. Medicaid prohibits payments to institutions for mental disease for beneficiaries ages 21-64, but allows such payments for the elderly and children. While historically states were responsible for serving the long-term care needs of people with mental retardation and mental illness, states have leveraged Medicaid matching funds over the years to varying degrees in order to finance both institutional and community-based long-term care for these populations.[6]

A significant source of funding for community-based long-term care stems from Medicaid home and community-based service programs offered through Medicaid 1915(c) waivers, also known as HCBS programs. HCBS programs encompass three main programs: the mandatory home health benefit, optional 1915(c) HCBS waivers, and the optional state plan personal care services benefit.[7] All states have at least one HCBS waiver program, although states have chosen to target different populations and provide different service packages through these waivers. Services provided through HCBS programs can include many services not covered by a state's mandatory Medicaid package, including adult day care, group homes, and home modifications to support an individual with a disability living in the community. Expenditures for these

community-based programs grew 46% between 1999 and 2002, reaching $25.5 billion in 2002.[8] While substantial, spending on community-based long-term care still does not match spending on institutional care in Medicaid.

Medicaid long-term care policy is integrally dependent on the Medicare program, since a large share of Medicaid beneficiaries who use long-term care services in Medicaid are also covered by Medicare. Virtually all of the elderly covered by Medicaid are dually enrolled in Medicare, while about one-third of adults under 65 who are eligible for Medicaid through a disability classification are also covered by Medicare. Medicare covers most of the acute care services used by these dual eligibles. However, it does not cover many services considered to be for long-term care, instead covering only short stays in skilled nursing facilities, rehabilitation, and home health services associated with post-acute care. For a small share of duals, Medicaid only pays Medicare premiums and coinsurance but does not provide full Medicaid eligibility. Historically, Medicare did not cover prescription drugs except through HMOs that chose to cover drugs under the Medicare Plus Choice Program and most recently the Medicare Advantage Program. Recent Medicare Part D legislation now extends prescription drug coverage to all Medicare beneficiaries who enroll in a prescription drug program and shifts prescription drug coverage for dual eligibles into Medicare from Medicaid. These recent changes in federal policy have heightened debate about how states and the federal government will continue to share responsibility for financing health care services for dual eligibles, especially long-term care services.

Data Sources and Methods

The data used in this analysis come from the FFY 2002 Medicaid Statistical Information System (MSIS) Summary File maintained by the Centers for Medicare and Medicaid Services (CMS). The MSIS contains demographic, eligibility, and expenditure information for all Medicaid enrollees, with spending aggregated into over 30 types of services. Expenditures reported in MSIS do not include disproportionate share payments to providers, payments to Medicare, or administrative payments.

We designate all enrollees using the Basis of Eligibility in MSIS as elderly (age 65 and older), disabled under age 65, or other adults or other children not classified as disabled.[9] The disabled under age 65 are adults and children who have been classified as disabled for the purposes of Medicaid eligibility. Some children and adults classified in this paper as "other" may have disabilities but qualified for Medicaid through other eligibility routes. We further differentiate enrollees based on dual status. We exclude individuals in MSIS with unknown eligibility. Finally, we combine enrollees classified as disabled with enrollees eligible through all other pathways to describe the long-term care use of the full child and adult populations.

This analysis focuses on individuals who used long-term care services. Some individuals may use nursing home or home health care during short-term recovery or rehabilitation from an acute care episode. We sought to identify beneficiaries who used long-term care services on a long-term basis rather than as post-acute or respite care. To this end, we did not count individuals as long-term care users if their spending on long-term care services fell in the lowest decile of spending.[10] We divide long-term care beneficiaries into two types, those receiving institutional long-term care and those receiving community-based long-term care. To designate individuals as long-term care users in institutional settings, we identified enrollees who had spending greater than the 10th percentile for nursing facilities, ICF/MR, institutions for individuals with mental disease for those over 65, or inpatient psychiatric services for those 21 and under. Because the

populations residing in these institutions are virtually mutually exclusive of each other, and because average payments to each type of institution varies widely, this percentile threshold was determined separately for each institutional type. In addition, each percentile threshold was determined at the state-level in order to account for state differences in Medicaid packages, reliance on institutional care, and cost-of-living.

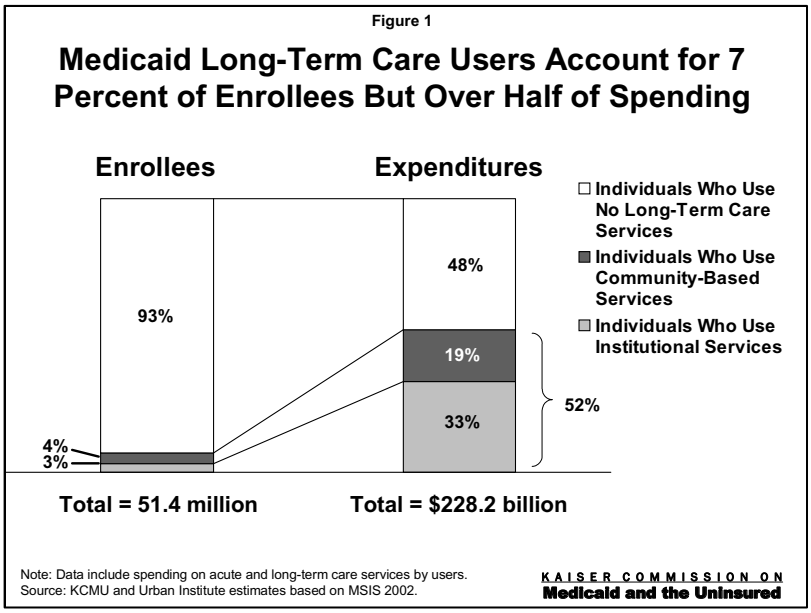
The same methodology was applied to designate individuals using community-based long-term care, and included enrollees who had spending greater than the 10th percentile for any of the services of home health, personal care, or HCBS, referred to here in combination as community-based services. Because recipients in the community typically draw on a variety of services, we determined this percentile based on total spending across these three service areas. From this community-based group we excluded any enrollees with spending greater than the 10th percentile on any institutional care service, so as not to double-count enrollees. Therefore, individuals that received institutional care for a portion of the year and community-based care for the rest of the year would be classified as receiving institutional long-term care. The remainder of the population we designated as not receiving any long-term care services, and included those who fell in the bottom 10th percentile for all types of long-term care service. As a result, this remainder does include some individuals who had some spending on long-term care services; however, this spending was negligible.[11]

In the text and tables where we refer to institutional services, we are referring to care provided in nursing homes, intermediate care facilities for the mentally retarded (ICF/MR), mental disease institutions for individuals age 65 and older, and inpatient psychiatric facilities for individuals age 21 and under. Community-based long-term care includes spending in the service categories of home health, personal attendant or personal care services, and HCBS. It should be noted that other services not designated here could be considered to be community-based long-term care, but are not counted as such for the purposes of this analysis because these services are not identifiable in the MSIS. For instance, adult day care can be used to support independent living, but payments to these providers cannot be identified in the MSIS. This particular service falls under the umbrella of HCBS and is captured as such. We expect that other services we cannot identify, such as durable medical equipment, are likely to be used in conjunction with one of the three services we use to identify long-term care users. As mentioned above, we analyze an individual's total spending in Medicaid, including acute services.

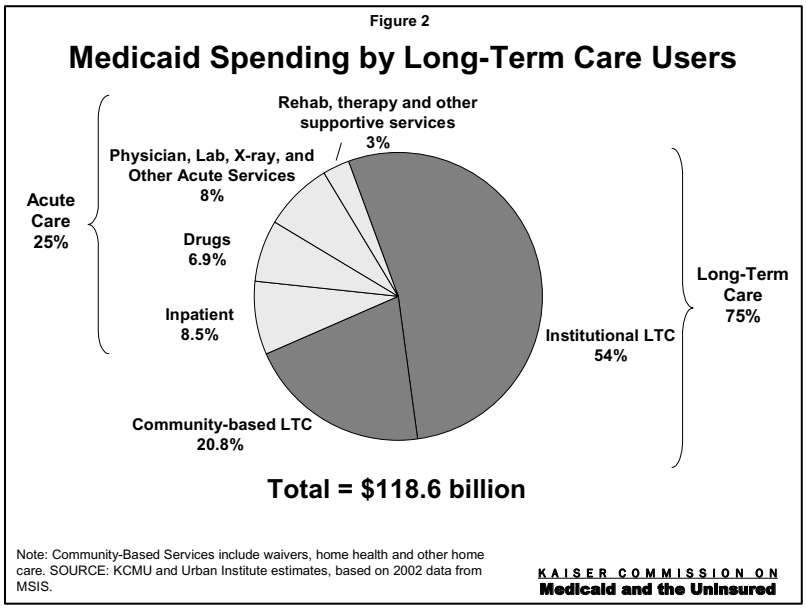
Total expenditures reported in MSIS for known beneficiaries fall short of the total aggregate Medicaid expenditures reported by states on the CMS-64 forms, in part because some payments to providers in Medicaid cannot be attributed to known beneficiaries.[12] We inflate expenditures in the MSIS up to CMS-64 reported totals by service category to better reflect total expenditures in Medicaid.[13]

Results

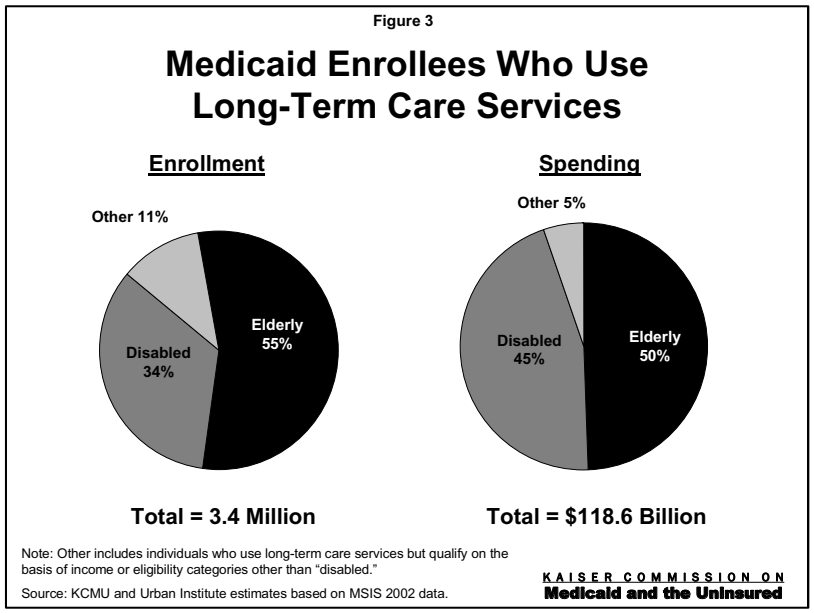
Medicaid beneficiaries who used long-term care services accounted for 7% of the entire Medicaid population and 52% of total spending in 2002 (Figure 1 and Table 1). Slightly greater numbers of Medicaid beneficiaries used community-based services, but beneficiaries who used institutional services accounted for a greater share of total spending (33% vs. 19%). The vast majority of Medicaid enrollees—93%—had little or no long-term care spending and accounted for less than half of total spending in Medicaid.



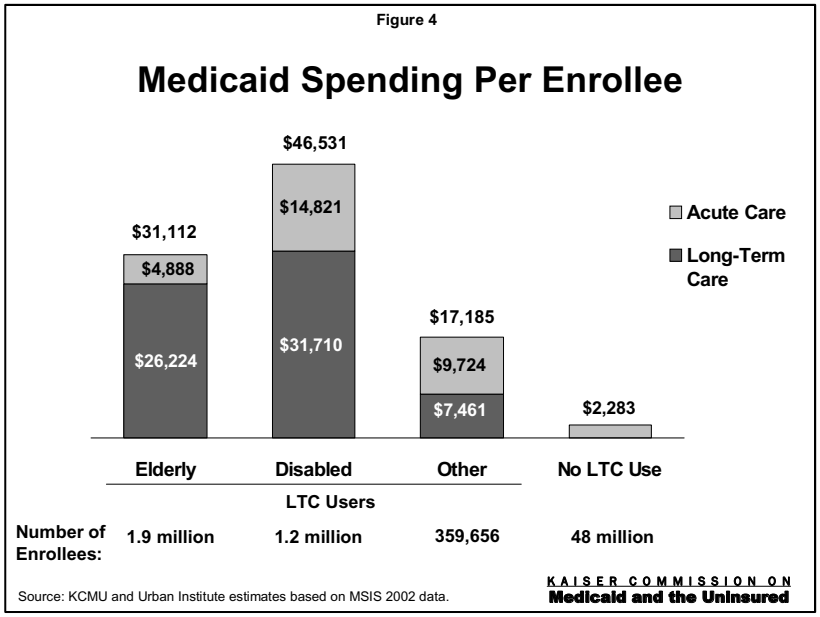
Individuals who relied on Medicaid for long-term care services also used a wide range of medical and other support services. Overall, long-term care services accounted for 75% of Medicaid spending on behalf of these individuals, with the majority going toward institutional services (Figure 2 and Table 2). The remaining 25% of Medicaid spending was devoted to acute care and other supportive services, such as inpatient hospital, prescription drugs, physician, rehabilitative and therapy services. The share of Medicaid spending that went toward acute and other supportive services was considerably higher for individuals using community-based services compared to those in institutions (44% vs. 14%).



Although most enrollees who use long-term care services qualify through elderly or disabled pathways, over 1 in 10 qualify for Medicaid on the basis of income or other eligibility category. The elderly comprised just over half (55%) of Medicaid enrollees who used long-term care services and half of Medicaid spending on these individuals (Figure 3 and Table 3). Individuals under age 65 classified as "disabled" accounted for just over a third of Medicaid enrollees who used long-term care services and 45% of spending. Adults and children who qualified for Medicaid on the basis of income or an eligibility category other than disability composed 11% of enrollees using long-term care services and 5% of spending.



Per enrollee spending varies substantially by whether an individual uses any long-term care services and on how they qualify for Medicaid. Among those using long-term care services, per enrollee spending was highest for the disabled ($46,531) followed by the elderly ($31,112) (Figure 4). Higher spending for the disabled was due primarily to greater spending on long-term care services, but also to higher levels of spending on acute and other supportive services. Medicaid per enrollee acute care spending on the elderly is lower than such spending on the disabled because a higher proportion of the elderly are duals and Medicare pays for most of their acute care services. Spending on the other enrollees who used long-term care services was lower, averaging $17,185. The population with little or no long-term care use incurs much lower spending. Average spending per enrollee for this group was $2,283.

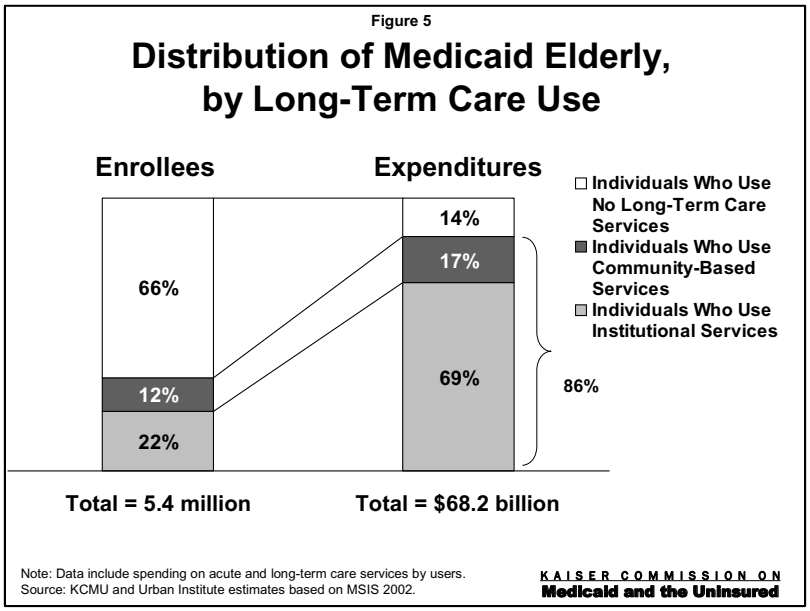


Examination of Spending by Population Group

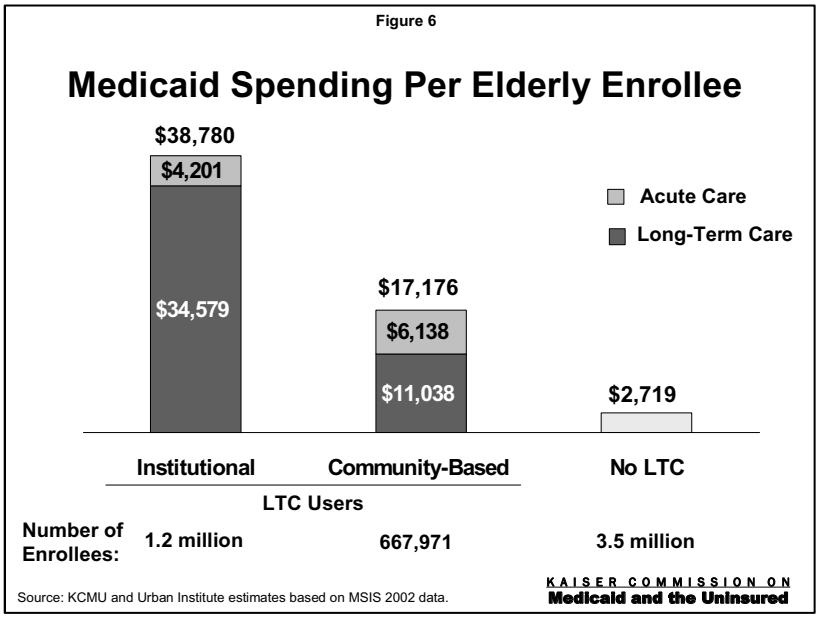
Medicaid spending patterns differ substantially by population group. These differences reflect a number of factors, including use of long-term care services and the balance between institutional and community-based care, how acute and other supportive services are used, and whether enrollees also have Medicare coverage. In this section, we examine spending for the following major groups: the elderly, the disabled (adults and children), dual eligibles, and all children (0-18) and all adults (19-64).

Elderly Enrollees

One-third of elderly Medicaid enrollees used long-term care services, but they accounted for 86% of total Medicaid spending on the elderly (Figure 5). Most (65%) of the elderly who used long-term care services relied on institutional care, predominantly nursing facilities. Reflecting the high cost of institutional care, nearly 70% of total Medicaid spending on the elderly went toward individuals who used institutional services. The elderly relying on community-based long-term care services accounted for a much smaller share of spending (17%). While those with no long-term care use accounted for two-thirds of elderly beneficiaries, they accounted for only 14% of spending.

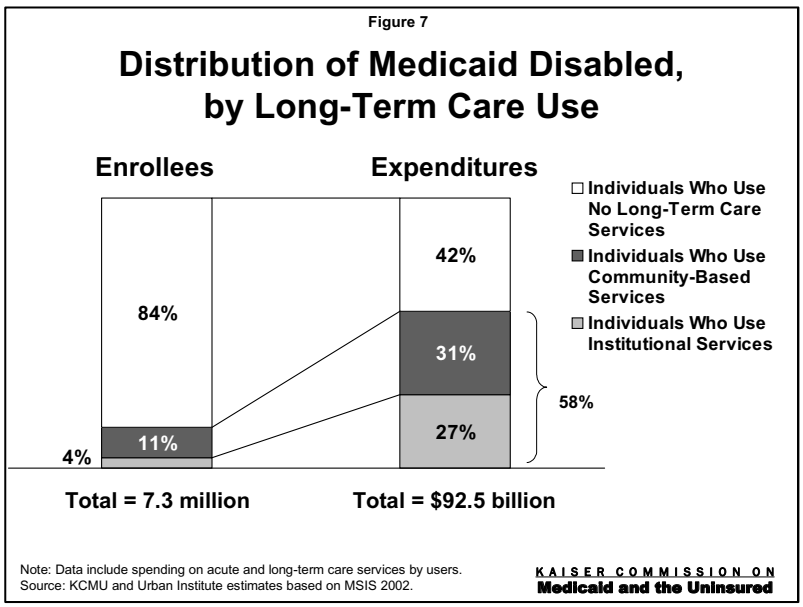


On a per enrollee basis, Medicaid spending for the elderly who used institutional services averaged about twice the level of spending for those using community-based services ($38,780 vs. $17,176) (Figure 6 and Table 4). Most of the spending by those with institutional care was for long-term care (89%), with the remainder going toward acute care, primarily prescription drugs and inpatient care. The distribution of spending for elderly enrollees using community based long-term care is quite different from those with institutional care. Average per enrollee spending for those in the community is lower for long-term care, but higher for acute care. Per enrollee spending on acute care services for those who used community-based long-term care services was about one third higher compared to those using institutional services ($6,138 vs. $4,201), reflecting greater use of inpatient care, prescription drugs, and other medical services by those in community settings. Medicaid per enrollee spending on elderly people who did not use long-term care services was considerably lower, averaging $2,719.

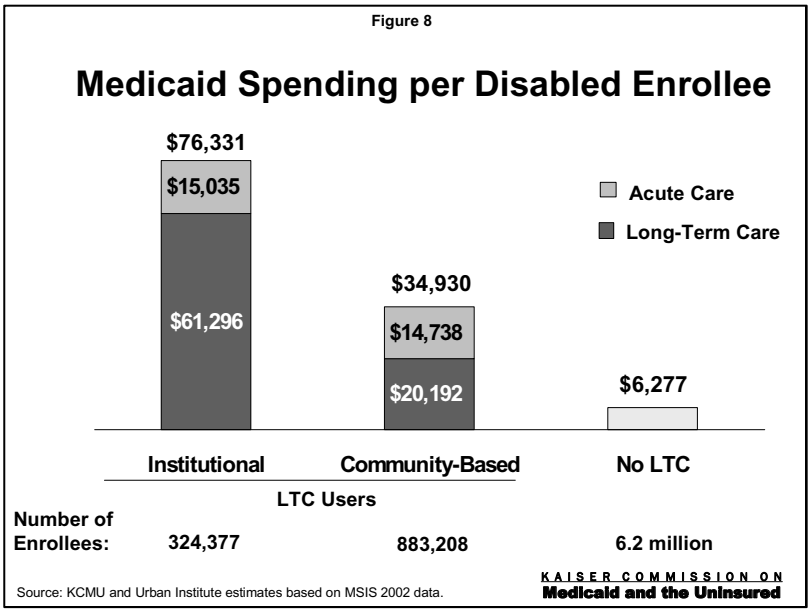


Disabled Enrollees

Fifteen percent of disabled Medicaid enrollees used long-term care services, accounting for 58% of total Medicaid spending on the disabled (Figure 7)**.** Among the disabled who used long-term care services, nearly three quarters (72%) relied on community-based services, while the remainder used institutional services. Just over half of Medicaid spending on the disabled who used long-term care services went toward those who received services in the community (Figure 7). The vast majority (84%) of disabled Medicaid beneficiaries used no long-term care services, but relied on Medicaid for an array of acute and other supportive services.



Medicaid per enrollee spending on the disabled who used community-based services was half the spending level for those in institutions ($34,930 vs. $76,331) (Figure 8 and Table 5). Spending on acute and other supportive services averaged about $15,000 per enrollee regardless of setting, but spending on long-term care services in the community was considerably lower than in institutions. Although relatively few disabled enrollees (324,377) used institutional services, per capita spending is substantial, reflecting their high level of service need. Over a third (37%) of these individuals resided in intermediate care facilities for the mentally retarded (ICF/MR) or in facilities providing inpatient psychiatric services (Table 6). Average spending per enrollee was almost twice as much for these residents ($104,583) as for nursing home residents ($59,499). Also, average spending for institutional services was much higher for these residents ($93,931) compared to nursing home residents ($39,122). The goal of ICF/MR facilities is to promote independence along a continuum of functional capacity by providing the residents with basic personal care needs but also with services that allow them to engage in and contribute to the community. Job coaching, education, self-help, and transportation are some of the services offered to residents of ICF/MR facilities to help them with "special care and services to achieve their potential."[14] In contrast, the elderly who were institutionalized overwhelmingly resided in nursing facilities and received help primarily with personal care and some rehabilitation services.

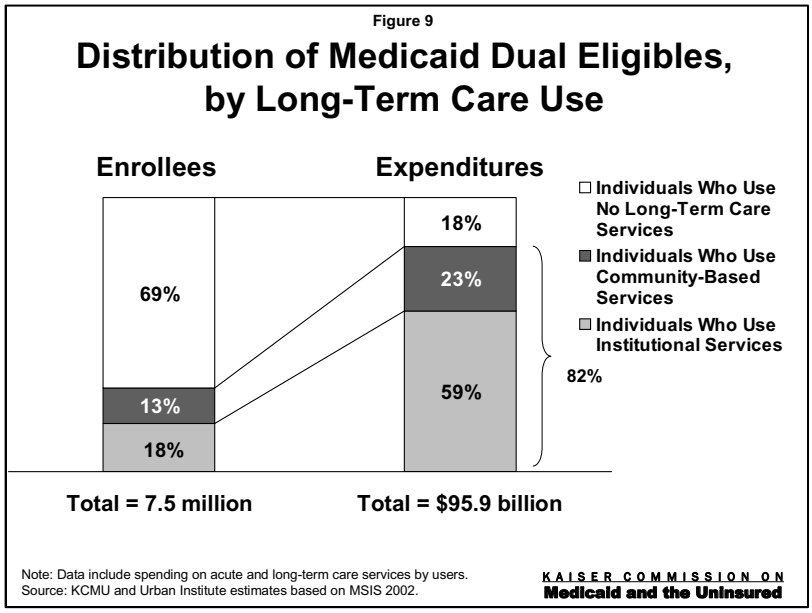


Compared to the elderly, disabled enrollees who used long-term care services are much more likely to rely on services in the community. Average per enrollee spending for the disabled is about two times higher compared to the elderly regardless of setting. Medicaid spending is higher for both long-term care spending and acute care spending. This is partly because the disabled population differs from the elderly with respect to the source of disabilities and nature of interventions, given their longer life expectancy. Another factor is that a majority of elderly enrollees are duals and have Medicare in addition to Medicaid, while most of the disabled are not duals.

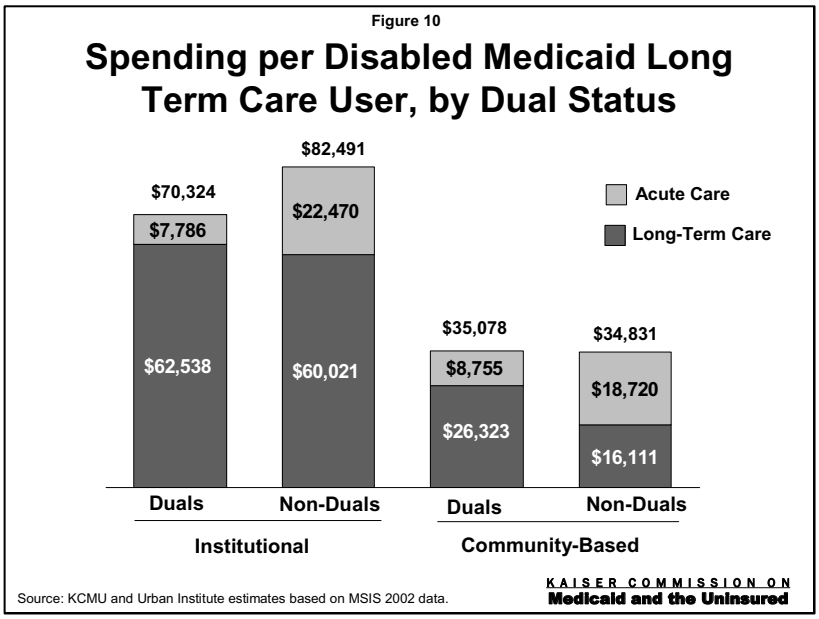
Dual Eligibles

Dual eligibles accounted for the majority (67%) of Medicaid enrollees who used long-term care services and a similar share of Medicaid spending on their behalf. Dual eligibles, or elderly and disabled individuals whose health care services are jointly covered by Medicare and Medicaid, exhibit very different Medicaid spending patterns in the long-term care population. Medicare covers primarily hospital and physician services, but few long-term care services. Medicaid fills in the gaps in Medicare's coverage providing payment for Medicare's financial obligations and uncovered services, most notably long-term care.

Thirty-one percent of Medicaid's dual eligible enrollees used long-term care services and comprised 82% of total Medicaid spending on dual eligibles (Figure 9 and Table 7). The vast majority (84%) of this spending was for long-term care services that are largely uncovered by Medicare. However, Medicaid also spent substantial amounts on acute care services, including prescription drugs, but also other medical and supportive services.



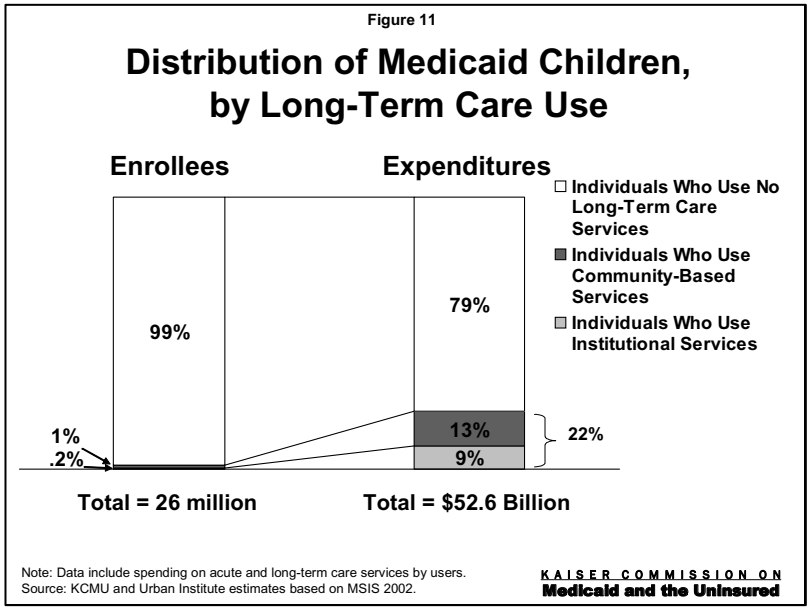
Most dual eligibles have lower acute care spending per enrollee in Medicaid than non-duals because Medicare provides coverage of acute care services. To illustrate this point, we examine difference in the non-elderly disabled population, since the elderly are almost all duals. Of all non-elderly disabled using long-term care services, 43% are dual eligibles and 57% are non-dual eligibles (these individuals may not qualify for Medicare or may be in the two year waiting period). Disabled duals with institutional care spent an average in Medicaid of $70,324 on all services, while non-duals spent $82,491 on average (Figure 10 and Table 8). Most of this difference is from payment for acute care services—duals spent an average of $7,786 on acute care services in Medicaid, while non-duals spent almost three times as much - $22,740. Disabled individuals with community based services showed similar differences by dual status. This difference does not mean that duals received fewer acute care services, but more likely reflects Medicare's coverage of some, but not all, of the costs of acute care services for dual eligibles.

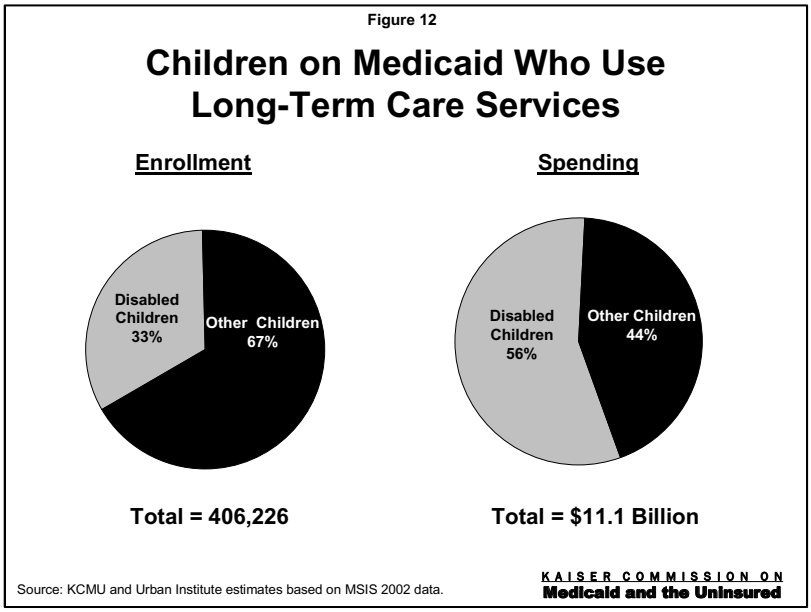


Next we combine enrollees classified as disabled with enrollees eligible through all other categories in order to describe the long-term care use of the full child (0-18) and adult (19-64) population.

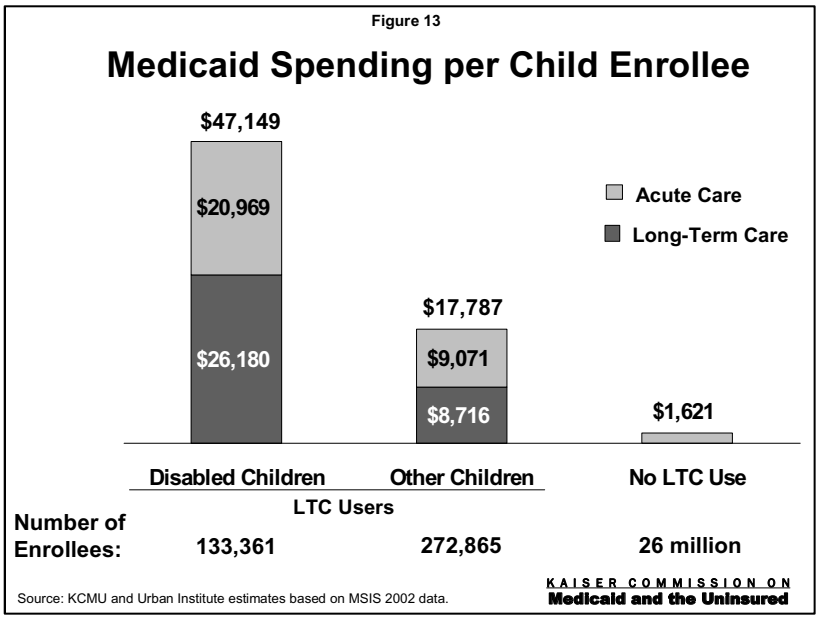
Children

Although only a small proportion (1%) of children who were covered by Medicaid used long-term care services, these approximately 406,000 children accounted for a disproportionate share (22%) of Medicaid spending on children (Figure 11). The majority (67%) of children who used long-term care services qualified through welfare-related cash assistance, poverty-related income routes, or other categories such as foster care assistance, rather than through "disabled" eligibility categories (Figure 12). Some of these children might meet disability classification requirements if assessed, but since eligibility requirements and income thresholds for children are typically higher compared to other enrollee groups, it is possible that some families choose not to pursue classification by disability. Children qualifying on the basis of other eligibility categories differ in a number of ways from children with a disability using long-term care. For instance, children in other categories are younger, with 75% under age 12 compared to 57% of disabled children (data not shown).



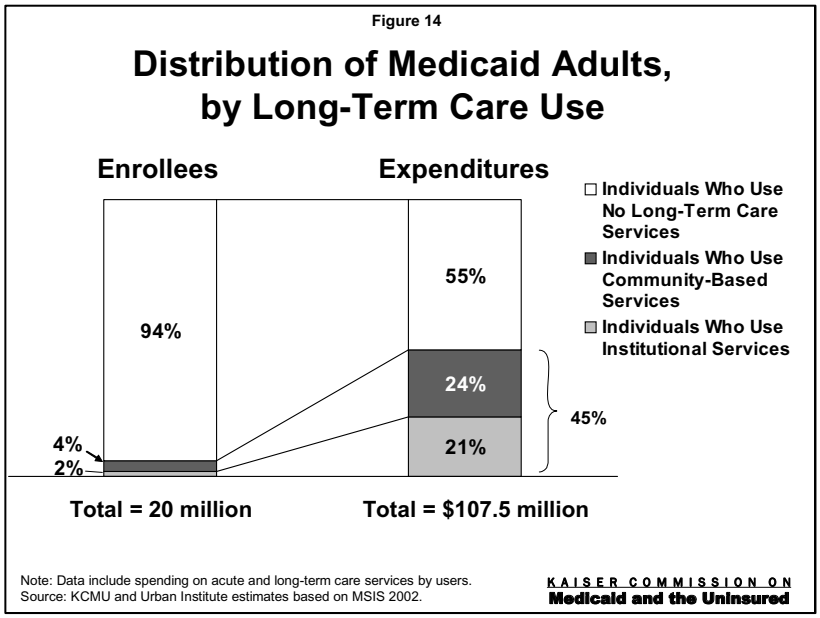


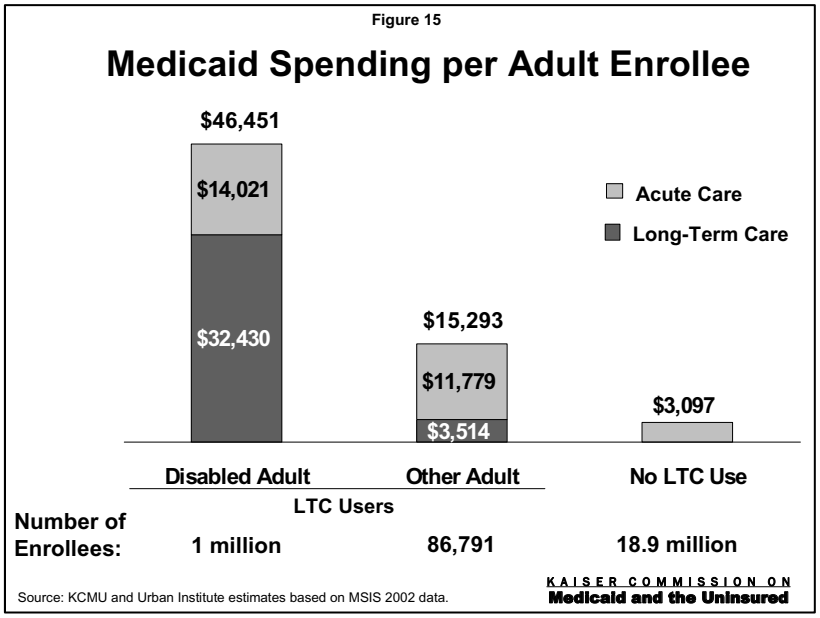
Per enrollee spending among children using long-term care services was higher for disabled children compared to children who qualified through other categories ($47,149 vs. $17,787) (Figure 13 and Tables 9a & 9b). Although about the same proportion of disabled and other children using long-term care relied on institutional care (15%) average spending for those with institutional care was much higher for disabled children. Similarly, average spending for children using community-based care was also much higher for disabled children. Finally, disabled children had higher average spending for acute care services than other children using long-term care services. Spending for both groups was considerably higher than for children who did not use any long-term care services and rely on Medicaid primarily for preventive and acute care services ($1,621).



Adults

Six percent of adults ages 19-64 in Medicaid used long-term care services, accounting for 45% of total Medicaid spending on adults (Figure 14). In contrast to children, most adults (92%) using long-term care services qualified on the basis of disability, reflecting Medicaid's exclusion of childless adults who are not disabled and low eligibility levels for parents. Average spending for adults who qualified for Medicaid on the basis of disability was higher ($46,451) than for adults who used long-term care services but qualified through other pathways ($15,293) (Figure 15 and Tables 10a & 10b). A far higher share of disabled adults with long-term care spending used institutional services (30%) compared to other adults (9%). Spending for adults who did not use long-term care services was much lower, averaging $3,097. Compared to children, adults who used long-term care services had higher average spending ($44,017 vs. $27,426) due to greater use of institutional care and higher spending on community-based long-term care services.





Policy Implications

Analysis of long-term care spending in Medicaid shows that a very small proportion of the Medicaid population, the 7 percent of enrollees who use long-term care services, accounts for just over one-half of all Medicaid spending. Long-term care users are a heterogeneous population who use a mix of long-term and acute services. Spending and enrollment patterns vary widely across different types of users of long-term care services. Enrollees under age 65 are more likely to use community-based long-term care services, while the elderly rely more heavily on institutional care. Among the disabled, people in ICF/MR facilities have the highest spending per enrollee, but these facilities serve a very broad array of services for people with mental retardation and serve a different function than nursing homes. Continued attention to serving individuals in the most appropriate setting should be a priority.

Medicaid enrollees who receive long-term care services in the community have lower overall per enrollee spending compared to their counterparts in institutional settings. That is not to say that enrollees residing in institutional settings would cost less if they were moved to the community, and for some portion of these residents, there may be no alternative to institutional care. However, it is also likely that some portion of the 374,000 Medicaid enrollees under age 65 and 1.2 million elderly served in institutions could be served in community settings if adequate services and supports were available. A comprehensive long-term care system includes a continuum of service settings, including institutional care, but investing in community-based long-term care resources should be a priority.

A small percentage of children use long-term services. However, children in Medicaid who use long-term services are a unique population whose health needs must be better understood in light of recent DRA-related Medicaid changes.[15] Most of these children are eligible for Medicaid through a route other than the disability classification, so reforms that place new restrictions on benefits for non-disabled children may place unique burdens on this population, either by eliminating access to potentially critical services, or placing especially high cost-sharing burdens on families with long-term care needs for their children. Similar concerns are raised for the smaller number of adults who are not classified as disabled but who require long-term care services.

Adults and children who use no long-term care services—and most adults and children do not—represent the lowest cost groups in Medicaid. Nonetheless, some reforms under current consideration and being implemented at the state level have focused on capping expenditures or limiting benefits for the non-disabled as a means to reign in costs. Due to this group's low average cost and the low share of spending in Medicaid attributable to this group, sizable administrative outlays to restructure the Medicaid program based on expenditure patterns and enrollment behavior of the non-disabled may yield marginal and short-term returns based primarily on new barriers to access.

Similarly, most disabled and elderly enrollees use no long-term care services, and average spending for these groups is substantially lower than average spending for their counterparts who use long-term care services. This finding may run counter to expectations, given that the elderly and disabled are typically singled out as groups with high average spending. In fact, both the elderly and disabled populations show substantial distributions in spending and represent heterogeneous populations with respect to the need for health care services. Targeting high costs long-term care users for cost savings needs to be balanced against the significant health and

long-term care needs of this population to ensure that quality and access to care are not undermined.

Finally, about one-third of all Medicaid dollars are spent on dual eligible beneficiaries who are eligible for Medicare, but need Medicaid-financed acute and long-term care services to fill in Medicare's gaps. Prescription drug coverage has now been shifted from Medicaid to Medicare, but Medicaid spending for long-term care and other acute care services remains substantial. Continued policy discussion of the relative roles of Medicaid and Medicare covering acute and long-term care services for dual eligibles is warranted. These enrollees account for two-thirds of Medicaid spending on enrollees who use long-term care services. As a result, this population will continue to be a focus of cost containment and innovative care models in the Medicaid program. The MSIS data does not allow us to estimate total spending by the dual eligibles across programs because we cannot account for their spending in Medicare. This limitation is common in available databases and reflects a silo approach to program administration that leads to fragmentation of care and data collection for these constituents, compromising evaluation of care systems. New databases should seek to integrate spending and service utilization data across programs to support research and evaluation from a population perspective rather than a programmatic perspective.

The authors would like to acknowledge the helpful feedback received from Diane Rowland, Barbara Lyons and David Rousseau of the KCMU, and John Holahan of The Urban Institute on multiple revisions, and Dawn Miller for her research assistance.

Endnotes

[1] Calculations based on KCMU Issue Brief, March 2005, using 2003 data and CMS Historical National Health Expenditure Data, 2003.
[2] Calculations based on CMS-64 Medicaid Expenditure Forms, 2004, excluding disproportionate share payments (DSH) and accounting adjustments. Including DSH, the percentage is 34 percent.
[3] Based on 2003 data. KCMU Issue Brief. "Medicaid and Long-Term Care". March 2005
[4] Feder, Judith. June 2005. "Long-Term Care and Medicaid: The Critical Role of Public Financing." Washington, DC: Center for American Progress.
[5] KCMU Issue Paper. July 2005. "Medicaid 1915(c) Home and Community-Based Service Programs: Data Update."
[6] Vladeck, Bruce C. "Where the Action Really Is: Medicaid and the Disabled." Health Affairs, January/February 2003,Vol. 22, No. 1, pp. 90-100.
[7] KCMU Issue Paper, July 2005.
[8] KCMU Issue Paper, July 2005.
[9] We reclassify some individuals eligible as "disabled under 65" into the "elderly" category and visa versa based on date of birth to align these categories with their titled age groups.
[10] We also evaluated the 20th percentile but did not find notable differences in spending or enrollment patterns. For example, using the 20th percentile as a cutoff point, total institutionalized enrollment decreases from 1,588,454 to 1425,508. They still account for 3% of all enrollees. Additionally, spending decreased from $74.6 billion to $72.1 billion, and the percentage of total spending went from 33% to 32%.
[11] Some of these individuals may have died or begun to use long-term care services at the end of the fiscal year. To this extent, we may not capture all users of long-term care we sought to identify for the purposes of this analysis.
[12] About $22 billion dollars in expenditures reported in the MSIS cannot be attributed to beneficiaries with known eligibility. CMS-64 reports also include payments to providers in excess of actual costs of medical services for Medicaid beneficiaries, which are not reported in MSIS.
[13] Some expenditure lines in CMS-64 do not have comparable service categories in MSIS, or are not reported separately in MSIS. We group some services in MSIS to better align totals to comparable groups in CMS-64. MSIS does not account for prescription drug "offsets," or rebates that are reported on the CMS-64. To account for this savings, we inflate prescription service expenditures in the MSIS up to prescription drug expenditures reported on the CMS-64 minus offsets.
[14] Congressional Research Service. January 1993. Medicaid Source Book: Background Data and Analysis.
[15] KCMU Issue Brief, March 2006, "Deficit Reduction Act of 2005: Implications for Medicaid" http://www.kff.org/medicaid/7465.cfm

Table 1
Enrollment and Spending of Medicaid Enrollees by Long-Term Care Status, 2002

Enrollee Type	Enrollees	Percent of Enrollees	Total Medicaid Spending (in millions)	Percent of Spending
Medicaid Enrollees	**51,419,754**	**100%**	**$228,238**	**100%**
Enrollees with Institutional Care	1,588,454	3%	$74,607	33%
Enrollees with Community-Based Care	1,810,873	4%	$43,993	19%
Enrollees with No Long-Term Care	48,020,427	93%	$109,637	48%

Source: Urban Institute estimates based on MSIS 2002 data

Table 2
Spending and Enrollment for ALL Medicaid Enrollees with Long Term Care by Setting, 2002

All Enrollees with LTC	Total Spending (in millions)	Percent of Spending	Spending Per Enrollee
Enrollment	*3,399,327*		
Total Spending	$118,601	100%	$34,889
Long-Term Care	$88,746	75%	$26,107
Inpatient	$10,134	9%	$2,981
Drugs	$8,194	7%	$2,410
Physician/ Lab-Xray	$1,893	2%	$557
Outpatient/ Clinic	$3,287	3%	$967
Rehab and Therapy	$804	1%	$236
Other Supportive Services	$2,107	2%	$620
Other Acute	$3,436	3%	$1,011

Institutionalized Enrollees	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*1,588,454*		
Total Spending	$74,607	100%	$46,969
Long-Term Care	$64,068	86%	$40,333
Inpatient	$3,367	5%	$2,120
Drugs	$3,722	5%	$2,343
Physician/ Lab-Xray	$547	1%	$344
Outpatient/ Clinic	$930	1%	$585
Rehab and Therapy	$245	0%	$154
Other Supportive Services	$730	1%	$460
Other Acute	$1,000	1%	$629

Community-based Enrollees	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*1,810,873*		
Total Spending	$43,993	100%	$24,294
Long-Term Care	$24,678	56%	$13,628
Inpatient	$6,767	15%	$3,737
Drugs	$4,472	10%	$2,470
Physician/ Lab-Xray	$1,346	3%	$743
Outpatient/ Clinic	$2,357	5%	$1,302
Rehab and Therapy	$559	1%	$309
Other Supportive Services	$1,378	3%	$761
Other Acute	$2,437	6%	$1,346

Source: Urban Institute estimates based on MSIS 2002 data

Table 3
Enrollment and Spending for Medicaid Enrollees with Long-Term Care Services, 2002

All Long-Term Care Users in Medicaid	Enrollment	Percent of Enrollees	Total Medicaid Spending (in millions)	Spending Per Enrollee
Elderly	1,882,086	55%	$58,556	$31,112
Disabled	1,157,585	34%	$53,864	$46,531
Other Adults and Children*	359,656	11%	$6,181	$17,185
Total	**3,399,327**	**100%**	**$118,601**	**$34,889**

Source: Urban Institute estimates based on MSIS 2002 data
* "Other" includes individuals who qualified for Medicaid through a pathway not related to disability

Table 4
Spending and Enrollment for Elderly Medicaid Enrollees with Long Term Care, 2002

All Elderly with LTC	Total Spending (in millions)	Percent of Spending	Spending Per Enrollee
Enrollment	*1,882,086*		
Total Spending	$58,556	100%	$31,112
Long-Term Care	$49,356	84%	$26,224
Inpatient	$1,926	3%	$1,023
Drugs	$4,137	7%	$2,198
Physician/ Lab-Xray	$422	1%	$224
Outpatient/ Clinic	$624	1%	$332
Rehab and Therapy	$141	0%	$75
Other Supportive Services	$662	1%	$352
Other Acute	$1,289	2%	$685

Institutionalized Elderly	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*1,214,115*		
Total Spending	$47,083	100%	$38,780
Long-Term Care	$41,982	89%	$34,579
Inpatient	$1,060	2%	$873
Drugs	$2,575	5%	$2,121
Physician/ Lab-Xray	$207	0%	$170
Outpatient/ Clinic	$258	1%	$213
Rehab and Therapy	$35	0%	$29
Other Supportive Services	$469	1%	$386
Other Acute	$498	1%	$410

Community-based Elderly	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*667,971*		
Total Spending	$11,473	100%	$17,176
Long-Term Care	$7,373	64%	$11,038
Inpatient	$866	8%	$1,297
Drugs	$1,562	14%	$2,339
Physician/ Lab-Xray	$215	2%	$322
Outpatient/ Clinic	$366	3%	$548
Rehab and Therapy	$107	1%	$160
Other Supportive Services	$193	2%	$289
Other Acute	$791	7%	$1,184

Source: Urban Institute estimates based on MSIS 2002 data

Table 5
Spending and Enrollment for All Disabled Medicaid Enrollees with Long Term Care, 2002

All Disabled with LTC	Total Spending (in millions)	Percent of Spending	Spending Per Enrollee
Enrollment	*1,157,585*		
Total Spending	$53,864	100%	$46,531
Long-Term Care	$36,707	68%	$31,710
Inpatient	$6,346	12%	$5,482
Drugs	$3,735	7%	$3,226
Physician/ Lab-Xray	$1,127	2%	$973
Outpatient/ Clinic	$2,285	4%	$1,974
Rehab and Therapy	$557	1%	$481
Other Supportive Services	$1,299	2%	$1,122
Other Acute	$1,809	3%	$1,563

Institutionalized Disabled	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*324,377*		
Total Spending	$24,760	100%	$76,331
Long-Term Care	$19,883	80%	$61,296
Inpatient	$2,140	9%	$6,597
Drugs	$1,081	4%	$3,332
Physician/ Lab-Xray	$296	1%	$912
Outpatient/ Clinic	$582	2%	$1,793
Rehab and Therapy	$164	1%	$505
Other Supportive Services	$224	1%	$691
Other Acute	$391	2%	$1,205

Community-based Disabled	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*833,208*		
Total Spending	$29,104	100%	$34,930
Long-Term Care	$16,824	58%	$20,192
Inpatient	$4,207	14%	$5,049
Drugs	$2,654	9%	$3,185
Physician/ Lab-Xray	$831	3%	$997
Outpatient/ Clinic	$1,703	6%	$2,044
Rehab and Therapy	$393	1%	$472
Other Supportive Services	$1,075	4%	$1,290
Other Acute	$1,418	5%	$1,702

Source: Urban Institute estimates based on MSIS 2002 data

Table 6
Disabled Medicaid Enrollees with Institutional Care:
Enrollment and Spending by Type of Institution, 2002

		Type of Institution	
All Disabled Enrollees with Institutional Care	**Total**	**Nursing Facility**	**Other Facility***
Enrollment	324,377	203,271	121,106
Percent of All Disabled Institutionalized Enrollment	100%	63%	37%
Spending for All Services in Medicaid (in millions)	$24,760	$12,094	$12,666
Spending per Enrollee for All Services	$76,331	$59,499	$104,583
Spending for Institutional Care (in millions)	$19,328	$7,952	$11,376
Institutional Care as Percent of Total Spending	78%	66%	90%
Spending per Enrollee for Institutional Services	$59,585	$39,122	$93,931

Source: Urban Institute estimates based on MSIS 2002 data

* Includes intermediate care facilities for people with mental retardation (ICF/MR) and facilities providing inpatient psychiatric services to children. Most of these enrollees are in ICF/MR facilities.

Table 7
Spending and Enrollment for All Dually-Eligible Medicaid Enrollees with Long Term Care by Setting, 2002

All Duals with LTC	Total Spending (in millions)	Percent of Spending	Spending Per Enrollee
Enrollment	*2,276,049*		
Total Spending	$78,573	100%	$34,522
Long-Term Care	$66,190	84%	$29,081
Inpatient	$1,874	2%	$823
Drugs	$5,640	7%	$2,478
Physician/ Lab-Xray	$496	1%	$218
Outpatient/ Clinic	$1,233	2%	$542
Rehab and Therapy	$307	0%	$135
Other Supportive Services	$1,054	1%	$463
Other Acute	$1,780	2%	$782

Institutionalized Duals	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*1,314,958*		
Total Spending	$56,271	100%	$42,793
Long-Term Care	$50,391	90%	$38,322
Inpatient	$989	2%	$752
Drugs	$2,999	5%	$2,281
Physician/ Lab-Xray	$223	0%	$170
Outpatient/ Clinic	$429	1%	$326
Rehab and Therapy	$103	0%	$78
Other Supportive Services	$519	1%	$395
Other Acute	$618	1%	$470

Community-based Duals	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*961,091*		
Total Spending	$22,302	100%	$23,205
Long-Term Care	$15,798	71%	$16,438
Inpatient	$885	4%	$921
Drugs	$2,641	12%	$2,747
Physician/ Lab-Xray	$273	1%	$284
Outpatient/ Clinic	$804	4%	$837
Rehab and Therapy	$205	1%	$213
Other Supportive Services	$535	2%	$556
Other Acute	$1,162	5%	$1,209

Source: Urban Institute estimates based on MSIS 2002 data

Table 8
Spending and Enrollment for Disabled Medicaid Enrollees with LTC Use by Dual Status, 2002

Disabled Dual			
Institutionalized Disabled	**Total Spending (in millions)**	**Percent of Spending**	**Spending Per Enrollee**
Enrollment	*164,229*		
Total Spending	$11,549	100%	$70,324
Long-Term Care Spending	$10,271	89%	$62,538
Acute Care Spending	$1,279	11%	$7,786
Community-based Disabled			
Enrollment	*332,959*		
Total Spending	$11,680	100%	$35,078
Long-Term Care Spending	$8,765	75%	$26,323
Acute Care Spending	$2,915	25%	$8,755

Disabled Non-Dual			
Institutionalized Disabled	**Total Spending (in millions)**	**Percent of Spending**	**Spending Per Enrollee**
Enrollment	*160,148*		
Total Spending	$13,211	100%	$82,491
Long-Term Care Spending	$9,612	73%	$60,021
Acute Care Spending	$3,599	27%	$22,470
Community-based Disabled			
Enrollment	*500,249*		
Total Spending	$17,424	100%	$34,831
Long-Term Care Spending	$8,059	46%	$16,111
Acute Care Spending	$9,365	54%	$18,720

Source: Urban Institute estimates based on MSIS 2002 data

Table 9
Spending and Enrollment for ALL Child (Disabled and Other) Medicaid Enrollees with Long Term Care, 2002

All Children with LTC (Disabled and Other)	Total Spending (in millions)	Percent of Spending	Spending Per Enrollee
Enrollment	*406,226*		
Total Spending	$11,141	100%	$27,426
Long-Term Care	$5,870	53%	$14,449
Inpatient	$2,358	21%	$5,804
Drugs	$521	5%	$1,282
Physician/ Lab-Xray	$414	4%	$1,019
Outpatient/ Clinic	$507	5%	$1,249
Rehab and Therapy	$294	3%	$725
Other Supportive Services	$514	5%	$1,266
Other Acute	$663	6%	$1,633

Institutionalized Children	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*63,871*		
Total Spending	$4,496	100%	$70,385
Long-Term Care	$3,682	82%	$57,642
Inpatient	$200	4%	$3,135
Drugs	$102	2%	$1,591
Physician/ Lab-Xray	$59	1%	$930
Outpatient/ Clinic	$131	3%	$2,057
Rehab and Therapy	$73	2%	$1,141
Other Supportive Services	$59	1%	$931
Other Acute	$189	4%	$2,958

Community-based Children	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*342,355*		
Total Spending	$6,646	100%	$19,411
Long-Term Care	$2,188	33%	$6,391
Inpatient	$2,157	32%	$6,302
Drugs	$419	6%	$1,225
Physician/ Lab-Xray	$355	5%	$1,036
Outpatient/ Clinic	$376	6%	$1,098
Rehab and Therapy	$222	3%	$647
Other Supportive Services	$455	7%	$1,328
Other Acute	$474	7%	$1,385

Source: Urban Institute estimates based on MSIS 2002 data

Table 9a
Spending and Enrollment for Disabled CHILD (0-18) Medicaid Enrollees with Long Term Care, 2002

All Disabled CHILDREN with LTC	Total Spending (in millions)	Percent of Spending	Spending Per Enrollee
Enrollment	*133,361*		
Total Spending	$6,288	100%	$47,149
Long-Term Care	$3,491	56%	$26,180
Inpatient	$1,072	17%	$8,038
Drugs	$306	5%	$2,298
Physician/ Lab-Xray	$178	3%	$1,333
Outpatient/ Clinic	$265	4%	$1,989
Rehab and Therapy	$196	3%	$1,470
Other Supportive Services	$382	6%	$2,865
Other Acute	$397	6%	$2,977

Institutionalized Children	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*21,860*		
Total Spending	$2,046	100%	$93,616
Long-Term Care	$1,671	82%	$76,435
Inpatient	$108	5%	$4,954
Drugs	$48	2%	$2,185
Physician/ Lab-Xray	$23	1%	$1,065
Outpatient/ Clinic	$55	3%	$2,531
Rehab and Therapy	$29	1%	$1,317
Other Supportive Services	$25	1%	$1,155
Other Acute	$87	4%	$3,974

Community-based Children	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*111,501*		
Total Spending	$4,241	100%	$38,039
Long-Term Care	$1,820	43%	$16,327
Inpatient	$964	23%	$8,642
Drugs	$259	6%	$2,320
Physician/ Lab-Xray	$154	4%	$1,385
Outpatient/ Clinic	$210	5%	$1,883
Rehab and Therapy	$167	4%	$1,500
Other Supportive Services	$357	8%	$3,200
Other Acute	$310	7%	$2,781

Source: Urban Institute estimates based on MSIS 2002 data

Table 9b
Spending and Enrollment for Child (0-18) Medicaid Enrollees Eligible through Categories Other than Disability with Long Term Care, 2002

All Other Children with LTC	Total Spending (in millions)	Percent of Spending	Spending Per Enrollee
Enrollment	*272,865*		
Total Spending	$4,853	100%	$17,787
Long-Term Care	$2,378	49%	$8,716
Inpatient	$1,286	26%	$4,712
Drugs	$214	4%	$786
Physician/ Lab-Xray	$236	5%	$866
Outpatient/ Clinic	$242	5%	$887
Rehab and Therapy	$98	2%	$361
Other Supportive Services	$132	3%	$484
Other Acute	$266	5%	$976

Institutionalized Children	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*42,011*		
Total Spending	$2,449	100%	$58,298
Long-Term Care	$2,011	82%	$47,863
Inpatient	$92	4%	$2,189
Drugs	$54	2%	$1,282
Physician/ Lab-Xray	$36	1%	$859
Outpatient/ Clinic	$76	3%	$1,811
Rehab and Therapy	$44	2%	$1,049
Other Supportive Services	$34	1%	$815
Other Acute	$102	4%	$2,429

Community-based Children	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*230,854*		
Total Spending	$2,404	100%	$10,414
Long-Term Care	$367	15%	$1,592
Inpatient	$1,194	50%	$5,171
Drugs	$161	7%	$695
Physician/ Lab-Xray	$200	8%	$867
Outpatient/ Clinic	$166	7%	$719
Rehab and Therapy	$54	2%	$235
Other Supportive Services	$98	4%	$424
Other Acute	$164	7%	$711

Source: Urban Institute estimates based on MSIS 2002 data

Table 10
Spending and Enrollment for ALL Adult (Disabled and Other) Medicaid Enrollees with Long Term Care, 2002

All Adults with LTC (Disabled and Other)	Total Spending (in millions)	Percent of Spending	Spending Per Enrollee
Enrollment	*1,111,015*		
Total Spending	$48,903	100%	$44,017
Long-Term Care	$33,521	69%	$30,171
Inpatient	$5,851	12%	$5,266
Drugs	$3,536	7%	$3,182
Physician/ Lab-Xray	$1,057	Ta	$951
Outpatient/ Clinic	$2,155	4%	$1,940
Rehab and Therapy	$368	1%	$331
Other Supportive Services	$931	2%	$838
Other Acute	$1,485	3%	$1,336

Institutionalized Adults	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*310,468*		
Total Spending	$23,029	100%	$74,174
Long-Term Care	$18,404	80%	$59,277
Inpatient	$2,108	9%	$6,788
Drugs	$1,045	5%	$3,366
Physician/ Lab-Xray	$281	1%	$904
Outpatient/ Clinic	$540	2%	$1,739
Rehab and Therapy	$137	1%	$442
Other Supportive Services	$201	1%	$648
Other Acute	$313	1%	$1,009

Community-based Adults	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*800,547*		
Total Spending	$25,875	100%	$32,321
Long-Term Care	$15,117	58%	$18,883
Inpatient	$3,744	14%	$4,676
Drugs	$2,491	10%	$3,111
Physician/ Lab-Xray	$776	3%	$970
Outpatient/ Clinic	$1,616	6%	$2,018
Rehab and Therapy	$231	1%	$288
Other Supportive Services	$730	3%	$912
Other Acute	$1,171	5%	$1,463

Source: Urban Institute estimates based on MSIS 2002 data

Table 10a
Spending and Enrollment for Disabled ADULT (19-64) Medicaid Enrollees with Long Term Care, 2002

All Disabled ADULTS with LTC	Total Spending (in millions)	Percent of Spending	Spending Per Enrollee
Enrollment	*1,024,224*		
Total Spending	$47,576	100%	$46,451
Long-Term Care	$33,216	70%	$32,430
Inpatient	$5,275	11%	$5,150
Drugs	$3,428	7%	$3,347
Physician/ Lab-Xray	$949	2%	$926
Outpatient/ Clinic	$2,019	4%	$1,972
Rehab and Therapy	$361	1%	$352
Other Supportive Services	$917	2%	$895
Other Acute	$1,412	3%	$1,378

Institutionalized Adults	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*302,517*		
Total Spending	$22,714	100%	$75,082
Long-Term Care	$18,212	80%	$60,202
Inpatient	$2,032	9%	$6,715
Drugs	$1,033	5%	$3,415
Physician/ Lab-Xray	$273	1%	$901
Outpatient/ Clinic	$526	2%	$1,740
Rehab and Therapy	$135	1%	$446
Other Supportive Services	$199	1%	$657
Other Acute	$304	1%	$1,005

Community-based Adults	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*721,707*		
Total Spending	$24,862	100%	$34,450
Long-Term Care	$15,004	60%	$20,789
Inpatient	$3,243	13%	$4,493
Drugs	$2,395	10%	$3,319
Physician/ Lab-Xray	$676	3%	$937
Outpatient/ Clinic	$1,493	6%	$2,069
Rehab and Therapy	$226	1%	$313
Other Supportive Services	$718	3%	$995
Other Acute	$1,108	4%	$1,535

Source: Urban Institute estimates based on MSIS 2002 data

Table 10b
Spending and Enrollment for Adult (19-64) Medicaid Enrollees Eligible through Categories Other than Disability with Long Term Care, 2002

All Adults with LTC Other than Disabled	Total Spending (in millions)	Percent of Spending	Spending Per Enrollee
Enrollment	*86,791*		
Total Spending	$1,327	100%	$15,293
Long-Term Care	$305	23%	$3,514
Inpatient	$577	43%	$6,643
Drugs	$107	8%	$1,237
Physician/ Lab-Xray	$108	8%	$1,245
Outpatient/ Clinic	$136	10%	$1,569
Rehab and Therapy	$07	1%	$82
Other Supportive Services	$14	1%	$165
Other Acute	$73	5%	$838

Institutionalized Adults	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*7,951*		
Total Spending	$315	100%	$39,618
Long-Term Care	$192	61%	$24,117
Inpatient	$76	24%	$9,562
Drugs	$12	4%	$1,509
Physician/ Lab-Xray	$8	3%	$991
Outpatient/ Clinic	$14	4%	$1,708
Rehab and Therapy	$2	1%	$273
Other Supportive Services	$2	1%	$304
Other Acute	$9	3%	$1,154

Community-based Adults	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*78,840*		
Total Spending	$1,012	100%	$12,840
Long-Term Care	$113	11%	$1,436
Inpatient	$501	49%	$6,349
Drugs	$95	9%	$1,209
Physician/ Lab-Xray	$100	10%	$1,271
Outpatient/ Clinic	$123	12%	$1,555
Rehab and Therapy	$5	0%	$62
Other Supportive Services	$12	1%	$151
Other Acute	$64	6%	$806

Source: Urban Institute estimates based on MSIS 2002 data

Table 11
Spending and Enrollment for ALL (Adult and Child) Medicaid Enrollees Eligible through Categories Other than Disability with Long Term Care, 2002

All Other Adults and Children with LTC	Total Spending (in millions)	Percent of Spending	Spending Per Enrollee
Enrollment	*359,656*		
Total Spending	$6,181	100%	$17,185
Long-Term Care	$2,683	43%	$7,461
Inpatient	$1,862	30%	$5,178
Drugs	$322	5%	$895
Physician/ Lab-Xray	$344	6%	$957
Outpatient/ Clinic	$378	6%	$1,052
Rehab and Therapy	$105	2%	$293
Other Supportive Services	$146	2%	$407
Other Acute	$339	5%	$942

Institutionalized Adults and Children	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*49,962*		
Total Spending	$2,764	100%	$55,325
Long-Term Care	$2,203	80%	$44,084
Inpatient	$168	6%	$3,363
Drugs	$66	2%	$1,318
Physician/ Lab-Xray	$44	2%	$880
Outpatient/ Clinic	$90	3%	$1,795
Rehab and Therapy	$46	2%	$925
Other Supportive Services	$37	1%	$733
Other Acute	$111	4%	$2,226

Community-based Adults and Children	Total Spending	Percent of Spending	Spending Per Enrollee
Enrollment	*309,694*		
Total Spending	$3,417	100%	$11,032
Long-Term Care	$481	14%	$1,552
Inpatient	$1,694	50%	$5,471
Drugs	$256	7%	$826
Physician/ Lab-Xray	$300	9%	$970
Outpatient/ Clinic	$289	8%	$932
Rehab and Therapy	$59	2%	$191
Other Supportive Services	$110	3%	$354
Other Acute	$228	7%	$735

Source: Urban Institute estimates based on MSIS 2002 data

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.