kaiser commission on medicaid and the uninsured

MEDICAID FACTS

THE HENRY J. KAISER FAMILY FOUNDATION

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MEDICAID'S ROLE IN LONG-TERM CARE

As the nation's long-term care safety-net, Medicaid is the major source of financing for long-term care for the elderly and for nonelderly persons with disabilities. Medicaid provides critical assistance for people with long-term care needs in the community and nursing homes, covering services often excluded from private insurance and Medicare. However, Medicaid's long-term care protections are focused on the low-income and are limited in reach. Consequently, many people with long-term care needs, and their informal caregivers—spouses, family, and friends—often bear substantial out-of-pocket costs and burdens.

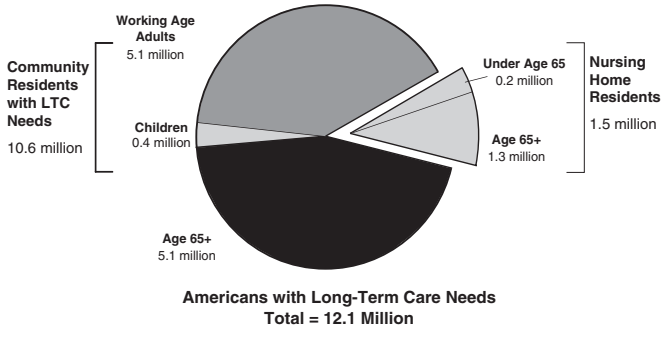
Who Needs Long-Term Care?

Over 12 million people in the United States need long-term care. Long-term care refers to a broad range of personal, social and medical services required by people with chronic illnesses and disabilities. The need for long-term care is usually measured by the extent to which an individual requires assistance in performing basic "activities of daily living" (ADLs) such as bathing and dressing, or "instrumental activities of daily living" (IADLs) such as preparing meals and managing money. Alzheimer's disease, heart disease, mental retardation, spinal cord injury, and stroke are just a few of the chronic illnesses and conditions that cause physical and mental impairment and the need for long-term care.

The elderly are most at risk of needing assistance with ADLs and IADLs—about a quarter of the elderly require at least some assistance with 1 or more ADLs. Although the likelihood of needing long-term care services rises with age, nearly half of those requiring care are under age 65, including 5.3 million working age adults and 400,000 children (Figure 1).

Figure 1

The Long-Term Care Population, 1995



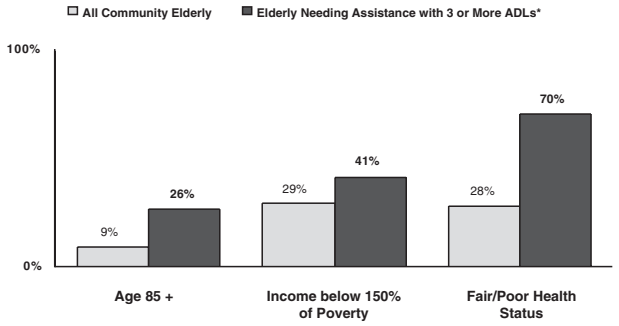
SOURCE: Georgetown University Institute for Health Care Research and Policy estimates from the 1994-1995 National Health Interview Survey on Disability, Phase II.; and The American Health Care Association, "The Nursing Facility Sourcebook: Facts and Trends, 1997;" data from the 1995 National Nursing Home Survey.

Long-term care services are provided at home, in the community, and in institutional settings. Most people who need long-term care receive that care at home or in the community. Only 12% are in nursing homes or other institutional facilities, such as intermediate care facilities for the mentally retarded (ICFs/MR).

The level of impairment and needs of those who use long-term care services varies considerably. Some require only limited assistance with household tasks, while others require around-the-clock care. Of the 1.3 million elderly in nursing homes, half are over age 85 and more than 80% are severely impaired (requiring assistance with 3 or more ADLs). However, a comparable number of elderly persons (1.5 million) have substantial long-term care needs and receive care in the community. They are disproportionately low-income, very old, and in fair or poor health (Figure 2).

Figure 2

Characteristics of Community-Dwelling Elderly with Substantial Long-Term Care Needs



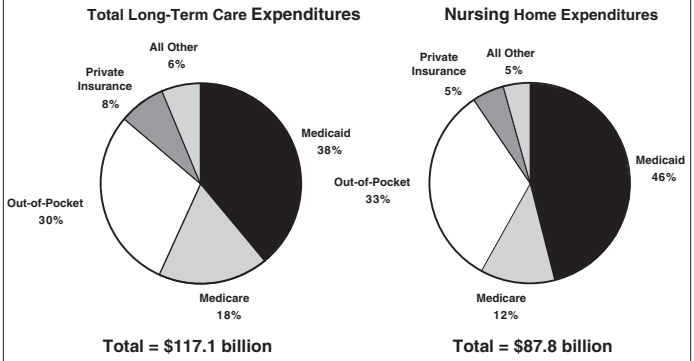
* "Activities of daily living" (ADLs), including: bathing, dressing, eating, transferring, toileting, and walking.
SOURCE: Georgetown University Institute for Health Care Research and Policy, estimates from the 1994-1995 National Health Interview and National Health Interview Survey on Disability, Phase II.

Who Pays for Long-Term Care?

Although many people who need long-term care rely on informal, unpaid help from family and friends, more than $117 billion was spent on long-term care in 1998 (Figure 3). Public programs accounted for the majority of this spending, but individuals still

Figure 3

Long-Term Care Financing, 1998



SOURCE: HCFA, National Health Accounts, 2000.
Estimates include spending on home care and nursing home care only.

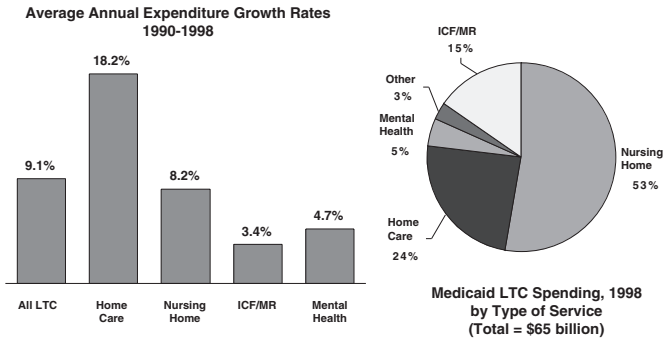
pay 30% of these costs out-of-pocket. Medicare pays for some short stay long-term care through its skilled nursing facility benefit and its home health care benefit, but Medicaid pays the largest share of public expenditures for long-term care. Three-fourths of long-term care spending is for nursing home care, nearly half of which was funded by Medicaid and a third of which was paid by individuals out-of-pocket.

Long-Term Care in Medicaid

Spending on long-term care for Medicaid's elderly and disabled beneficiaries (including nursing home care, ICFs/MR, home health, and mental health services) represents a substantial share of national Medicaid spending—42 percent in 1998. Although spending on nursing home care still accounts for the largest share of Medicaid long-term care (53 percent), pressure to move individuals from institutional settings to the community has shifted spending patterns. Between 1990 and 1998, spending on home care services grew at an average annual rate of 18 percent, compared to 8 percent growth in Medicaid spending for nursing home care and just 3 percent growth for care in ICFs/MR (Figure 4), while spending on acute care services grew at an average annual rate of 12 percent. Spending on home care has grown as a share of Medicaid long-term care from 13 percent of spending in 1990 to 24 percent in 1998, as spending on all institutional care (nursing home and ICFs/MR) has dropped from 81 percent to 68 percent of the total.

Figure 4

Medicaid Long-Term Care Spending



SOURCE: Urban Institute estimates based on HCFA-2082 and HCFA-64 reports.

Qualifying for Medicaid: The major Medicaid eligibility pathways for the elderly and disabled are:

Supplemental Security Income (SSI): States are required to provide Medicaid to elderly and disabled individuals who qualify for the SSI cash assistance program (in 2001, income ≤ $530 a month and non-housing assets ≤ $2,000).

Spend down: In 36 states, individuals in the community and in nursing homes can qualify for Medicaid if they "spend down" their medical expenses to a state established level.

Special income rule: In 33 states, individuals in nursing homes or other institutions can qualify if their income is less than 3 times the SSI level (in 2001, $1,590).

After qualifying for nursing home assistance through Medicaid, individuals must contribute all of their monthly income toward the cost of care, except for a small personal needs allowance. Special protections exist to provide income to be allocated for spouses remaining in the community to prevent "spousal impoverishment".

State Variation in Medicaid Long-Term Care

States have considerable flexibility in designing their long-term care programs, controlling access, and determining eligibility and benefit levels. Although states must cover home health services under Medicaid, states have the option of providing personal care services and also have the flexibility to design home and community-based care programs under federal waivers. Using these waivers, states can provide needed services in community settings at a lower cost than institutional care. Nearly half a million individuals in 49 states receive care through the home and community-based care option. These waivers allow states to establish limits on the total number of people enrolled, as well as target programs to selected population groups or geographic areas within the state, in order to limit costs. States also regulate the supply of nursing home beds and control the rates paid to nursing homes for Medicaid beneficiaries, which can affect beneficiaries' access to care.

Policy Issues

Access. The current long-term care system does not adequately meet the needs of many persons with disabilities. Medicare's long-term care benefits are limited and Medicaid only reaches the poor or those who incur catastrophic expenditures. Individuals with long-term care needs may eventually receive assistance from Medicaid, but often must "spend down"—impoverishing themselves before assistance becomes available.

Assistance for those wishing to receive care at home—rather than in a nursing home—is often limited, even though most people would prefer to receive care at home. Nearly all states provide home and community-based services, but few spend most of their long-term care budgets on home-based care. Nationally, nearly 70 percent of Medicaid long-term care expenditures goes toward nursing homes and other institutional care. Persons with disabilities and their advocates have long called for increased financing for home and community-based long-term care through Medicaid. A 1999 Supreme Court decision (*Olmstead v. L.C.*) promotes the broader use of home care as an alternative to institutionalization.

In addition, low payments to nursing homes have historically limited access to care for Medicaid beneficiaries. Long-standing concerns about the quality of care in nursing homes and in the community persist. As states continue to increase the use of community-based care, better measurement and quality monitoring systems will need to be developed.

Financing. As the population ages, the need for long-term care and pressure to improve the system will grow. A few recent proposals—long-term care tax credits or incentives for the purchase of private long-term care insurance—may help alleviate some burdens on individuals and their caregivers, but they are limited in scope and unlikely to substantially improve access to long-term care for low-income Americans who are most at risk. Because public programs will continue to incur most of these costs, additional public resources will be needed to fill gaps in the current system, improve access to home and community-based care, and address concerns about the quality of long-term care.

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