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Long-Term Care: Trends in Public and Private Spending

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Summary

Long-term care refers to a broad range of health and social services needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or chronic condition resulting in functional impairment(s) for an extended period of time. The need for long-term care affects persons of all ages — children born with disabling conditions such as mental retardation or cerebral palsy; working-age adults with inherited or acquired disabling conditions; and the elderly with chronic conditions or illnesses such as Alzheimer's disease or severe cardiovascular disease.

Spending on long-term care services is a significant component of health care spending in the United States. Of the $1.56 trillion spent on personal health care services in 2004, $194.3 billion (12.5%) was spent on long-term care services — comparable in size to spending on prescription drugs. Long-term care expenditures include services in both institutional settings — e.g., nursing homes and intermediate care facilities for individuals with mental retardation (ICFs/MR) — and a wide range of home- and community-based services such as home health care services, personal care services, and adult day care.

The dominant payer in the U.S. for long-term care services is Medicaid, a means-tested program jointly funded by states and the federal government. In 2004, Medicaid paid for nearly one-half of all long-term care expenditures (49.3%), spending $95.7 billion. Medicare was the second-largest source of payment, funding about 19.2% of expenditures ($37.4 billion). Out-of-pocket spending was nearly as large, representing 19.0% of all expenditures ($36.9 billion). Other payers such as private insurers, and other public and private sources covered the remainder.

From 1990-2004, long-term care expenditures grew slightly faster than expenditures for all personal health care services; the average annual growth rates were 7.4% and 7.0%, respectively. Over this same time period, funding for long-term care has increasingly been paid by public sources, and has increasingly been spent on home- and community-based settings. In 1990, 22.0% of long-term care spending went toward home- and community-based services; this increased to 36.7% of spending in 2004. This trend has largely been driven by the increased spending within the Medicaid program toward these types of services.

This report will be updated as additional data become available.

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Overview

Long-term care refers to a broad range of health and social services needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or chronic condition resulting in functional impairment(s) for an extended period of time. The need for long-term care affects persons of all ages — children born with disabling conditions such as mental retardation, or cerebral palsy; working-age adults with inherited or acquired disabling conditions; and the elderly with chronic conditions or illnesses such as Alzheimer's disease or severe cardiovascular disease.

Spending on long-term care services is a significant component of health care spending in the United States. Of the $1.56 trillion spent on all U.S. personal health care services in 2004, $194.3 billion, 12.5%, was spent on formal long-term care services[1] — comparable in size to spending on prescription drugs. Spending for long-term care includes services in both institutional settings — nursing homes and intermediate care facilities for individuals with mental retardation (ICFs/MRs) — and a wide range of home- and community-based services such as home health care services, personal care services, and adult day care.[2]

This report discusses the financing of long-term care services, including how much is spent, who the primary payers are, and what types of services are purchased. The report does not discuss indirect long-term care benefits through federal and/or state tax deductions for long-term care expenditures.

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[1] Formal long-term care refers to those services that have been paid for. This report does not address the economic value of long-term care services provided informally by unpaid friends and family which is the primary source of long-term care for most people.

[2] This report defines long-term care expenditures as those expenditures reported in the nursing home and home health categories of the National Health Accounts data, at [http://www.cms.hhs.gov/statistics/nhe/default.asp], which represent freestanding nursing homes and home health providers. This data is supplemented with information on Medicare and Medicaid *hospital-based* nursing home and home health services. A nursing home or home health service is considered "hospital-based" when the provider's operations, licensure, governance and professional supervision are integrally linked or a subordinate part of a hospital. The data used in this report is also supplemented with information on Medicaid home- and community-based waiver programs. The services described in this report may be provided for a limited time period, such as rehabilitation to restore an individual's functional abilities. However, the data does not allow expenditures to be disaggregated by the length of time a service is provided.

It is also important to keep in mind that there can be tremendous variation in the types of services that are considered "long-term care." Examples of long-term care services could include a nurse administering medication, a contractor building a wheelchair ramp onto a home, or a nursing facility where a person resides. This variation creates significant challenges for researchers in evaluating long-term care services and expenditures, and establishing a common definition of "long-term care."[3] For example, some argue that the Medicare expenditures for skilled nursing facilities and home health services are a post-acute service that generally follows a hospitalization, and should not be categorized as "long-term care."[4] Others argue that Medicare is an important payer in the continuum of long-term care services, since many nursing facility residents start with Medicare paying for the cost of the service; but after the Medicare coverage period ends, Medicaid pays for these expenditures. This report follows the latter argument and includes Medicare freestanding and hospital-based skilled nursing facility and home health expenditures as part of long-term care services.[5] If these Medicare expenditures were excluded, long-term care expenditures would total $156.9 billion, a 19.2% lowering of the 2004 total. **See Figure 1**.

Who Pays for Long-term Care Services?

Formal long-term care services in the U.S. are paid for by a wide variety of public and private sources. More than two-thirds of long-term care spending is paid for by public sources (i.e., Medicaid, Medicare and other public programs); the remainder is paid by private sources (i.e., out-of-pocket expenditures, private insurance and other private programs).

The largest payer of long-term care expenditures in the U.S. is Medicaid (a means-tested program jointly funded by the federal and state governments). In 2004, Medicaid paid $95.7 billion, or 49.3% of all long-term care expenditures. Medicare was the was the next highest source of funding totaling $37.4 billion (19.2% of expenditures). Out-of-pocket spending was slightly lower, accounting for 19.0% of total long-term care spending, or $36.9 billion.[6] Private insurance paid for 7.3% of

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[3] This has also been a challenge for the international research community; the Organization for Economic Cooperation and Development (OECD) has been working to develop a common definition of long-term care to be able to compare long-term care expenditures across countries, located at [http://europa.eu.int/comm/economy_finance/ events/2005/ workshop0205/7en.pdf].

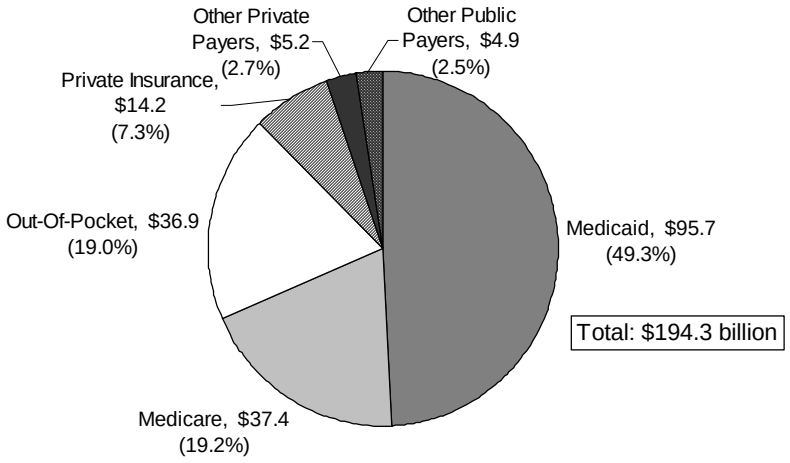
[4] The average length of stay in a skilled nursing facility has been declining, and is currently 24 days. In addition, recipients of home health services are increasingly in need of physical therapy services which could evidence rehabilitation of an individual's physical functioning versus services that provide an ongoing care. As described earlier, the data does not allow a disaggregation of services based on the length of time the beneficiary received the service.

[5] It does not include Medicare expenditures for long-term care hospitals or inpatient rehabilitation facilities.

[6] As discussed later in this report, some out-of-pocket expenditures for certain long-term (continued...)

long-term care expenditures, or $14.2 billion. Other public sources (e.g., veterans and state-funded programs) and other private sources (e.g., foundations and philanthropic organizations) paid for a significantly lower share, totaling 5.2% of expenditures ($10.0 billion). **See Figure 1.**

Figure 1. Long-term Care Expenditures by Payer, CY2004 (expenditures in billions)



Source: CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). This analysis also includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers, and data for the Medicaid 1915(c) home and community-based waivers. It does not include expenditures for hospital-based nursing home and home health providers paid for by other sources, and certain expenditures similar in nature to the Medicaid 1915(c) waiver which are paid for by other sources (e.g., home modifications, housekeeping).

Trends in Long-term Care Spending: 1990-2004

From 1990-2004, national long-term care expenditures grew at an average annual rate of 7.4% — slightly higher than the 7.0% average annual growth rate for all personal health care spending.[7] During this period, two major trends in long-term care spending have emerged: first, the role of public payers has increased as a proportion of total spending; second, spending for home- and community-based services as a share of total spending has increased, while institutional spending as a

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[6] (...continued)
care services may not be included in this estimate due to data limitations.

[7] This report specifically discusses trends in long-term care service expenditures from 1990-2004. Data prior to 1990 has not been included because of inconsistency in data elements. Actual expenditure data is only available through 2004. Personal health care spending includes health care services and supplies, and does not include expenditures such as public health services and investments in research, structures, and equipment. These types of expenditures are included in measures of total national health expenditures.

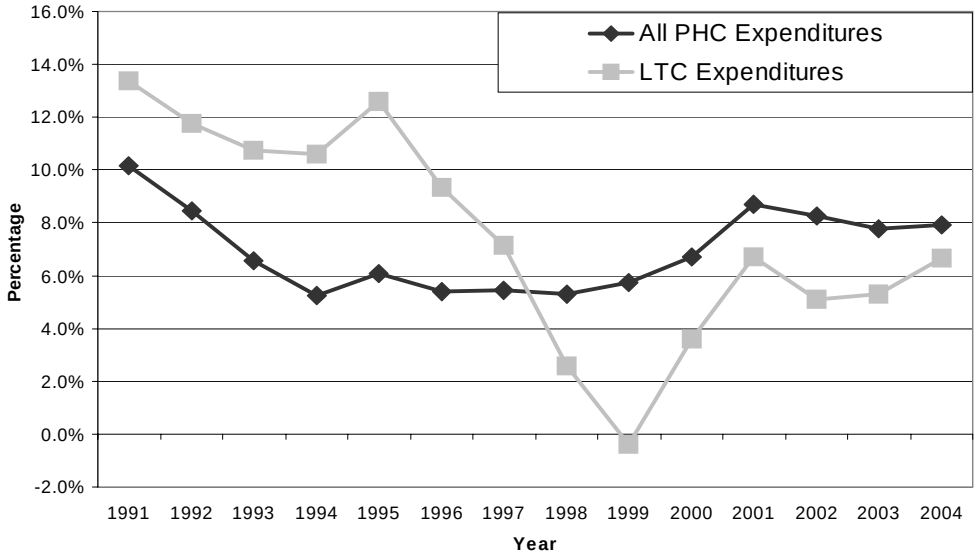
share of the total has declined.[8] These trends are discussed in more detail later in this report.

Long-term Care Expenditures Relative to All U.S. Personal Health Care Spending

Over the 14-year period considered, spending on long-term care has ranged from 11.7% to 15.2% of all personal health care spending. In 1990, long-term care expenditures totaled $71.2 billion, representing 11.7% of personal health care spending. Long-term care spending, as a percentage of personal health care spending, peaked at 15.2% in 1997, but by 2004 had declined to 12.5%. The decline between 1997 and 2004 is the result of a faster growth rate in all personal health care (which averaged 7.2% per year during that period) than in long-term care (which averaged 4.1% per year).

As shown in **Figure 2**, the annual rates of spending growth for all personal health care services differ from the growth rate for long-term care services. Several factors influence spending in these various categories, including the types of providers, market factors, service delivery systems, and legislation.

Figure 2. Annual Percent Change in All Personal Health Care (PHC) Expenditures and Long-Term Care (LTC) Expenditures, 1990-2004



Source: CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). It includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers and data for the Medicaid 1915(c) home and community-based waivers. It does not include expenditures for hospital-based nursing home and home health providers paid for by other sources, and certain expenditures which are similar in nature to Medicaid 1915(c) waiver

[8] This report defines home- and community-based services expenditures as the sum of total expenditures for the home health category of the National Health Accounts, Medicaid home- and community-based waivers, and Medicare and Medicaid spending for hospital-based home health services.

Factors that Influenced Spending Growth for *All Personal Health Care Services* Between 1990 and 2004. As mentioned above, the average annual growth rate for all personal health care services between 1990 and 2004 was 7.0%. The annual growth rate ranged from 5.3% to 10.2% per year during this period. The highest annual rate of growth (10.2%) occurred during the 1990-1991 period. Between 1991-1994, the growth rate of spending declined largely due to slower price growth and increased enrollment in managed care.[9] During the 1995-1999 period, the growth rate for personal health care spending leveled off as: (1) large segments of the population were enrolled into managed care plans; (2) excess capacity among some service providers boosted competition; (3) the economy as a whole and, specifically for medical services, had low rates of inflation; and (4) Medicare payment policies restricted payments for certain service providers.[10]

The relatively level rate of PHC growth did not last. Between 1999-2001, the annual rate of growth accelerated from 5.7% to 8.7% as consumers called for fewer restrictions on managed care; hospitals, facing less competition, negotiated higher prices; the price of certain services increased due to inflation and shortages of health care workers; and Medicare and Medicaid spending increased.[11] In 2002 and 2003, the rate of growth declined slightly, to under 8% per year, due largely to slower growth in Medicaid and Medicare — prompted by state fiscal constraints and expiring payment increases in Medicare.[12]

In 2004, the rate of growth increased slightly (0.1%). The growth rate in Medicaid spending declined due to continued cost-containment efforts on the part of states. However, offsetting this decline was an an acceleration in the growth of Medicare spending — resulting in an overall increase in the rate of growth. The higher growth rate in Medicare spending was, in part, due to provisions in the Medicare Prescription Drug and Modernization Act of 2003, (P.L. 108-173), which established a Medicare transitional drug benefit for 2004, and provided payment increases for capitated health plans and rural providers. This growth, however, also reflected the increased use of certain Medicare services such as physician and home health services.[13]

Factors that Influenced Spending Growth for *Long-Term Care Services* Between 1990 and 2004. For long-term care spending, the change in the annual growth rates between 1990-2004 have been somewhat more volatile.

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[9] K. Levit, et al., "Health Spending in 1994: Slowest in Decades," *Health Affairs*, summer 1996.

[10] K. Levit, et al., "National Health Spending Trends in 1996," *Health Affairs*, Jan/Feb 1998.

[11] K. Levit, et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs*, Jan/Feb 2003.

[12] K. Levit, et al., "Health Spending Rebound Continues in 2002," *Health Affairs*, Jan/Feb 2004; and C. Smith, et al., "Health Spending Growth Slows in 2003," *Health Affairs*, Jan/Feb 2005.

[13] C. Smith, et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs*, Jan./Feb. 2006.

From 1990-1994, similar to the trend in all personal health care services, the size of the rate of growth for long-term care spending declined. Notwithstanding this overall deceleration in the growth rate, spending on Medicare home health services was growing at an average annual rate of 37.4% during this period (from $4.2 billion in 1990, to $15.1 billion in 1994).

After an increase in the growth rate from 1994-1995,[14] the rate of growth for long-term care spending dropped significantly through 1999. The growth rate decline is largely the result of changes to Medicare payment policies for home health and nursing facility services. In addition, Congress and the federal government took steps in 1997 and 1998 to curtail fraud and abuse in Medicare home health services.

From 1999-2001, long-term care spending growth accelerated from a -0.4% to 6.7%. This acceleration was due to: (1) temporary payment increases for Medicare nursing facilities; (2) starting at the end of 2000, a new payment system for Medicare home health services; and (3) increases in spending for Medicaid long-term care services.[15] In 2002 and 2003, the growth rate for long-term care spending slowed to 5.1% and 5.3%, respectively, due to slower spending in Medicaid, because of state budget constraints; and Medicare, because of changes to payment policies for nursing home and home health services. In 2004, the growth rate for long-term care spending increased to 6.7% because of increased spending for home- and community-based settings under Medicaid and increased spending for Medicare home health services.[16]

The Changing Roles of Long-Term Care Payers

Across all payers, the average annual growth rate in long-term care expenditures was 7.4% between 1990 and 2004. However, as described above, the growth rates for different long-term care payers varied widely. Medicare and Medicaid grew at an average annual rate of 13.0% and 8.5%, respectively, while private insurance spending and out-of-pocket spending grew at an average annual rate of 6.6% and 4.0%, respectively.[17]

Collectively, public sources grew at an annual average rate of 9.3%, and private sources grew at an average annual rate of 4.2% between 1990-2004. These different growth rates have resulted in a shift in the proportion of long-term care spending by type of payer — from private to public payers. In 1990, public payers, including Medicaid and Medicare, paid for about 55% of long-term care expenditures. In 2004, public programs paid for approximately 71% of these expenditures. **Figure 3**

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[14] Increases in Medicare accounted for about a third of the increase in spending between 1994 and 1995. The remaining two-thirds of the increase is divided relatively evenly among Medicaid, out-of-pocket, and private insurance spending.

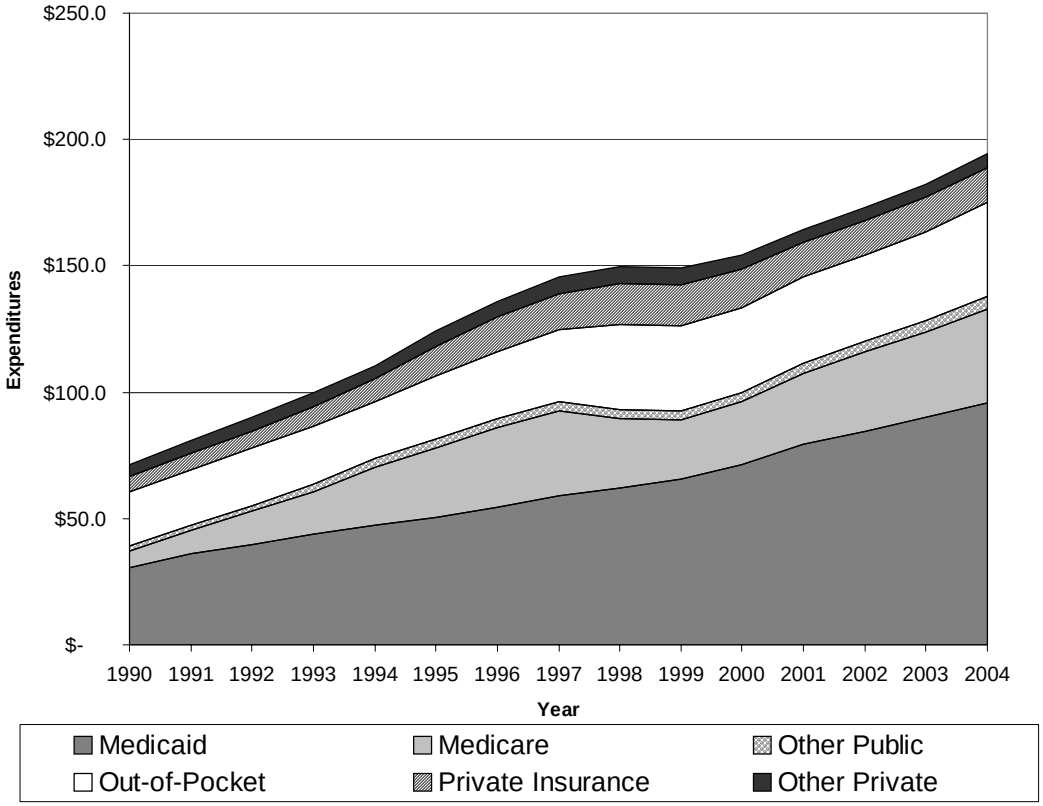
[15] K. Levit, et al., "Health Spending Rebound Continues in 2002," *Health Affairs*, Jan/Feb 2004.

[16] C. Smith, et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs*, Jan./Feb. 2006.

[17] CRS analysis of National Health Accounts Data.

illustrates the trend in expenditures from 1990-2004 by type of payer. See **Appendix A** for detailed tables.

Figure 3. Long-term Care Expenditures by Payer, CY1990-CY2004 (expenditures in billions, nominal dollars)



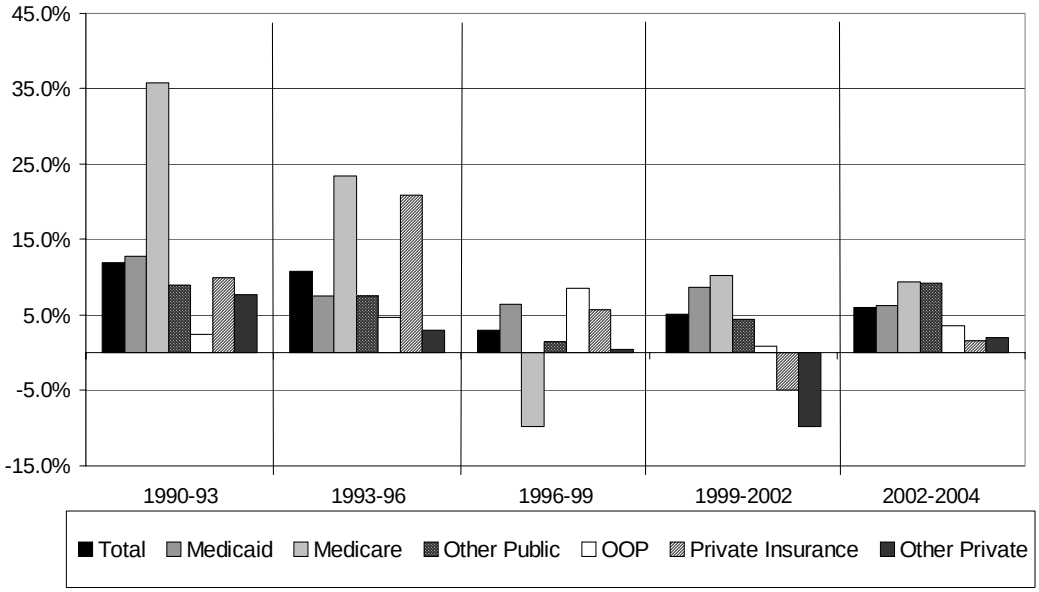
Source: CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). It includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers and data for the Medicaid 1915(c) home and community-based waivers. It does not include expenditures for hospital-based nursing home and home health providers paid for by other sources, and certain expenditures which are similar in nature to Medicaid 1915(c) waiver services, but are paid for by other sources (e.g., home modifications).

Though, in general the rate of spending growth by public payers was faster than that of private payers, there were significant differences within each type of payer and between various time periods. For example, Medicare and Medicaid long-term care spending grew significantly in the early 1990s, declined in the mid-1990's (due largely to Medicare payment changes), re-accelerated in the 1999-2002 period, and slowed slightly in 2003 in response to state fiscal constraints and the expiration of certain Medicare payment provisions. In 2004, the rate of growth in Medicaid spending remained relatively low, (6.2%). However, the rate of growth in Medicare increased to double-digits (11.4%).

For private payers, the growth rates in long-term care expenditures also varied, though less information is available to interpret the causes of this variation. The annual average growth in out-of-pocket spending remained below 5% per year between 1990-2004, with the exception of the 1996-1999 period when the annual spending growth averaged 8.5% per year. Spending growth by private insurance for

long-term care services varied much more widely from an average annual rate of growth of -5.0% between 1999 and 2002 to 20.8% between the 1993-1996 period. There is insufficient data to pinpoint the reasons behind the growth or decline in private insurance spending which has varied widely between 1990-2004. One factor may be changes to retiree health benefits which for some individuals (particularly for public sector retirees) include a limited nursing facility or home health benefit.[18] See **Figure 4** and **Appendix A** for additional information.

Figure 4. Annual Average Percentage Growth in Long-term Care Expenditures by Payer, 1990-2004



Source: CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). It includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers and data for the Medicaid 1915(c) home and community-based waivers. It does not include expenditures for hospital-based nursing home and home health providers paid for by other sources, and certain expenditures which are similar in nature to Medicaid 1915(c) waivers services, but are paid for by other sources (e.g., home modifications).

Types of Long-term Care Services Purchased

Institutional care — primarily nursing facilities — dominates long-term care spending. However, spending for home- and/or community-based services (e.g., home care, personal care) has increased, as a portion of total spending. In 1990, 22.0% of long-term care spending was for home- and community-based services; by 2004, it had increased to 36.7% of all spending. The growing share of expenditures for home- and community-based services, in part, reflect Medicaid program expansions made by policymakers, particularly those at the state level. For example,

[18] For additional information, see P. Fronstin, "The Impact of the Erosion of Retiree Health Benefits on Workers and Retirees," *EBRI Issue Brief*, Mar. 2005, at [http://www.ebri.org/pdf/briefspdf/0305ib.pdf].

the total number of individuals who received Medicaid home-and community-based waiver services, authorized under Section 1915(c) of the *Social Security Act*, grew from 235,580 in 1992, to 920,833 in 2002.[19] The increased expenditures on home- and community-based, long-term care services is also aligned with most people's preferences to remain in their homes and communities rather than relocating to institutions.[20]

These program expansions, in part, led to corresponding increases in Medicaid expenditures for home- and community-based services. In 1990, Medicaid payments for home- and community-based services totaled $4.3 billion; by 2004, expenditures grew to an estimated $39.1 billion — a 17.1% average annual rate of growth.[21] In contrast, Medicaid institutional spending grew at an annual average rate of growth of 5.6%, from $26.3 billion to $56.7 billion, over the same time period.

Medicare saw a decline in its share of spending on home care services through 2001 resulting from changes to the federal payment system for Medicare home health services, followed by an increase from 46.2% in 2001, to the 2004 rate of 51.2%.[22] Between 1990 and 2004, the share of out-of-pocket spending for home- and community-based services ranged from 10.6% to 17.7%. In 2004, 13.4% of out-of-pocket expenditures were spent on home- and community-based services. From 1990-2004, private insurance and other public and private payers saw a decline in their proportion of long-term care spending for home- and community-based services. (See **Table 1**).

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[19] M. Kitchener, et al., *Medicaid 1915(c) Home and Community-Based Service Programs: Data Update, Issue Paper*, Kaiser Commission on Medicaid and the Uninsured, July 2005.

[20] M. Greenwald and Associates, Inc., *These Four Walls ... Americans 45+ Talk About Home and Community*, AARP Report, May 2003, at [http://assets.aarp.org/rgcenter/il/four_walls.pdf].

[21] Expenditures for the Section 1915(c) waiver for the last quarter of calendar year 2004 are estimated because actual expenditures are part of FY2005, which have not yet been released.

[22] For additional information, see CRS Report RS21814, *Medicare Home Health — Benefits and Payments*, by J. Boulanger. (Hereafter cited as CRS Report RS21814.)

Table 1. Home and Community-Based Services as a Percentage of Long-Term Care Spending by Payer, CY1990-CY2004

	1990	1995	2000	2004
Medicaid	14.0%	21.9%	32.0%	40.8%
Medicare	63.0%	64.9%	47.9%	51.2%
Other public	50.3%	49.9%	44.0%	40.2%
Out-of-pocket	10.6%	17.7%	15.5%	13.4%
Private insurance	49.4%	49.9%	47.2%	36.5%
Other private	20.2%	20.0%	21.7%	18.4%
All payers	**22.0%**	**33.9%**	**32.3%**	**36.7%**

Source: CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). Also includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers and data for the Medicaid 1915(c) home- and community-based waivers. Does not include expenditures for hospital-based nursing home and home health providers paid for by other sources and certain expenditures which are similar in nature to Medicaid 1915(c) waiver services, but are paid for by other sources (e.g., home modifications).

Specific Long-Term Care Payers

Of the various payers, none is designed to cover the full range of long-term care service needed by all people with long-term care needs. The eligibility requirements and benefits provided by these public and private programs vary widely. The section below describes the primary long-term care payers — Medicaid, Medicare, private insurance, out-of-pocket and other public and private sources.

Medicaid Spending

Medicaid is a means-tested health insurance program jointly funded by the states and the federal government. Though the specific percentage varies by state, historically states have paid about 43% of Medicaid service expenditures and the federal government has paid 57% of expenditures. Medicaid eligibility is limited to certain groups of low-income children, pregnant women, parents of dependent children, people with disabilities, and the elderly. Each state designs and administers its own program within broad federal guidelines. All states cover at least some long-term care services for Medicaid beneficiaries, though the specific services and the duration and/or scope of those services vary widely among states.

As discussed earlier, Medicaid is the dominant payer of long-term care services; in 2004, the program covered nearly one-half of all long-term care expenditures. Its spending of $95.7 billion covered nursing facilities, ICF/MR services, home health services, personal care services, and home- and community-based waiver programs.

Medicaid long-term care expenditures increased by an average rate of 8.5% per year between 1990-2004.

Many policymakers believe that Medicaid continues to have an "institutional bias" because nursing facility services must be covered by the state and states have the option of covering most home- and community-based services. Almost two-thirds of Medicaid long-term care expenditures were spent in institutional settings — nursing facilities and ICF/MR services. For example, estimated Medicaid expenditures in FY2004 totaled $45.8 billion for nursing facilities, and $11.8 billion in ICF/MR services.[23] On average, per capita institutional services generally exceed the per person annual cost of services in the community.[24]

Medicaid has increasingly paid for home- and community-based services. In 1990, Medicaid payments for home- and community-based services were 14.0%, ($4.3 billion) of Medicaid long-term care spending; by 2004, expenditures were 40.8%, ($39.1 billion) of spending, (**Table 2**). The cost of institutional spending decreased from 86.0% of Medicaid long-term care spending in 1990, to 59.2% of spending in 2004.

Table 2. Medicaid Long-Term Care Spending in the U.S., CY1990-CY2004

(in nominal dollars)

Total U.S. (50 states and the District of Columbia)	CY1990	CY1995	CY2000	CY2004
Total Medicaid spending (in billions)	$69.7	$136.3	$187.9	$272.6
Total Medicaid long-term care spending (in billions)	$30.5	$50.4	$71.5	$95.7
Long-term care spending as a percent of Medicaid spending	43.8%	37.0%	38.0%	35.1%
Institutional care spending as a percent of long-term care spending	86.0%	78.0%	68.0%	59.2%
Home and community-based services (HCBS) spending as a percent of long-term care spending*	14.0%	21.9%	32.0%	40.8%

Source: Congressional Research Service (CRS) analysis of National Health Expenditure (NHE) data and estimated expenditures from CMS-Form 64. Includes expenditures for Medicare and Medicaid hospital-based nursing facility and home health providers and expenditures for Medicaid home- and community-based services from unpublished data by the Centers for Medicare and Medicaid Services (CMS), National Health Statistics Group.

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[23] CRS analysis of CMS, Form 64 data published by B. Burwell. Due to the unavailability of data for FY2005, calendar year data for 2004 cannot be estimated with confidence.

[24] In FY2003, the average per person cost of nursing facility services and ICF/MR services was $23,800 and $95,300, respectively. The average per person cost of Medicaid home- and community-based waiver services was $18,600.

Note: Calendar year data were used in this analysis to maintain consistency with other information presented in this report.

Some home- and community-based services, such as home health services, have been available to Medicaid beneficiaries since the inception of the program in 1965. Over time, other home- and community-based services have been added to Medicaid. In 1978, the Department of Health and Human Services (HHS) extended Medicaid coverage to personal care services.[25] In 1981, Congress authorized the home- and community-based (HCBS) waiver program under Section 1915(c) of the *Social Security Act*. The HCBS waiver program gave states the ability to provide a wide range of services to individuals who would otherwise require the level of care in an institution. Unlike other Medicaid programs available under the state plan, the HCBS waiver program allows states to limit the number of individuals to be served and to target a certain population (e.g., persons with developmental disabilities). In July 2003, there were 275 HCBS waivers authorized by the Centers for Medicare and Medicaid Services (CMS). As described earlier, the number of individuals served in these waiver programs has been growing. In FY1992, approximately 236,000 individuals received waiver services; a decade later enrollment had grown to an estimated 920,833 individuals.[26] (See **Appendix B** for examples of HCBS waiver services.)

Medicaid expenditures for the HCBS waiver programs represent a significant share of the growth in Medicaid long-term care spending. From 1990-2004, the increase in HCBS waiver spending accounted for nearly one-third of the total increase in Medicaid long-term care expenditures. In 1990, Medicaid expenditures for HCBS waivers were $1.3 billion; by 2004, expenditures grew to $21.9 billion — an average annual growth rate of 22.2%. (See **Appendix C** for additional information.)

Despite the growth in the HCBS waiver programs, many states have been unable to meet the demand for services, and maintain significant waiting lists. A 2003 estimate reported 180,347 individuals on waiting lists for HCBS waiver services. Of those on the waiting list, 52% were individuals who were elderly or persons under age 65 with a physical disability; 47% were individuals with mental retardation or developmental disability. The remaining 1% were for individuals with traumatic brain injury and children with significant long-term care needs.[27]

Though not reflected in the data presented in this report, Congress established home- and community-based services as an optional Medicaid benefit under the *Deficit Reduction Act of 2005* (P.L. 109-171), effective January 2007. Under this

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[25] 43 *Federal Register* 45228, Sept. 29, 1978, effective Oct. 1, 1978. Congress added personal care services as a covered Medicaid service to the Social Security Act in the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66).

[26] M. Kitchener, et al., "Medicaid Home and Community-Based Services: National Program Trends," *Health Affairs*, vol. 24, no. 1, Jan./Feb. 2005. See also, M. Kitchener, et al., Medicaid 1915(c) Home and Community-Based Service Programs: Data Update, Issue Paper, Kaiser Commission on Medicaid and the Uninsured, July 2005.

[27] Ibid.

new benefit, states can provide home- and community-based long-term care services to individuals who meet certain targeting criteria and whose income does not exceed 150% of the federal poverty level. States may also limit the number of individuals who can participate in this benefit and establish waiting lists.[28]

Medicare Spending

Medicare is a nationwide health insurance program for the elderly, and certain individuals with disabilities who are generally also receiving Social Security cash benefits. Medicare covers primarily acute care benefits; however, it provides *some* coverage for two long-term care services: skilled nursing facilities and home health services. In 2004, Medicare spent $37.4 billion on skilled nursing facility (SNF) and home health care services; of the total, 51.2%, or $19.1 billion, was for home health services, and 48.8%, or $18.3 billion was for SNFs.

Medicare covers skilled nursing facility (SNF) care following a beneficiary's discharge from a hospitalization of at least three days. If the beneficiary needs skilled care, Medicare will pay for a portion of the cost for up to 100 days of SNF care per "spell of illness."[29]

To qualify for Medicare's home health benefit, a beneficiary must be confined to his or her home (that is, be "homebound"), be under the care of a physician, and need skilled nursing care on an intermittent basis or skilled therapy care. If an individual meets these eligibility criteria, the home health benefit is not limited to a certain number of visits or dollar value.

From 1990-2004, Medicare's share of long-term care expenditures doubled growing from $6.7 billion in 1990, (9.4% of expenditures), to $37.4 billion in 2004, (19.2% of expenditures). During this time period, the average annual growth rate for Medicare long-term care expenditures was 13.0% — the highest average annual growth rate among all other types of long-term care payers.

Medicare's growth did not steadily increase between 1990 and 2004 — most of the growth was concentrated in the early to mid-1990s. Between 1990 and 1996, Medicare's spending as a share of total long-term care expenditures grew from 9.4% to 23.3%. Between 1997 and 2004, Medicare expenditures, as a share of total expenditures, actually declined to 19.2%.

Federal law governs the payment rates for both SNFs and home health services. The fluctuations in expenditures for these services have been influenced by legislation or administrative action that changed the federal payment systems. In

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[28] For additional information, see CRS Report RL33131, *Budget Reconciliation FY2006: Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP) Provisions*, by E. Baumrucker, et al.

[29] A spell of illness begins when a beneficiary receives inpatient hospital or Part A covered SNF care and ends when the beneficiary has not been an inpatient of a hospital or in a covered SNF stay for 60 consecutive days (§1861(a) of the Social Security Act). A beneficiary may have more than one spell of illness per year.

1997, in response to escalating SNF and home health spending, Congress enacted a number of provisions in the *Balanced Budget Act of 1997* (BBA 97) to control the growth in spending. BBA 97 required CMS to implement a prospective payment system (PPS) for SNFs to be phased-in over three years.[30] For the home health benefit, BBA 97 implemented an interim payment system and limited the number of home health visits that Medicare would pay for, until a PPS system could be fully implemented.

In response to concerns raised by the nursing home industry regarding adequacy of SNF PPS payments, as established by BBA 97, Congress twice enacted temporary payment increases for SNF services in the Balanced Budget Refinement Act of 1999, (BBRA 99, P.L. 106-113), and the Benefits Improvement and Protection Act of 2000, (BIPA 2000). Two of the three temporary increases enacted in BBRA 99 and BIPA 2000 expired September 30, 2002.[31]

After BBA 97, Medicare payments for home health services decreased sharply falling 32% in 1998, and an additional 16% in 1999. After the final PPS system was implemented in October 2000, payments for home health services again began increasing, though at a slower rate of annual growth than occurred in the early to mid-1990s. More recently, in the Medicare Prescription Drug, Improvement, and Modernization Act 2003 (MMA, P.L. 108-173), Congress provided a temporary increase for home health services provided to beneficiaries in rural settings. (**See Figure 5**).[32]

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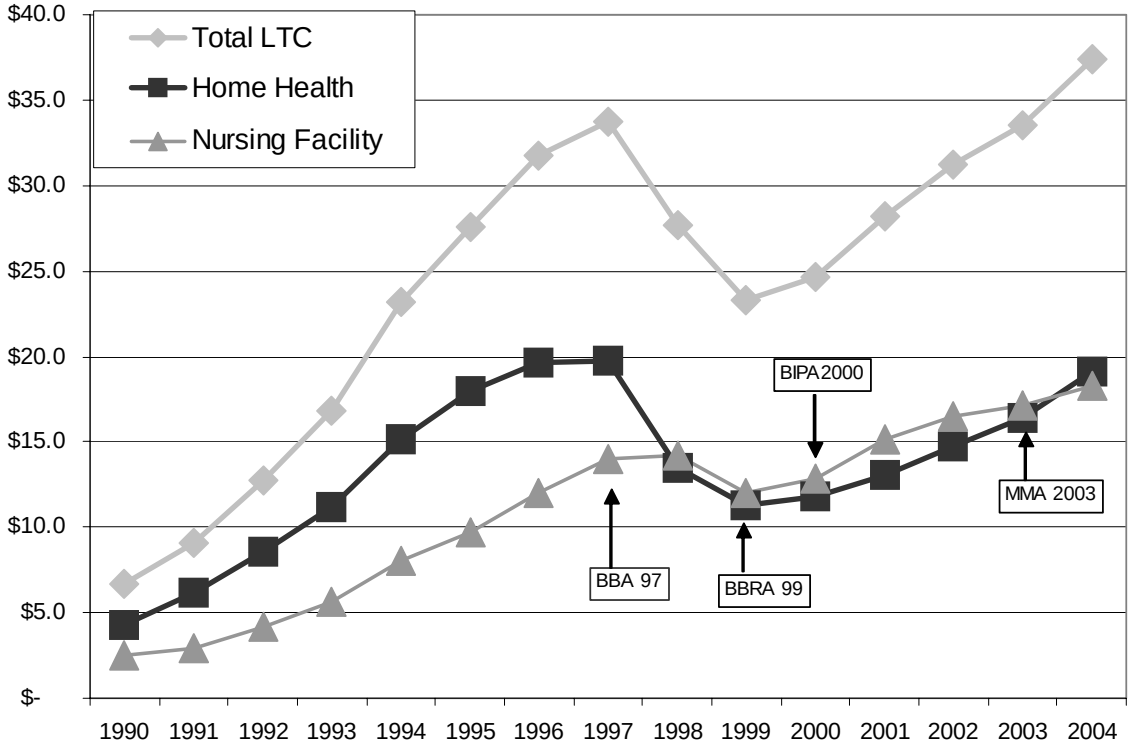
[30] A prospective payment system (PPS) is a fixed payment set in advance rather than retrospectively for specific service charges. The fixed payment can be based on a variety of factors such as the clinical needs or diagnosis of the individual, the type of the facility or the average wages of service providers.

[31] For additional information, see CRS Report RS21465, *Medicare's Skilled Nursing Facility Payment*, by Julie Stone-Axelrad.

[32] For additional information, see CRS Report RS21814, *Medicare Home Health — Benefits and Payments*, by J. Boulanger.

Figure 5. Medicare Long-Term Care Expenditures, CY1990-CY2004 (expenditures in billions, in nominal dollars)



Source: Congressional Research Service (CRS) analysis of National Health Expenditure (NHE) data. Includes expenditures for hospital-based nursing facility and home health providers from unpublished data by CMS, National Health Statistics Group.

Out-of-Pocket Spending

Out-of-pocket payments are the third largest source of payment for long-term care services. Out-of-pocket expenditures include both direct payments of long-term care services, and deductibles and co-payments for services that are primarily paid for by another source.

Direct payments for long-term care services could include private pay nursing facility or home health services if no other third parties cover such services. Out-of-pocket payments may also include, however, co-payments for a nursing facility-stay that is primarily funded by Medicaid or Medicare.

Based on the National Health Accounts data, from 1990-2004, out-of-pocket spending, as a share of all long-term care expenditures, decreased from 29.9% to 19.0%. Generally, the growth in Medicare and Medicaid spending has outpaced the growth in out-of-pocket spending. As described earlier, the annual average growth rate for out-of-pocket spending remained below 5% for much of the 1990s with the exceptions of the 1996-1999 period when the growth rate averaged 8.5% per year.

It is important to note that the data presented in this report have limitations in documenting out-of-pocket spending for long-term care services. These limitations may underestimate out-of-pocket contributions. First, spending amounts do not include premiums paid by individuals for private insurance.[33] For example, many individuals pay premiums for insurance policies that supplement Medicare coverage (Medigap). Although a portion of the Medigap premium goes for coverage of acute care services (e.g., hospital), some of the insurance premium would also cover the co-payments of skilled nursing facilities.[34] Insurance premiums paid for private long-term care insurance are also excluded from this category.

In addition, certain out-of-pocket expenditures which may be directly related to a person's long-term care needs, but which are not provided by home health agencies are not included in this analysis. However, these types of expenditures are counted as part of Medicaid because the long-term care data includes HCBS waiver services. For example, if an individual in a wheelchair hires someone to build a ramp on his or her home, and pays for that service out-of-pocket, the expenditure would not be counted. Because some states' Medicaid HCBS waiver programs cover home modifications, Medicaid expenditures for this type of service would be counted. It is difficult to estimate what the total value of out-of-pocket contributions for these types of services would be.

Private Insurance Spending

The private insurance category of the National Health Accounts Data includes a variety of insurance products including supplemental Medicare coverage (Medigap), traditional health insurance, certain types of life insurance,[35] and private long-term care insurance. In 1990, private insurance covered $5.8 billion of long-term care spending and grew to $14.2 billion in 2004, a 6.6% annual average rate of growth. As a share of all long-term care expenditures, private insurance covered 8.2% in 1990, grew to 10.9% in 1998, but declined to 7.3% in 2004.

Data are not available that would disaggregate private insurance expenditures into different types of insurance products. One product is likely to be Medigap policies which often cover co-payments for Medicare SNF services and may also cover an extended home health benefit.[36] However, Medigap's share of spending in this category is unknown, and the spending trends for long-term care paid by private insurance do not precisely follow trends in Medicare expenditures. Additional data would be needed to further analyze the components of this source of payment.

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[33] Expenditures for premium payments are shown separately in the National Health Accounts Data and are not reflected as part of the long-term care expenditures.

[34] Data are not available that would allow CRS to dissaggregate or estimate the amount of the Medigap premium going towards acute versus long-term care services.

[35] Certain life insurance policies offer a long-term care rider that pays out a portion of the death benefit in advance if the person demonstrates long-term care needs.

[36] An estimated 10.7 million individuals had purchased Medigap policies in 1999 [http://www.gao.gov/new.items/d01941.pdf].

Another type of product could include some retiree health benefits. Some retiree health insurance (particularly those covering public employees) provides a limited long-term care benefit which can include the Medicare co-payments for a skilled nursing facility stay, or a certain number of home health visits per year.

One of the private insurance payers, private long-term care insurance, has been of particular interest to some policymakers. Private long-term care insurance provides coverage for policyholders who pay premiums, and who need a certain level of long-term care. Benefit features of these policies vary widely, and care may be covered in a variety of settings such as nursing facilities, assisted living facilities, or the individual's own home through home health, respite care for caregivers, and homemaker services.

Private long-term care insurance policies started developing in the early 1980s. Though the private long-term care insurance market is still limited in size, compared to other payers, it has been growing. The annual number of individuals purchasing private long-term care insurance has grown from 315,000 in 1988, to 901,000 in 2002. Approximately 9.2 million long-term care insurance policies have ever been sold; however, about 30% of these policies are no longer in force (e.g., the policy has lapsed, the policyholder has died).[37]

Despite the growth in the number of policies, private long-term care insurance currently covers a very small portion of all long-term care expenditures. In 2002, private long-term care insurance generally covered less than 1% of all long-term care spending; out of the $173.0 billion in total long-term care spending, private long-term care insurance policies held by individuals paid approximately $1.4 billion.[38]

It is unclear to what extent payment by private long-term care insurance will increase its coverage of long-term care relative to other payers in the future. For some individuals, purchasing long-term care insurance may be a viable strategy to protect their income and assets against the risk of needing long-term care services in the future, and significant growth in the private long-term care insurance market could ease future demand on public financing sources and on direct out-of-pocket expenditures. The *Deficit Reduction Act* (P.L. 109-171), enacted in February 2006, included several provisions to increase the incentives for individuals to purchase long-term care insurance by establishing certain standards for insurance policies,

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[37] S. Coronel, *Long-Term Care Insurance in 2002*, America's Health Insurance Plans, Washington, DC, June 2004, p. 24.

[38] Total long-term care spending for 2002 is taken from the National Health Accounts data used in this report. Data on the private long-term care insurance claims in 2002 came from the report by S. Coronel, *Long-Term Care Insurance in 2002*, referenced in footnote 38. The private long-term care insurance data include only individual long-term care policies. Individual policies represent 79% of all long-term care policies sold. Employer-sponsored policies represent the remaining 21% of policies sold. Expenditure data on employer-sponsored policies are not available. Individual long-term care insurance carriers have paid approximately $8.4 billion in claims cumulatively, since inception.

disseminating information about long-term care insurance, and expanding access to asset and estate protections for purposes of Medicaid eligibility.[39]

However, purchasing long-term care insurance is probably not an option for individuals who already have long-term care needs. These individuals may not be able to access private long-term care insurance because of the underwriting process and the cost of insurance premiums which consider factors such as age and medical history.

Spending by Other Public and Private Payers

Of all long-term care expenditures in the United States, only a small portion of the costs are paid for with *public* funds other than Medicare or Medicaid.[40] Examples of spending in this category would include nursing facilities or home health care services paid for or operated by the U.S. Department of Veterans Affairs or state-funded long-term care programs.

Collectively, these payers covered about 2.5% of all long-term care expenditures in 2004, totaling $4.9 billion. Sixty percent of this spending was for institutional settings and 40% was for home- and community-based settings. Expenditures by other public payers grew at an average annual rate of 6.1% between 1990-2004.

Other private funds generally include philanthropic support which may be direct from individuals or may be obtained through philanthropic fund-raising organizations such as the United Way. Support may also be obtained from foundations or corporations. These payers cover a very small percentage of long-term care expenditures (2.7% in 2004), and expenditures for these services grew, on average, less than 1% per year between 1990-2004.

Projected Long-term Care Spending, 2005-2015

As policymakers look to the future, it is difficult to determine what the demand for long-term care services will be and how much it will cost. Trends that could increase demand for services include (1) the growing number of elderly individuals; (2) the rising disability rates among the non-elderly; and (3) the decreasing availability of informal caregivers due to mobility of the population, the increasing number of women in the workforce, and decreasing family size.

On the other hand, there are also countervailing trends and questions that could decrease the need for formal long-term care services, such as changes to the level of need and the types of services a person uses. For example, the use of equipment to

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[39] For additional information, see CRS Report RL33131, *Budget Reconciliation FY2006: Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP) Provisions*, by E. Baumrucker, et al.

[40] This does not include medical equipment sales or rentals not billed through home health agencies and non-medical types of home care (e.g., Meals on Wheels, chore-worker services, friendly visits, or other custodial services).

meet long-term care needs has increased, while the need for human assistance with *certain* types of long-term care services, such as shopping and money management, has decreased.[41] Other factors such as advances in medicine, technology, and home/environment modifications may also have a significant impact on the incidence and severity of disability, and the types of long-term care assistance required.[42]

CMS has projected future health care expenditures for the National Health Accounts data set for each service categories and payer. Their estimates consider various factors such as demographic and macroeconomic variables, inflation, and trends in Medicare, Medicaid and private health spending. Generally, CMS' estimates are based on assumptions about "macroeconomic conditions and their relationship to health care spending," and are "subject to considerable uncertainty."[43] Some of the uncertainty is due to the broader trends discussed above, but another component would be significant policy changes that could effect future long-term care expenditures.

CMS's estimates cover the 2005-2015 period and show a continuation of the current long-term care financing trends. Expenditures are expected to grow an average of 7% per year, totaling $419 billion in 2015 — comparable to the rate of growth in all personal health care spending. As a result, long-term care is expected to remain relatively constant as a share of personal health care spending.

In addition, the increasing share of spending financed by Medicaid is expected to continue. As a share of all payers, Medicaid is projected to grow from 49% of spending in 2004, to 56% in 2015. Medicare spending is expected to remain at just under one-fifth of all long-term care spending (19.1% in 2015). All other payers are projected to reduce their share of long-term care spending compared to 2004 levels (**Table 3**).

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[41] B. Spillman, *Changes in the Elderly Disability Rates and Implications for Health Care Utilization and Cost*, Urban Institute prepared for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Feb. 2003.

[42] J. Knickman and E. Snell, "The 2030 Problem: Caring for Aging Baby Boomers," *HSR: Health Services Research*, Aug. 2002, pp. 849-884. See also, W. He, et al., *65+ in the United States: 2005*, U.S. Census Bureau, Dec. 2005, at [http://www.census.gov/prod/2006pubs/p23-209.pdf].

[43] For additional information on how CMS projects future health care expenditures, see [http://new.cms.hhs.gov/NationalHealthExpendData/downloads/projections-methodology-2006.pdf].

Table 3. Projected Changes in Long-Term Care Spending by Payer, 2004 and 2015
(expenditures in billions, in nominal dollars)

	2004		2015	
	Total	**Percent of expenditures**	**Total**	**Percent of expenditures**
Medicaid	$95.7	49.3%	$236.3	56.4%
Medicare	$37.4	19.2%	$80.0	19.1%
Out-of-pocket	$36.9	19.0%	$63.6	15.2%
Private insurance	$14.2	7.3%	$21.3	5.1%
Other public	$4.9	2.7%	$9.4	2.2%
Other private	$5.2	2.5%	$8.0	1.9%
Total	**$194.3**	**100%**	**$418.7**	**100%**

Source: CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). Also includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers and data for the Medicaid 1915(c) home- and community-based waivers. It does not include expenditures for hospital-based nursing home and home health providers paid for by other sources and certain expenditures which are similar in nature to Medicaid 1915(c) waiver services, but are paid for by other sources (e.g., home modifications).

Conclusion

Long-term care includes a wide variety of services and supports for individuals with disabilities and chronic conditions. No single payer discussed in this report covers all services for all individuals. Each have different eligibility requirements and benefits. Medicaid, the primary payer for long-term care in this country, covers individuals who meet certain income and asset standards. After Medicaid, Medicare spending represented the second highest payment source for long-term care services though it provides a limited long-term care benefit. Out-of-pocket expenditures followed closely as the third largest source payer. Private long-term care insurance, while growing in the number of policyholders, remains a limited payer for long-term care expenditures.

As Congress continues its interest and oversight of this area, some questions that may arise include:

- To what extent will demand for long-term care services grow in the future; and if demand increases, is the current long-term care financing structure in a position to meet this increased demand for services?
- What should be the respective roles of public and private payers?

- Who should be eligible to receive publicly-funded long-term care services, and what should eligibility be based on (e.g., level of need, severity of disability, availability of personal resources)?
- Should individuals receive incentives to save personal funds to pay for long-term care services as part of planning for retirement?
- Is a different approach for financing long-term care needed for individuals who have (or acquire) a disability before age 65?

Appendix A. Data on Long-Term Care Expenditures and Trends

Table 4. Long-term Care Expenditures by Payer, 1990-2004

(in billions, nominal dollars)

Year	Total	Medicaid	Medicare	Out-of-pocket	Private insurance	Other public payers	Other private Payers
1990	$71.2	$30.5	$6.7	$21.3	$5.8	$2.1	$4.8
1991	80.8	36.1	9.0	21.9	6.3	2.3	5.1
1992	90.3	40.0	12.7	22.5	7.0	2.5	5.5
1993	100.0	43.8	16.9	22.9	7.7	2.8	5.9
1994	110.5	47.3	23.2	22.5	9.1	3.1	5.3
1995	124.4	50.4	27.6	25.3	11.6	3.3	6.2
1996	136.1	54.5	31.7	26.3	13.6	3.4	6.5
1997	145.8	59.1	33.7	28.3	14.5	3.5	6.8
1998	149.6	62.1	27.7	33.4	16.4	3.5	6.4
1999	149.0	65.9	23.3	33.5	16.1	3.6	6.6
2000	154.3	71.5	24.7	33.8	14.9	3.6	5.8
2001	164.6	79.4	28.2	34.2	13.9	4.0	5.0
2002	173.0	84.7	31.2	34.4	13.8	4.1	4.8
2003	182.1	90.1	33.5	35.2	13.9	4.4	4.9
2004	194.3	95.7	37.4	36.9	14.2	4.9	5.2

Source: CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). Also includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers and data for the Medicaid 1915(c) home- and community-based waivers. It does not include expenditures for hospital-based nursing home and home health providers paid for by other sources and certain expenditures which are similar in nature to Medicaid 1915(c) waiver services, but are paid for by other sources (e.g., home modifications).

Table 5. Annual Percentage Growth in Long-term Care Expenditures by Payer, 1990-2004

	Total	Medicaid	Medicare	Out-of-pocket	Private insurance	Other public	Other private
1990-1991	13.4%	18.1%	34.2%	3.1%	9.0%	6.4%	7.9%
1991-1992	11.8%	10.8%	41.1%	2.7%	10.4%	10.1%	7.8%
1992-1993	10.7%	9.6%	32.2%	1.6%	10.4%	10.6%	7.4%
1990-1993	12.0%	12.8%	35.8%	2.5%	9.9%	9.0%	7.7%
1993-1994	10.6%	8.0%	37.6%	-1.5%	18.2%	12.2%	-11.3%
1994-1995	12.6%	6.6%	19.1%	12.1%	27.4%	4.5%	
1995-1996	9.4%	8.2%	14.8%	3.9%	17.1%	5.9%	4.4%
1993-1996	10.8%	7.6%	23.5%	4.7%	20.8%	7.5%	3.1%
1996-1997	7.2%	8.4%	6.2%	7.7%	6.1%	1.2%	4.1%
1997-1998	2.6%	5.1%	-17.7%	18.0%	13.3%	1.0%	-4.7%
1998-1999	-0.4%	6.0%	-16.0%	0.5%	-1.8%	2.4%	2.4%
1996-1999	3.1%	6.5%	-9.8%	8.5%	5.7%	1.5%	0.5%
1999-2000	3.6%	8.5%	6.1%	0.9%	-7.3%	0.5%	-12.7%
2000-2001	6.7%	11.0%	14.3%	1.1%	-7.0%	9.4%	-13.2%
2001-2002	5.1%	6.7%	10.7%	0.5%	-0.6%	3.6%	-3.2%
1999-2002	5.1%	8.7%	10.3%	0.8%	-5.0%	4.4%	-9.8%
2002-2003	5.3%	6.5%	7.4%	2.5%	0.9%	7.6%	1.5%
2003-2004	6.7%	6.2%	11.4%	4.8%	2.4%	10.9%	4.7%
2002-2004	6.0%	6.3%	9.4%	3.6%	1.6%	9.2%	2.0%

Source: CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). Also includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers and data for the Medicaid 1915(c) home- and community-based waivers. It does not include expenditures for hospital-based nursing home and home health providers paid for by other sources and certain expenditures which are similar in nature to Medicaid 1915(c) waiver services, but are paid for by other sources (e.g., home modifications).

Appendix B. Medicaid Home and Community-Based Waiver Services

Below is a list of the wide array of services that states have opted to cover under the Medicaid home- and community-based waiver program. Each state may determine which services will be covered, and the amount, duration or scope of each particular services.

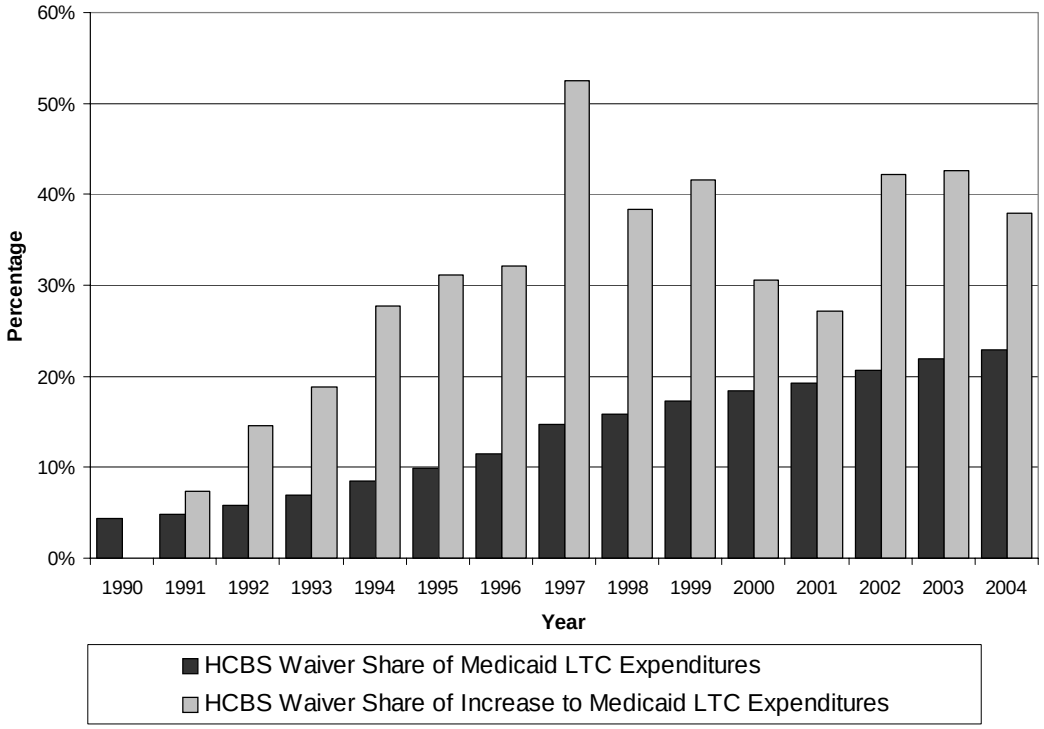
Some of the items provide additional services beyond what is normally available under the Medicaid program (e.g., expanded dental benefits and/or prescription drugs). These types of services are not normally considered within the definition of long-term care services. However, national data do not exist that would disaggregate the Medicaid home- and community-based waiver expenditures into specific sub-types of services. As a result, for purposes of this report, all of these services are considered included in the definition of "long-term care."

- Adult day care
- Services in community-based residential setting
- Assistive technology
- Personal care/Homemaker support services
- Nursing services
- Companion services
- Counseling/Mental health services
- Case management
- Consumer and family skills training
- Dental
- Home and environmental access and modifications
- Home-delivered meals
- Hospice
- Interpreter
- Nutrition counseling and supplements
- Prescription drugs
- Medication management
- Emergency response, crisis intervention, and protective services
- Therapies: speech, physical, occupational
- Physician Services
- Respite
- Massage/Acupuncture
- Transportation

Appendix C. The Role of Medicaid Home and Community-Based (HCBS) Waivers in Medicaid Long-Term Care

The expansion in Medicaid home- and community-based (HCBS) waiver program has comprised a significant share of the increase to Medicaid long-term care expenditures particularly given the relative size of HCBS waiver spending compared to institutional spending. Since 1994, the increase in HCBS waiver spending has contributed at least a quarter of the total increase to Medicaid long-term care and for several years has been over one-third of the increase. The growth in HCBS waiver spending has resulted in a steady increase in HCBS waiver programs as a share of total Medicaid LTC spending. (**See Figure 6**.)

Figure 6. Medicaid HCBS Waiver Spending Relative to all Medicaid Long-Term Care (LTC) Spending, 1990-2004



Source: CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). Also includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers and data for the Medicaid 1915(c) home and community-based waivers. It does not include expenditures for hospital-based nursing home and home health providers paid for by other sources and certain expenditures which are similar in nature to Medicaid 1915(c) waiver services, but are paid for by other sources (e.g., home modifications).