GEORGETOWN UNIVERSITY
Long-Term Care Financing Project
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fact sheet

Medicaid and long-term care

The Medicaid program is the nation's major source of public financing for long-term care, which many people with disabilities need to function daily. Fiscal pressures threaten Medicaid's ability to finance long-term care services, however. The federal and state governments jointly finance the Medicaid program. As states face fiscal crises, there is pressure to contain Medicaid spending, which accounts for approximately 15 percent of state spending.[1] Virtually all states already have implemented policies to cut or contain Medicaid spending for fiscal year 2003. Some 19 states have reduced or plan to reduce spending specifically for long-term care services.[2]

What Is Medicaid's Role in Financing Long-Term Care?

The Medicaid program accounts for 44 percent of the $173 billion spent in 2001 for long-term care in the United States.[3] Medicaid spending has grown. Between fiscal years 1991 and 2001, Medicaid spending for long-term care increased substantially, after adjusting for inflation, from $44.0 billion (in 2001 dollars) to $75.3 billion.[4] Currently, long-term care services account for more than one-third—35 percent—of Medicaid spending (see Figure 1).

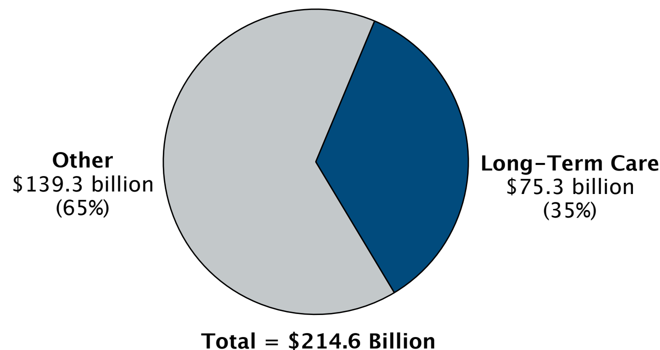
The majority of Medicaid long-term care spending is for care in institutions such as nursing homes. The proportion of Medicaid spending for noninstitutional, or home and community-based care, however, has more than doubled over the last decade, from 14 percent in fiscal year 1991 to 29 percent in fiscal year 2001 (see Figure 2). If funding permits, this spending is expected to keep growing as consumers request this type of service and states respond.

How Do Medicaid Benefits Vary Across States?

States have such flexibility in designing Medicaid long-term care programs that Medicaid really is not one program but more than 50 programs. The factor that has the most impact on the availability of services is the choices states make regarding the level of resources they are willing to devote to long-term care.

One indicator of these choices is variation in program eligibility rules. At a minimum, states must set income eligibility limits for long-term care services at a level equal to the benefit level for the Supplemental Security Income program ($552 per month for an individual in 2003), but states may set income limits

Figure 1
Medicaid Spending (2001)

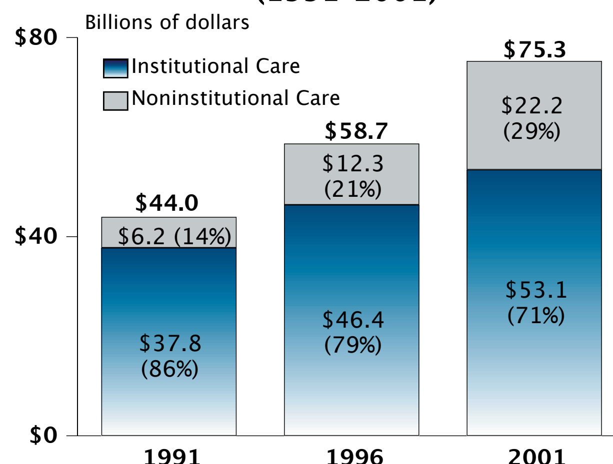


Note: Data are for federal fiscal year 2001.
SOURCE: Health Policy Institute, Georgetown University, based on data from B. Burwell, S. Eiken, and K. Sredl, "Medicaid long-term care expenditures in FY2001" (Cambridge, MA: The MEDSTAT Group, 10 May 2002, memorandum).

up to three times as high ($1,656 per month). The optional Medicaid "Medically Needy" programs allow individuals to deduct medical expenses from income to qualify for coverage, but 16 states did not use this option in 2001.[5] Limits on the amount of assets or resources individuals may own also differ, and each state has developed different criteria to determine whether applicants meet functional eligibility requirements. As a result of these differences, the same person might qualify for Medicaid assistance in one state, but not in another.

Individuals who do qualify for Medicaid are not entitled to the same types of services in every state. For example, the extent to which states offer home and community-based care through Medicaid differs considerably. The proportion of Medicaid long-term care spending devoted to home and community-based care ranges from 55 percent in New Mexico and Vermont to 6 percent in the District of Columbia.[6] Thus, residents of some states are much more likely than residents of other states to have the option of receiving long-term care services at home or in a community setting rather than in an institution.

Figure 2
Medicaid Spending for Long-Term Care (1991-2001)



NOTE: Spending is adjusted for general inflation to 2001 dollars using the Consumer Price Index. Years are federal fiscal years.
SOURCE: Health Policy Institute, Georgetown University, based on data from B. Burwell, S. Eiken, and K. Sredl, "Medicaid long-term care expenditures in FY2001" (Cambridge, MA: The MEDSTAT Group, 10 May 2002, memorandum).

How Does Medicaid Provide Home and Community-Based Care?

Medicaid pays for some home health services, a mandatory benefit, which must be ordered by a physician based on medical necessity. States may also choose to cover personal care services that people with disabilities need to perform basic tasks. The largest share of Medicaid spending for home and community-based care—65 percent—is for home and community-based waiver programs, also known as 1915(c) waivers.[7] Waiver programs allow states to control expenditures for noninstitutional long-term care. States may target the waivers to different groups of people. States set limits on the number of people who can receive services. They are also free to determine what services will be covered, the settings where services will be provided, and the geographic areas where they will be provided.

People with mental retardation or developmental disabilities accounted for 38 percent of participants but 75 percent of waiver program expenditures (see Figure 3). Although over half of waiver program participants in 1999 were people with other disabilities, this group represented only 23 percent of spending for all waiver program participants. Other groups have also been targeted for waiver services, such as people with AIDS or AIDS-related conditions and people with traumatic brain or head injuries. They account for a very small proportion of participants and spending.

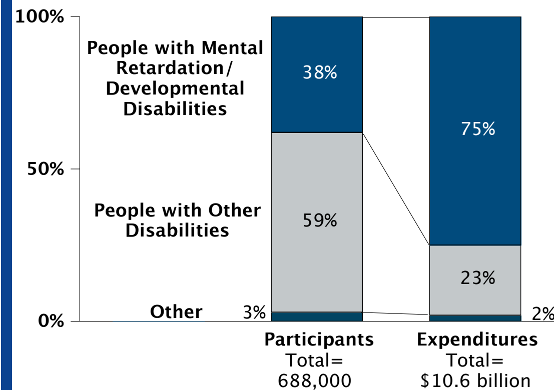
Options for community-based care are increasing. Assisted living facilities, which furnish care in a congregate residential setting, have become more common. Medicaid pays for long-term care services but not for housing. In 2002, some 41 state Medicaid programs paid for services in assisted living facilities for just over 100,000 residents compared with two years earlier, when 29 states were providing these services for about 60,000 people.[8]

The option of paying family or friends to provide personal care services also has become more widespread. More states are testing approaches to consumer-directed care, which may allow individuals to plan their care, to purchase or monitor the services they need, to hire and supervise their own caregivers, or to develop their own care plans. Consumer-directed care is not an option for everyone who needs long-term care. Current evaluations will help identify the limits and benefits of various approaches to consumer direction.

What Are the Most Pressing Issues with Regard to Medicaid and Long-Term Care?

Fiscal Pressure. The decline of state revenues and increases in the cost of care have put pressure on state Medicaid programs to contain costs. The demand for long-term care services already strains programs, and as the population ages, the need for long-term care services will grow.

Figure 3
Proportions of Home and Community-Based Waiver Participants and Expenditures, by Type of Participant (1999)



SOURCE: M. Kitchener, and C. Harrington, *Medicaid 1915(c) home and community based waivers: program data, 1992-1999*. available at http://www.hcbs.org/data/kaiser/kaiser_final.pdf, accessed 22 April 2003.

Varied Access. Access to care varies from state to state depending on decisions states make about program design. Thus, the same individual could receive benefits in one state, but not in another.

Choice and Quality. States are struggling to provide a balance between institutional and community-based care, to respond to provider shortages, to involve consumers in the direction of care, and to assure that quality services are provided. State Medicaid programs have been at the forefront of some innovations in the delivery of long-term care services, but with pressures to contain costs and the aging of the population, some innovations may be threatened.

Notes

[1] Kaiser Commission on Medicaid and the Uninsured, *State Budget Constraints: The Impact on Medicaid* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).
[2] V. Smith et al., *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).
[3] L. Shirey and H. Komisar, *Who Pays for Long-Term Care?* (Washington, DC: Georgetown University Long-Term Care Financing Project, May 2003, fact sheet).
[4] B. Burwell, S. Eiken, and K. Sredl, "Medicaid Long-Term Care Expenditures in FY 2001" (Cambridge, MA: The MEDSTAT Group, 10 May 2002, memorandum).
[5] A. Schneider et al., *The Medicaid Source Book* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2002).
[6] Burwell et al..
[7] Ibid.
[8] M. Kitchener and C. Harrington, *Medicaid 1915(c) Home and Community Based Waivers: Program Data, 1992-1999*, available at http://www.hcbs.org/data/kaiser/kaiser_final.pdf, accessed 22 April 2003.
[9] R. Mollica, *State Assisted Living Policy, 2002* (Portland, ME: National Academy for State Health Policy, 2002).

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About the Project
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Laura Summer wrote this *Fact Sheet*.