



Long-Term Services and Supports: Overview and Financing

Kirsten J. Colello

Specialist in Health and Aging Policy

Janemarie Mulvey

Specialist in Health Care Financing

Scott R. Talaga

Analyst in Health Care Financing

April 4, 2013

Congressional Research Service

7-5700

www.crs.gov

R42345

CRS Report for Congress

Prepared for Members and Committees of Congress

Summary

Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports that are needed by individuals over an extended period of time. The need for LTSS affects persons of all ages and is generally measured by limitations in an individual's ability to perform daily personal care activities (e.g., eating, bathing, dressing, walking) or activities that allow individuals to live independently in the community (e.g., shopping, housework, meal preparation). Most individuals prefer to be cared for in their own homes with the assistance of informal providers such as family members or friends, if available. The most recent published data estimating the number of Americans in need of LTSS indicate that about 10.9 million individuals living in the community need LTSS, or 4.1% of the community-resident population. It was estimated another 1.8 million individuals needing LTSS live in an institutional setting, such as a nursing home.

LTSS include a variety of services and supports to assist an individual in maintaining an optimal level of functioning and/or improving his or her quality of life. Examples include a home health aide administering medication, a contractor building a wheelchair ramp onto a home, or a nursing facility where a person resides. LTSS also vary in cost and intensity, depending on the individual's underlying conditions, the severity of his or her disabilities, the setting in which services are provided, and the caregiving arrangement (i.e., informal care versus formal care).

Formal, or paid, LTSS are a significant component of personal health care spending in the United States. In 2011, of the \$2.3 trillion spent on all U.S. personal health care services, \$317.1 billion (13.9%) was spent on LTSS. Spending for LTSS includes payments for services in nursing facilities and residential mental health and substance abuse facilities. Spending also includes LTSS provided in an individual's own home, such as home health services as well as a wide range of home and community-based services (HCBS), including personal care, homemaker or chore services (e.g., housework or meal preparation), and adult day health services. A substantial amount of LTSS is also provided by informal caregivers—family and friends—who provide care without compensation. As a result, spending on LTSS may be underestimated, as spending data do not include uncompensated care provided by informal caregivers.

LTSS are paid by a variety of public and private sources. Public sources accounted for the majority (72.8%) of spending on LTSS in 2011 and include Medicaid, Medicare, and other public programs such as the Veterans Health Administration (VHA) and the State Children's Health Insurance Program (CHIP). The remainder (27.2%) was paid by private sources, which include out-of-pocket spending, private insurance, and other charitable contributions. For 2011, Medicaid (combined federal and state spending) was the single largest payer of LTSS.

Given that the majority of LTSS are publicly funded with federal dollars, LTSS financing may be an important issue for Congress. On January 2, 2013, the President signed H.R. 8, the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240). Among other things, ATRA established a Congressional Long-Term Care Commission, which is required to develop a plan for the establishment, implementation, and financing of an LTSS system. A vote on the developed plan and any legislative proposals is required six months after its establishment.

This report provides an overview of LTSS, including who needs LTSS, how need for LTSS is determined, and how much LTSS costs. The report also provides information on who the primary LTSS payers are, how much they spend, and what types of services are purchased.

Contents

Introduction.....	1
What Are Long-Term Services and Supports?.....	2
Who Needs Long-Term Services and Supports?	3
How Much Do Long-Term Services and Supports Cost?.....	5
Who Pays for Long-Term Services and Supports?	6
Public Sources of Financing for Long-Term Services and Supports.....	8
Medicaid.....	9
Medicare.....	16
Other Public Payers.....	19
Private Sources of Financing for Long-Term Services and Supports.....	20
Out-of-Pocket Spending.....	20
Private Insurance.....	21
Other Private Funds.....	23

Figures

Figure 1. Long-Term Services and Supports (LTSS) Spending, by Payer, 2011	7
Figure 2. Proportion of Medicaid Long-Term Services and Supports (LTSS) Spending, by Setting, 1995-2011	13
Figure 3. Proportion of Medicare Long-Term Services and Supports (LTSS) Spending, by Service, 1995-2011	17

Tables

Table 1. Population Needing Long-Term Services and Supports (LTSS) in the United States, by Age and Setting	4
Table 2. Estimated Median Costs for Selected Long-Term Services and Supports (LTSS) Providers, 2012.....	6
Table 3. Long-Term Services and Supports (LTSS) Spending Among Payers, by Setting, 2011	8
Table 4. Medicaid Total and Long-Term Services and Supports (LTSS) Spending, 1995-2011	10
Table 5. Medicaid Long-Term Services and Supports (LTSS) Institutional Care Services.....	14
Table 6. Selected Medicaid Home and Community-Based Services (HCBS).....	15
Table 7. Long-Term Services and Supports (LTSS) Spending by Other Public Payers, 2011	19

Contacts

Author Contact Information.....	24
Acknowledgments	24
Area of Expertise by Author	24

Introduction

Spending on long-term services and supports (LTSS) is a significant component of personal health care spending in the United States. Of the \$2.3 trillion spent in 2011 on all U.S. personal health care services, \$317.1 billion, or 13.9%, was spent on formal, or paid, LTSS. Spending for LTSS includes services in both institutional settings—nursing facilities 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, personal care, and adult day health services.¹ The majority of spending on formal, or paid, LTSS is publicly financed by federal, state, and local governments through programs such as Medicaid, Medicare, the Veterans Health Administration (VHA), and the State Children’s Health Insurance Program (CHIP), among others. For 2011, Medicaid (combined federal and state spending) was the single largest payer at \$133.5 billion, or 42.1%, of spending on LTSS. However, LTSS spending may be underestimated as spending data do not include informal, or uncompensated, care provided by family caregivers.

The probability of needing LTSS increases with age. As the older population continues to increase in size and proportion, and as individuals continue to live longer post-retirement, the demand for health and LTSS is also expected to increase. In addition, advances in medical and supportive care may allow younger persons with disabilities to live longer lives. Given current spending on LTSS and the likely increase in demand for these services, the role of public financing in LTSS may be an important issue for the 113th Congress (see text box below entitled “**Long-Term Care Commission**”).

With respect to public LTSS financing, policymakers are generally concerned with issues of access, cost, and quality of care. For example, federal requirements as well as state decisions concerning eligibility for, or coverage of, certain LTSS determine who receives access to publicly-financed LTSS. These requirements and decisions also determine the care settings and the services that may be provided. Costly LTSS may exhaust an individual’s financial resources which may lead to reliance on public support. Federal and state policymakers concerned about overall spending may have an interest in controlling growth in LTSS expenditures or in reducing such expenditures. Moreover, how and where LTSS are delivered may lead to care fragmentation and lack of coordination among service providers and payers.

Long-Term Care Commission

On January 2, 2013, the President signed H.R. 8, the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240). Among other things, ATRA repealed provisions under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), which established the framework for a federally administered voluntary Long-Term Care (LTC) insurance program entitled the Community Living Assistance Services and Supports (CLASS) program.² In an effort to continue the policy discussion with respect to LTSS financing, ATRA established a Congressional Commission on Long-Term

¹ The range and variation in LTSS create significant challenges for researchers and policymakers in establishing a common definition of “long-term services and supports” for the purpose of evaluating LTSS expenditures and determining policy. For example, some argue that Medicare expenditures for skilled nursing facilities and home health services are post-acute services of limited duration and scope, and should not be categorized as LTSS. Others argue that Medicare is an important payer in the continuum of LTSS, since many nursing facility residents start with Medicare paying for the cost of the service; but after the Medicare coverage period ends, Medicaid may pay for these expenditures. This report includes Medicare freestanding and hospital-based skilled nursing facility and home health expenditures as part of LTSS.

² For further information on the CLASS program see CRS Report R40842, *Community Living Assistance Services and Supports (CLASS): Overview and Summary of Provisions*, by Kirsten J. Colello and Janemarie Mulvey.

Care. Specifically, Section 643 of ATRA required the LTC Commission (hereinafter referred to as the Commission) to develop a plan for the establishment, implementation, and financing of a LTSS system.³ For the purposes of developing the plan, the Commission must provide recommendations for addressing the interaction of LTSS with existing programs, such as Medicare and Medicaid, and private insurance, among other things. Composed of 15 members, Commission membership includes individuals who represent the interests of LTSS stakeholders and organizations, as described in statute.⁴ No later than six months after appointment, the LTC Commission will vote on a report based on the developed plan and any proposals for legislative action, referred to as the Commission bill. If approved by a majority vote of Commission members, the Commission bill will be transmitted to the President and other specified congressional leaders; the proposal and vote will also be made publicly available. If approved by a majority, the Commission bill must be introduced in the Senate and the House. The Commission will be terminated 30 days after the Commission vote.

The following provides an overview of LTSS and their financing, including information in response to the following questions: What are LTSS? Who needs LTSS? How much do LTSS cost? The report also provides information on who pays for LTSS, including how much is spent by payers 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 LTSS expenditures. Furthermore, this report does not address the economic value of informal caregiving.⁵

This report uses the term “long-term services and supports (LTSS)” rather than “long-term care (LTC).” LTSS is a term that is more commonly used by researchers and policymakers to better describe the types of assistance that are provided to persons with disability and the frail elderly. The term “long-term care” is still used in this report, for example, when referring to the named “Long-Term Care Commission,” as described above, or private long-term care insurance.⁶

What Are Long-Term Services and Supports?

Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive or mental, disability or condition. Often the individual’s disability or condition results in the need for hands-on assistance or supervision over an extended period of time. Moreover, an individual’s need for LTSS may change over time as his or her needs or conditions change. Thus, the need for these services and supports is on-going or “long-term.”

LTSS are not medical or acute care services. In general, acute care services are health services provided for the prevention, diagnosis, or treatment of a medical condition. Acute care services are often performed by licensed health care providers (e.g., physicians) in a clinical setting such as a doctor’s office or a hospital. While LTSS may be offered in combination with acute care

³ Section 643 of ATRA (P.L. 112-240) authorizes the Senate to disburse necessary LTC Commission expenses, as requested, and sets forth various staffing and ethical standards and powers of the Commission in carrying out its duties.

⁴ Section 643 of ATRA requires the LTC Commission to comprise 15 members with certain members appointed by the President and others by specified congressional leaders, no later than 30 days after enactment. For information on LTC Commission member appointments, see <http://www.forbes.com/sites/howardgleckman/2013/03/13/white-house-finally-fills-out-long-term-care-commission/>.

⁵ For information on the economic value and costs of caregiving, see CRS Report RL34123, *Family Caregiving to the Older Population: Background, Federal Programs, and Issues for Congress*, by Kirsten J. Colello.

⁶ The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), uses the term LTSS and defines the term to include certain institutionally-based and non-institutionally-based long-term services and supports [Section 10202(f)(1)].

services, LTSS are not intended to treat or cure a medical condition. In contrast, LTSS provide assistance to individuals in maintaining or improving an optimal level of physical functioning and quality of life.

Examples of LTSS include a home health aide assisting a frail elderly person with daily personal care activities such as bathing or dressing, a contractor building a wheelchair ramp onto a home, or a senior center providing transportation to a cognitively impaired individual. LTSS include the use of supports such as special equipment, assistive devices, or technology by a physically impaired person. Services also include more intensive nursing care, such as nursing care provided to a ventilator-dependent child. Residential LTSS settings such as group homes or assisted living facilities (ALFs) may provide LTSS such as meals, laundry and housework, and assistance with medication. Individuals who have severe physical or cognitive impairments often need the 24-hour supervision and nursing or convalescent care-related LTSS that are provided in a nursing facility.

LTSS are often provided by non-licensed providers such as certified nurse assistants (CNAs) or personal care attendants and include informal, or unpaid, caregivers such as family members or friends. LTSS can be provided in a private home or community-based setting such as an adult day health center. LTSS are also provided in a facility-based or institutional setting such as a nursing facility.

Who Needs Long-Term Services and Supports?

The need for LTSS 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, such as mental illness or traumatic brain injury; and the elderly with chronic conditions or diseases, such as severe cardiovascular disease or Alzheimer’s disease and related dementia. The need for LTSS is generally measured, irrespective of age and diagnosis, by the presence of functional limitations in the ability to perform basic personal care activities, known as activities of daily living (ADLs), or by the need for supervision or guidance with ADLs because of a mental or cognitive impairment.⁷

ADLs generally refer to activities such as eating, bathing, using the toilet, dressing, walking across a small room, and transferring (i.e., getting in or out of a bed or chair). Instrumental activities of daily living (IADLs) are also used to measure a person’s need for LTSS. These activities are necessary for an individual’s ability to live independently in the community. IADLs include activities such as preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone, doing laundry, getting around outside the home, and taking medications.

In practice, defining the need for LTSS as the presence of functional limitations measured by the number of limitations in specific ADLs or IADLs has important policy implications. For example, publicly-financed programs that cover LTSS such as Medicaid often use the number of limitations in ADLs to determine LTSS program eligibility, among other criteria. For those individuals who have a private long-term care insurance policy, the number of limitations in ADLs also forms the

⁷ In general, children who need LTSS are those who cannot perform age-appropriate activities, such as walking, or cannot perform other age appropriate self-care activities.

basis for triggering benefit eligibility. Thus, defining the need for LTSS through functional limitations and/or the need for supervision with ADLs determines eligibility for public and private financing.

The most recent published data that estimate the number of Americans in need of LTSS, indicated 10.9 million individuals of all ages living in the community were in need LTSS in 2005, or 4.1% of the community-resident population (see **Table 1**). Most individuals prefer to be cared for in their own homes with the assistance of informal providers such as family members or friends, if available. Among community residents who need LTSS, about half (49.8%) were older adults (ages 65 and older) while slightly less than half (46.6%) were adults ages 18 to 65, and 3.6% were children under age 18. Another 1.8 million individuals needing LTSS were estimated to live in an institutional setting, such as a nursing home, as of 2007. The majority of nursing home residents (86.0%) were adults ages 65 and over.

Table 1. Population Needing Long-Term Services and Supports (LTSS) in the United States, by Age and Setting

(data for community residents from 2005; institutional residents from 2007)

	All Ages	Less than Age 18 ^c	Ages 18 to 64	Ages 65 and Over
Community Residents^a (% of community residential population)	10,887,000 (4.1%)	393,000 (0.8%)	5,073,000 (2.8%)	5,421,000 (15.5%)
Institutional Residents^b	1,788,000	—	250,000	1,538,000

Source: H. S. Kaye, C. Harrington, and M. P. LaPlante, “Long-Term Care: Who Gets It, Who Provides It, Who Pays, And How Much?” *Health Affairs*, vol. 29, no. 1 (January 2010), p. 13.

- a. Kaye et al. estimates of community residents are based on data from the 2005 Survey of Income and Program Participation (SIPP) which define a “broadly defined long-term care population” as those persons needing help with one or more Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL).
- b. Kaye et al. estimates of institutional residents are based on data from the 2007 American Community Survey (ACS) from table S2601B at <http://factfinder.census.gov>.
- c. For estimates of community residents using SIPP, ADL data were collected for ages 6 and over and IADL data were collected for ages 15 and over; for estimates of institutional residents using ACS, ADL data were collected for those ages 18 and over.

While the need for, use of, and costs associated with LTSS vary across individuals over their lives, the probability of needing LTSS increases with age. Researchers have estimated that over two-thirds of individuals turning age 65 in 2005 will need long-term care before they die; 31% will not need any care.⁸ Thus, as the population ages the demand for LTSS is expected to increase. In addition, advances in medical care and supportive care are enabling younger persons with disabilities to live longer lives. Some observers speculate that with continued improvement in health status, people with intellectual and/or developmental disabilities could be expected to have a lifespan equal to that of the general population.⁹

⁸ Peter Kemper et al., “Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?” *Inquiry* 42, Winter 2005-2006. The definition of long-term care need is based on a moderate level of disability defined as one or more ADLs or four or more IADLs.

⁹ David Braddock, Richard Hemp and Mary Rizzolo, et. al, *State of the States in Developmental Disabilities: 2005*, (continued...)

How Much Do Long-Term Services and Supports Cost?

LTSS vary widely in their intensity and cost, depending on the individual's underlying conditions, the severity of his or her disabilities, the setting in which services are provided, and the caregiving arrangement (i.e., informal versus formal care). The cost of obtaining paid assistance for these services, especially over a long period of time, may far exceed many individuals' financial resources. Moreover, public programs that finance this care, such as Medicaid or Medicare, may not cover all the services and supports an individual may need. Large personal financial liabilities associated with paid LTSS may leave individuals in need of LTSS and their families at financial risk.

For those receiving LTSS at home, the cost for these services can vary depending on the amount and duration of care provided. According to research on the amount of paid LTSS received by adults living at home, those in need of paid personal care services received about 18 hours a week, on average. In 2012, the median cost of homemaker services (e.g., meal preparation, housework) is \$18 an hour, whereas the median cost of care provided by a home health aide (e.g., hands-on assistance with personal care needs) is \$19 an hour (see **Table 2**). Assuming care is provided 18 hours per week,¹⁰ the median annual cost for homemaker services would be just over \$17,000 in 2012, while the median cost of home health aide services would be about \$18,000. Those needing more intensive care at home would have higher costs associated with their care. Adult day health centers that provide social and other related support services in a community-based setting for part of the day, have a median cost of \$61 per day or almost \$16,000 per year in 2012. These estimates are national figures and can vary widely by geographic region.

Residential settings that provide housing and services as well as institutional settings that provide room and board tend to have higher annual costs than home care services, on average. Assisted living facilities that provide homemaker services (meals, laundry, or housework) and may provide personal care for those who need assistance with ADLs (but do not yet require constant care provided in a nursing home) have a median cost of almost \$40,000 annually in 2012. Nursing home care, on the other hand, generally costs more, because it provides assistance 24 hours a day and includes the cost of room and board. In 2012, the median annual cost of nursing home care is \$73,000 for a semi-private room and over \$81,000 for a private room.¹¹ As with estimated costs for home care services, these estimates are national figures and can vary widely by geographic region.

(...continued)

Coleman Institute for Cognitive Disabilities, University of Colorado, 2005; Jay Bhattacharya, Kavita Choudhry, and Darius Lakdawalla, *Chronic Disease and Trends in Severe Disability Among Working-Age Populations*, In *Workshop in Disability in America, A New Look, Summary and Background Papers*, Institute of Medicine, Washington, DC, 2005; Darius Lakdawalla, Dana P. Goldman, Jay Bhattacharya, Michael Hurd, Geoffrey Joyce, and Constantijn Panis, "Forecasting the Nursing Home Population," *Medical Care*, v. 41, no. 1, 2003.

¹⁰ CRS analysis of monthly and annual rates for home health aide and homemaker services assume 18.4 hours of paid personal care per week, on average, based on analysis of national estimates of the number of caregivers and number of hours of care per week based on 2009 data published in L. Feinberg et al., *Valuing the Invaluable: 2011 Update The Growing Contributions and Costs of Family Caregiving*, AARP Public Policy Institute, June, 2011.

¹¹ Genworth Financial, *Genworth 2012 Cost of Care Survey: Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes*, 2012.

Table 2. Estimated Median Costs for Selected Long-Term Services and Supports (LTSS) Providers, 2012

	Median Hourly Rate	Median Daily Rate	Median Monthly Rate	Median Annual Rate
Nursing Home (Private Room) ^a	—	\$222	\$6,660	\$81,030
Nursing Home (Semi-Private Room) ^a	—	\$200	\$6,000	\$73,000
Assisted Living Facility ^b	—	—	\$3,300	\$39,600
Home Health Aide (Licensed) ^c	\$19	—	\$1,398	\$18,179
Homemaker Services (Licensed) ^d	\$18	—	\$1,325	\$17,222
Adult Day Health Services ^e	—	\$61	\$1,220	\$15,860

Source: CRS analysis of data from Genworth Financial, *Genworth 2012 Cost of Care Survey: Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes, 2012*; assumption of 18.4 hours of paid care for Home Health Aide and Homemaker Services based on analysis of national estimates of the number of caregivers and number of hours of care per week based on 2009 data published in L. Feinberg, et al., *Valuing the Invaluable: 2011 Update The Growing Contributions and Costs of Family Caregiving*, AARP Public Policy Institute, June, 2011.

- a. Nursing Home monthly and annual rates are based on daily rates, multiplied by 30 and 365 days, respectively.
- b. For Assisted Living Facility, this is the rate for a one-bedroom or single-occupancy unit. Assisted Living Facility annual rates are based on a median monthly rate multiplied by 12 months. These costs exclude entrance fees.
- c. For Home Health Aide Services, this is the rate charged by a non-Medicare certified, licensed agency. Home Health Aide Services monthly and annual rates are based on 18.4 hours/week multiplied by 4 and 52 weeks, respectively.
- d. For Homemaker Services, this is the rate charged by a non-Medicare certified, licensed agency. Homemaker Services monthly and annual rates are based on 18.4 hours/week multiplied by 4 and 52 weeks, respectively.
- e. Adult Day Health Services monthly and annual rates are based on 5 days/week multiplied by 4 and 52 weeks, respectively.

Who Pays for Long-Term Services and Supports?

Total U.S. spending on formal LTSS is a significant component of all personal health care spending.¹² In 2011, an estimated \$317.1 billion was spent on LTSS; representing 13.9% of the \$2.3 trillion spent on personal health expenditures in the U.S.¹³ There is disagreement among policy analysts as to whether LTSS spending should include Medicare.¹⁴ Excluding Medicare

¹² LTSS expenditure data are from the National Health Expenditure Accounts (NHEA) published annually by the U.S. Department of Health and Human Services (HHS). NHEA data represent aggregate health care spending. Data reported are for 2011 and are for personal health expenditures which is a subcategory of national health expenditures, and excludes the following expenditure categories: government administration, net cost of health insurance, government public health activities, and investment. LTSS personal care expenditures by payer and setting for 2011 were obtained through personal communication with the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

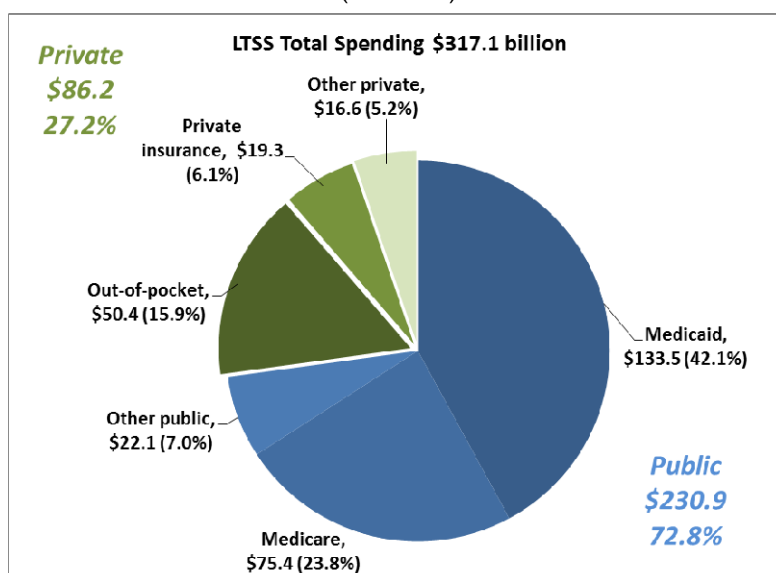
¹³ Based on CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

¹⁴ See footnote 1.

spending on home health and skilled nursing facilities, total LTSS spending was \$241.7 billion or 10.6% of U.S. personal health expenditures in 2011.

Formal LTSS are paid by a variety of public and private sources. **Figure 1** shows LTSS spending by payer for 2011. In addition to each payer source, the figure also provides total public and private funding amounts. Public sources accounted for the majority (72.8%) of LTSS spending. These sources include Medicaid, Medicare, and other public programs. The remaining 27.2% was paid by private sources including private health and long-term care insurance policies, out-of-pocket expenditures, and other private sources. For 2011, Medicaid (combined federal and state spending) was the single largest payer at \$133.5 billion, or 42.1%, of LTSS spending. Medicare represented the next largest share of spending at \$75.4 billion, or 23.8%, of all LTSS expenditures in 2011. Other public sources of funding, such as the Veterans Health Administration (VHA) and the State Children’s Health Insurance Program (CHIP), and other state and local financing for LTSS paid \$22.1 billion, or 7.0%, of the total.

Figure 1. Long-Term Services and Supports (LTSS) Spending, by Payer, 2011
(in billions)



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

LTSS spending is distributed between three types of settings—nursing care facilities; home care; and other residential facilities for persons with mental retardation, mental health conditions, and substance abuse issues. **Table 3** shows LTSS spending in 2011 for each of these settings by payer. For 2011, about half of LTSS spending (49.3%) was for care provided in nursing facilities, totaling \$156.5 billion, while more than one-third of LTSS (36.7%) was for LTSS in the home and 13.9% for LTSS in residential facilities. Across all settings, public payers were the predominant source of LTSS spending. Public spending accounted for a substantial share of home care (90.0%) but less so among residential and nursing facilities (62.9% and 62.8%, respectively). In all three settings, Medicaid was the predominant public source of payment. While private payments represent a smaller share of LTSS spending for each setting, notably, out-of-pocket expenditures was the second largest source of payment for nursing facilities following Medicaid.

Table 3. Long-Term Services and Supports (LTSS) Spending Among Payers, by Setting, 2011
(in billions)

	Nursing Facilities		Home Care		Residential Facilities	
Public Payers	\$98.3	62.8%	\$104.8	90.0%	\$27.8	62.9%
Medicaid	50.4	32.2	67.6	58.0	15.4	34.9
Medicare ^a	40.4	25.8	35.0	30.0	—	—
Other Public ^b	7.4	4.7	2.3	2.0	12.4	28.0
Private Payers	\$58.2	37.2%	\$11.6	10.0%	\$16.4	37.1%
Out-of-Pocket	39.9	25.5	5.6	4.8	4.9	11.1
Private Insurance	12.4	7.9	5.1	4.4	1.7	3.9
Other Private ^c	5.9	3.8	0.9	0.8	9.7	22.0
Total	\$156.5	100.0%	\$116.5	100.0%	\$44.2	100.0%
Total as % of LTSS Spending	49.3%		36.7%		13.9%	

Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

Notes: Amounts may not sum to total due to rounding.

- a. Medicare expenditures include estimated shares of Medicare Advantage (Medicare Part C) capitated payments attributable to skilled nursing facility care, home health care, and hospice care provided by home health agencies.
- b. Includes LTSS expenditures from the Veterans Health Administration, the State Children’s Health Insurance Program, state and local programs, general assistance programs (e.g., State Pharmaceutical Assistance Programs), and Residential Mental Retardation, Mental Health, and Substance Abuse Facilities.
- c. Includes philanthropic support from individuals and charitable organizations.

Public Sources of Financing for Long-Term Services and Supports

As previously indicated, public sources account for the majority of LTSS spending. Medicaid and Medicare are the first and second largest public payers, respectively, and accounted for nearly two-thirds (65.9%) of all LTSS spending nationwide in 2011 (see **Figure 1**). Other public programs that finance LTSS for specific populations provide a much smaller share of total LTSS funding (7.0%). These public sources of funding include LTSS funding through the VHA and CHIP, among others.¹⁵ It is important to note that the eligibility requirements and benefits provided by these public programs vary widely.¹⁶ Moreover, among the various public sources of

¹⁵ Data from the National Health Expenditure Accounts (NHEA) do not include federal discretionary funding for LTSS provided under the Older Americans Act (OAA) or Title XX of the Social Security Act (SSA), the Social Services Block Grant Program (SSBG). OAA nutrition services programs, such as congregate and home-delivered meals (also referred to as “Meals on Wheels,”) are excluded from the NHEA because these programs are viewed as nutrition programs rather than health service programs. For information on these programs see CRS Report RL33880, *Funding for the Older Americans Act and Other Aging Services Programs*, by Angela Napili and Kirsten J. Colello and CRS Report 94-953, *Social Services Block Grant: Background and Funding*, by Karen E. Lynch.

¹⁶ For further information about these programs, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz; CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga; CRS Report R40444, (continued...)

LTSS financing, none is designed to cover the full range of services and supports that may be desired by individuals with long-term care needs. The following describes these public LTSS payers—Medicaid, Medicare, and other public sources.

Medicaid

Medicaid is a means-tested health and LTSS program funded jointly by federal and state governments. The federal match rate for Medicaid expenditures varies from state-to-state. For FY2013, the federal medical assistance percentage (FMAP) ranges from 50% to 74%, with the federal contribution covering about 57% of the total cost of Medicaid in a typical year.¹⁷ Due to the temporary FMAP increase provided through the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and extended through P.L. 111-226, on average the federal government paid about 64% while states paid the remaining 36% in 2011.¹⁸ Medicaid funds are used to pay for a variety of health care services and LTSS, including inpatient and outpatient hospital care, physician services, family planning, certain screening and diagnostic services, nursing facility care, and home health care. Each state designs and administers its own program within broad federal guidelines.

As stated previously, Medicaid is the largest single payer of LTSS in the United States; in 2011, the program paid 42.1% of all LTSS expenditures at \$133.5 billion. Since 1995, Medicaid LTSS expenditures have grown at an average annual rate of 6.2%. For 2011, Medicaid LTSS spending increased 1.6% over the previous year. Even though the growth rate for 2011 is slower than the average annual rate since 1995, some policymakers are still concerned with growth in LTSS spending given that such spending is high relative to the number of people served. In 2011, Medicaid LTSS accounted for over one-third (35.6%) of all Medicaid spending (see **Table 4**) despite the fact that LTSS recipients represent a relatively small share of the total Medicaid population. The most recent data available estimated that 6.7% of Medicaid recipients (or 4.2 million beneficiaries) received LTSS in 2009.¹⁹ In other words, 6.7% of beneficiaries account for over one-third of the costs. Out of concern, some states are re-examining their Medicaid programs in an effort to control state spending. However, since 1995, the share of Medicaid LTSS spending relative to total Medicaid spending has remained relatively constant, as shown in **Table 4**.

(...continued)

State Children's Health Insurance Program (CHIP): A Brief Overview, by Elicia J. Herz and Evelyne P. Baumrucker, CRS Report R41944, *Veterans' Medical Care: FY2012 Appropriations*, by Sidath Viranga Panangala.

¹⁷ See CRS Report RL32950, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2013*, by Alison Mitchell and Evelyne P. Baumrucker.

¹⁸ Christopher J. Truffer, John D. Klemm, Christian J. Wolfe, et al., *2012 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, 2012. For FY2009 through FY2011, the federal share of Medicaid expenditures was higher than usual due to the temporary FMAP increase provided to states from October 1, 2008 through June 30, 2011. The temporary FMAP increase was originally provided through the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and extended through P.L. 111-226.

¹⁹ Medicaid and CHIP Payment and Access Commission (MACPAC), *Overview of Medicaid and CHIP*, January 31, 2013, pg. 67.

Table 4. Medicaid Total and Long-Term Services and Supports (LTSS) Spending, 1995-2011

(in billions, nominal dollars)

Total U.S. (50 states and D.C.)	1995	2000	2005	2010	2011
Total Medicaid spending	\$136.3	\$186.9	\$287.7	\$371.6	\$374.5
Medicaid LTSS spending	\$51.0	\$72.8	\$102.5	\$131.3	\$133.5
Medicaid LTSS spending as a % of total Medicaid spending	37.4%	38.9%	35.6%	35.3%	35.6%

Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

Eligibility for Long-Term Services and Supports

Medicaid coverage of LTSS is intended to serve as a safety net for persons who cannot afford the cost of institutional or home and community-based care. In general, to qualify for Medicaid individuals must be in an *eligibility group* and meet the financial criteria for that group through either a mandatory or optional eligibility pathway to receive Medicaid services, including LTSS. Eligibility for certain LTSS under Medicaid may also require individuals to meet state-defined level-of-care eligibility criteria. That is, eligibility for Medicaid LTSS is typically based on the need for LTSS, as defined by the state.

The federal Medicaid statute defines over 50 distinct population groups as being potentially eligible for states' programs. Some eligibility groups are mandatory, meaning that all states that participate in the Medicaid program must cover them; other groups are optional.²⁰ Medicaid mandatory and optional eligibility groups provide coverage to various populations, including non-disabled children, pregnant women, adults, individuals with disabilities (i.e., blind or disabled), and people aged 65 and older (i.e., aged). Each eligibility group is further defined by its financial requirements. These requirements place limits on the amount of income, and sometimes assets,²¹ eligible individuals may possess (often referred to as standards or thresholds);²² income and assets above these amounts generally make an individual ineligible for coverage. For the most part, persons who apply to Medicaid for coverage of LTSS fall into the categories of aged, blind, or disabled.²³

²⁰ Medicaid eligibility is limited to certain groups of low-income children, pregnant women, parents of dependent children, people with disabilities, and the elderly. The ACA created a new mandatory Medicaid eligibility group for all nonelderly, non-pregnant individuals (e.g., childless adults, certain parents, and certain people with disabilities) who are not otherwise eligible for Medicaid and are also not entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B, beginning in 2014. States have the option to cover this new eligibility group before 2014.

²¹ For purposes of Medicaid eligibility, assets are often referred to as resources and the terms may be used interchangeably. Resources include, for example, cash and other liquid assets or personal property that individuals (or their spouses) own and could convert to cash.

²² Additional guidelines specify how states should calculate these amounts (i.e., counting methodologies).

²³ Many elderly and disabled Medicaid beneficiaries are also covered under Medicare. When persons qualify for both Medicaid and Medicare they are considered "dual eligibles." Dual eligibles primarily receive their acute care services through Medicare and LTSS through Medicaid. Medicaid also pays Medicare premiums and most cost-sharing for dual eligibles and other qualified low-income Medicare beneficiaries. For prescription drug coverage, dual eligibles are automatically enrolled in Medicare Part D and receive assistance with their premiums and cost sharing through the Part D low-income subsidy. In general, Medicaid pays secondary for any drugs that Medicare does not cover.

The major mandatory eligibility pathway for aged, blind, or disabled individuals covers most individuals receiving cash assistance from the Supplemental Security Income (SSI) program (SSI-Related), who have income up to about 75% of the federal poverty level (FPL). Traditionally, Medicaid eligibility rules for aged, blind, or disabled individuals have been linked to the SSI program.²⁴ Thus, individuals receiving SSI automatically qualify for Medicaid in most, but not all, states. States may elect to use disability and/or financial eligibility criteria that are more restrictive than SSI [the so-called 209(b) states].²⁵ For aged, blind, or disabled individuals who are not receiving SSI, the SSI program eligibility rules also form the basis for Medicaid eligibility. That is, an aged, blind, or disabled individual who is not receiving SSI but meets SSI program eligibility criteria in that state is also eligible for Medicaid.

Optional eligibility pathways that states may choose to offer for aged, blind, or disabled individuals include the following:

- 100% FPL—individuals with income that does not exceed 100% FPL.
- Buy-In Groups—working individuals with disabilities who pay Medicaid premiums and cost-sharing to participate.
- Special Income Rule—individuals with higher income who require a level of care offered in an institution, such as a nursing home.
- Medically Needy—individuals with high medical expenses (including LTSS expenses) who deplete their income to specified levels.

Younger persons with disabilities may also qualify for Medicaid through eligibility pathways applicable to children and adults. In general, these optional eligibility pathways allow states to cover aged, blind, or disabled individuals with income that exceeds SSI or 209(b) levels.²⁶

Once enrolled, Medicaid beneficiaries, in general, are entitled to those services that are either required or otherwise made available, at state's option, under the Medicaid state plan. In addition to categorical and financial requirements, individuals in need of LTSS may be required to meet level-of-care eligibility criteria that may include, but are not limited to, the need for the level of care provided in an institution, such as a nursing facility or a hospital. These level-of-care criteria are often measured by an individual's functional limitations in ADLs or IADLs and/or limitations in cognitive capacity and the need for supervision to carry out ADLs and IADLs.²⁷

²⁴ To qualify for SSI, a person must satisfy the program criteria for age or disability and meet SSI's income and resources requirements. For adults, disability is defined as the inability to engage in substantial gainful activity (SGA) by reason of a medically determinable physical or mental impairment expected to result in death or last at least 12 months. In general, the individual must be unable to do any kind of work that exists in the national economy, taking into account age, education, and work experience. A child under the age of 18 may qualify as disabled if he or she has an impairment that results in "marked and severe" functional limitations.

²⁵ Section 209(b) of the Social Security Amendments of 1972 (P.L. 92-603). The term "209(b)" refers to the statutory authority in the act, which allows states to use more restrictive eligibility criteria than the SSI program. There are eleven 209(b) states: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

²⁶ In addition to these optional income eligibility pathways for aged, blind, or disabled, other optional pathways include the Katie Beckett and Hospice Only Coverage pathways. For additional information, see CRS Report R41899, *Medicaid Eligibility for Persons Age 65+ and Individuals with Disabilities: 2009 State Profiles*, by Kirsten J. Colello and Scott R. Talaga.

²⁷ Persons must also meet certain citizenship and state residence criteria. Additionally, recipients may retain an allowance depending on setting. For example, nursing home residents may retain a personal needs allowance, while (continued...)

Coverage of Long-Term Services and Supports

A variety of acute care services and LTSS are available under Medicaid. With respect to LTSS, Medicaid funds services for beneficiaries in both institutional and home and community-based settings, though the portfolio of services offered differs substantially by state. Federal law requires state Medicaid programs to cover nursing facility services for certain Medicaid beneficiaries, while states have the option to cover services for other beneficiaries and in other institutional settings (e.g., ICFs/MR). States also have the option of offering home and community-based services (HCBS). This flexibility under Medicaid law has led to widespread variation in state Medicaid benefit packages offered to elderly, disabled and blind individuals. Medicaid law also offers states two broad authorities under which to offer HCBS to Medicaid beneficiaries, either as a benefit under the Medicaid state plan or through a waiver program which permits states to waive certain Medicaid requirements in the provision of these services (for more details see the section entitled “Home and Community-Based Care”).

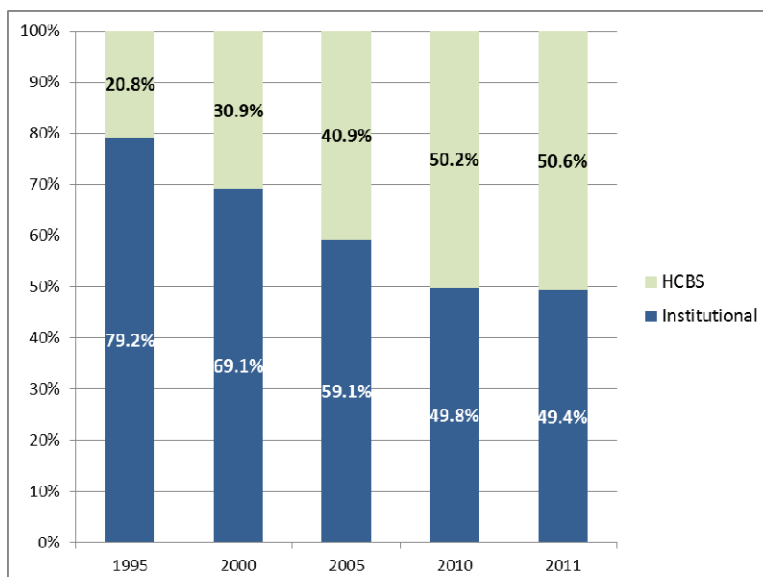
An important debate for Medicaid spending involves its perceived “institutional bias.” That is, states are required to cover nursing facility services for eligible Medicaid beneficiaries, but coverage of most HCBS is optional. **Figure 2** shows the share of institutional care and home and community-based care spending as a proportion of Medicaid LTSS spending for selected years since 1995. In 1995, more than three-quarters (79.2%) of all Medicaid LTSS spending was for institutional care. Since then, expanded federal legislative authorities and additional administrative activities have allowed states to further the provision of HCBS under Medicaid. These federal activities were, in part, prompted by the U.S. Supreme Court decision in *Olmstead v. L.C.*,²⁸ which held that the institutionalization of people who could be cared for in community settings was a violation of Title II of the Americans with Disabilities Act (ADA). As a result, the share of Medicaid LTSS spending for HCBS has increased steadily, from about 20.8% of Medicaid LTSS spending in 1995 to just over half (50.6%) of total Medicaid LTSS spending in 2011. As shown in **Figure 2**, Medicaid LTSS spending in 2010 marked a significant shift. In 2010 and 2011, HCBS spending was a greater proportion of Medicaid LTSS spending than institutional care spending. Over the same time period, the percentage of spending for institutional care as a proportion of Medicaid LTSS dropped steadily, to just under half in both 2010 and 2011.

(...continued)

residents in home and community-based settings may retain a monthly maintenance needs allowance. Beyond these allowances, Medicaid beneficiaries must apply their income toward the cost of care. For more information, see CRS Report R41899, *Medicaid Eligibility for Persons Age 65+ and Individuals with Disabilities: 2009 State Profiles*, by Kirsten J. Colello and Scott R. Talaga.

²⁸ 527 U.S. 581 (1999). For further information on *Olmstead v. L.C.*, see CRS Report R40106, *Olmstead v. L.C.: Judicial and Legislative Developments in the Law of Deinstitutionalization*.

Figure 2. Proportion of Medicaid Long-Term Services and Supports (LTSS) Spending, by Setting, 1995-2011



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

Institutional Care

Medicaid LTSS spending for institutional care covers nursing facility care and other types of institutional care. Federal Medicaid statute (Title XIX of the Social Security Act, SSA) requires states to provide nursing facility care to Medicaid recipients aged 21 and older. However, states may also offer nursing facility care to Medicaid recipients under age 21. States may also offer other types of institutional care including services in ICFs/MR and inpatient hospital services for persons aged 65 or older in Institutions for Mental Diseases (IMDs). Since 1995, Medicaid expenditures for institutional care have grown at an average annual rate of 3.1%. For 2011, Medicaid institutional spending increased 0.8% over the previous year. These growth rates are slower than the growth in overall Medicaid LTSS spending since 1995, on average (6.2%), and for 2010 to 2011 (1.6%). **Table 5** provides additional details about institutional care under Medicaid.

Table 5. Medicaid Long-Term Services and Supports (LTSS) Institutional Care Services

Service	Benefit Type	Description
Nursing Facility	Mandatory for ages 21 and over; Optional for ages under 21	States are required to cover nursing facility services for beneficiaries ages 21 and over under a state's Medicaid plan. States have the option to cover nursing facility services for those under age 21. Beneficiaries must also meet nursing home eligibility criteria, referred to as level of care criteria. Services include room and board, skilled nursing care and related services, rehabilitation, and health-related care. States may also cover therapeutic services, such as physical therapy, occupational therapy, and speech pathology and audiology services.
Intermediate Care Facilities for People with Mental Retardation (ICFs/MR)	Optional	States may provide ICF/MR services for those beneficiaries with mental retardation and developmental disabilities under a state's Medicaid Plan. Services include room and board and a wide range of specialized health and rehabilitative services to assist recipients to function at optimal levels.
Inpatient Hospital Care and Nursing Facility Care for Persons in Institutions for Mental Diseases (IMD) ^a	Optional	States may provide inpatient hospital and nursing facility services for certain beneficiaries aged 65 and over with mental diseases that are in IMDs under a state's Medicaid Plan. Services include diagnosis and medical treatment, as well as nursing care and related services under the direction of a physician.

Source: Compiled by CRS.

- a. This type of service includes the provision of acute health care services, thus it is not specifically an LTSS service.

Home and Community-Based Care

Medicaid LTSS spending on home and community-based care includes home health care services, personal care services and a range of home and community-based services (HCBS) typically funded under one or more waiver programs. The majority of HCBS services and program offerings are optional for states. The exception is home health services, which is a federally required benefit under a state's Medicaid state plan. Home health must be offered to individuals entitled to nursing facility coverage and must be deemed medically necessary and authorized by a physician as part of a written care plan. States, at their option, may offer other HCBS services such as personal care, respiratory care for persons who are ventilator-dependent, and case management and/or targeted case management. Since 1995, Medicaid expenditures for home and community-based care have grown at an average annual rate of 12.3%. For 2011, Medicaid home care spending increased 2.4% over the previous year. These growth rates are faster than the growth in overall Medicaid LTSS spending since 1995, on average (6.2%), and for 2010 to 2011 (1.6%). **Table 6** provides additional information on these home and community-based services.

Table 6. Selected Medicaid Home and Community-Based Services (HCBS)

Services	Benefit Type	Description
Home Health ^a	Mandatory for ages 21 and over; Optional for ages under 21	States are required to provide home health services to beneficiaries entitled to nursing facility care under a state's Medicaid plan. ^a Services vary by state, and may include intermittent or part-time nursing services, home health aide services, medical supplies, medical equipment, and appliances suitable for use in the home.
Transportation to and from providers ^b	Mandatory	States are required to ensure necessary transportation to and from providers, in general. States have the option to provide such transportation as a state plan service or as an administrative expense, with either option eligible for federal Medicaid matching funds.
Case Management Services or Targeted Case Management ^b	Optional	States may provide case management services under a state's Medicaid plan or waiver program to assist beneficiaries residing in community-settings gain access to needed medical, social, educational, or other services. Services include development and implementation of a care plan and comprehensive assessment, and periodic reassessment, of needs. Targeted case management provides case management services to specific Medicaid beneficiary groups or individuals who reside in state-designated geographic areas.
Personal Care	Optional ^c	States may provide services to beneficiaries who need assistance with ADLs or IADLs under a state's Medicaid plan or waiver program. Services are furnished in a non-institutional setting, such as an individual's home. Services may include assistance with ADLs such as bathing, dressing, eating, toileting, personal hygiene, or assistance with IADLs such as light housework, laundry, meal preparation, and shopping, among others.
Respiratory Care for Persons Who Are Ventilator-Dependent ^b	Optional	States may provide respiratory care to beneficiaries who are dependent on a ventilator for life support at least six hours per day, under a state's Medicaid plan. Services include respiratory care by a respiratory therapist or a health professional trained in respiratory therapy in the recipient's home.

Source: Compiled by CRS. For more information on Medicaid HCBS see, CRS Report R41600, *Home and Community-Based Services Under Medicaid*, by Kirsten J. Colello and Scott R. Talaga.

Notes: ADLs = Activities of Daily Living; IADLs = Independent Activities of Daily Living; HCBS = Home and Community-Based Services.

- a. The coverage criterion for home health services is linked to the coverage criterion for nursing facility services. The phrase "entitled to nursing facility care" means that beneficiaries must meet a state's nursing facility level-of-care criteria in order to receive the home health benefit.
- b. This type of service includes the provision of acute health care services, thus it is not specifically a LTSS service.
- c. States have the option to cover personal care services, including options for self-directed personal care, under several optional statutory authorities under the Social Security Act such as: (1) the personal care state plan option; (2) the self-directed personal care state plan option under Section 1915(j); and (3) the home and community-based services state plan option under Section 1915(i). States may also use waivers [HCBS waivers under Sections 1915(c), (d), and (e) and research and demonstration waiver authority under Section 1115] to offer personal care. Finally, established under the ACA, the Community First Choice Option under Section 1915(k) allows states to offer consumer-directed personal care services and receive

an increased federal match rate of 6 percentage points for doing so, among other benefit requirements. CMS issued a proposed rule for this program on February 25, 2011, “Medicaid Program; Community First Choice Option,” 76 *Federal Register* 10736-10753. No final rule has been published to date.

States often use waivers to extend HCBS to individuals with disabilities of all ages residing in home and community-based settings. Such waivers are referred to by their SSA statutory reference, including Sections 1915(b), (c), (d), and (e), and Section 1115 (research and demonstration waivers). These waiver authorities allow states to provide HCBS services to certain targeted populations and limit the number of individuals served. Waivers permit states to waive certain Medicaid requirements so that states can provide HCBS services to a limited geographic area (e.g., “statedwideness” requirement) and/or provide services that are not necessarily comparable in amount, duration, or scope for selected eligibility categories (e.g., “comparability” requirement).²⁹ Waiver programs may include services such as: case management, personal care, homemaker/ home health aide, adult day health, habilitation, respite care, day treatment or other partial hospitalization, psychosocial rehabilitation, and clinic services for individuals with chronic mental illness. Depending on the waiver authority, states may have the flexibility to offer additional services approved by the Secretary of Health and Human Services (HHS).

States may also use state plan authority to provide HCBS to Medicaid beneficiaries with LTSS needs. For example, states may use the HCBS State Plan Option under Section 1915(i) of the SSA to provide HCBS to certain Medicaid beneficiaries who meet financial and functional needs-based criteria. The HCBS State Plan Option authorizes states to extend HCBS to certain Medicaid beneficiaries without requiring a Secretary-approved waiver for this purpose. The services provided under the HCBS State Plan Option are limited to those listed in **Table 6**. States may also use Section 1915(j) authority, also referred to as the “Community First Choice (CFC) Option,” to offer home and community-based attendant services to certain Medicaid beneficiaries under the state plan. Established under the ACA, the CFC option became available on October 1, 2011 and provides a 6% increase in federal matching payments to states for expenditures related to this option. States may also use Section 1929 authority to provide HCBS for functionally disabled Medicaid beneficiaries age 65 and over who meet certain income and resource requirements or are eligible for a state’s medically needy program.

Other authorized programs that provide HCBS include the Program for All-Inclusive Care for the Elderly (PACE).³⁰ PACE combines Medicare and Medicaid services under one common administrative/clinical provider, often at adult day or community centers, but also includes home service referrals. Services provided under PACE include homemaker/home health aide, personal care, adult day health, habilitation, respite care, day treatment and other partial hospitalization services, psychosocial rehabilitation services, and clinical services for individuals with chronic mental illness.

Medicare

Medicare is a federal program that pays for covered health services for the elderly and certain non-elderly individuals with disabilities. Medicare covers primarily acute care benefits; however,

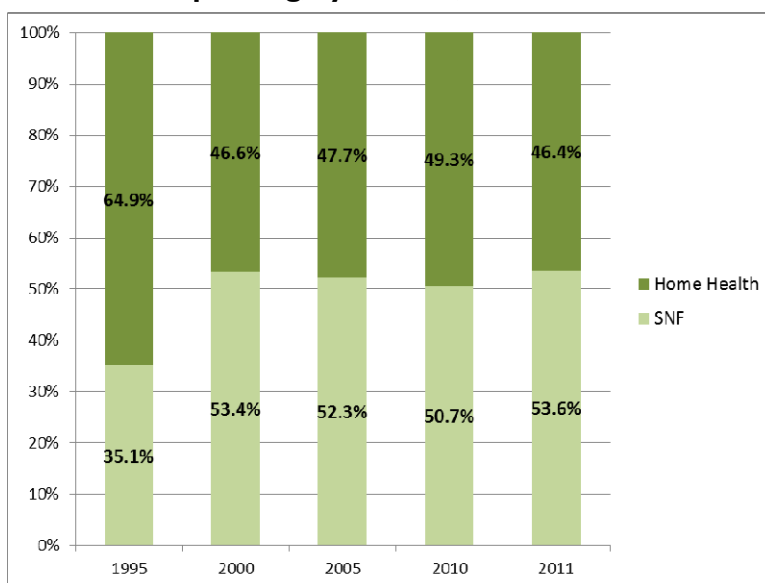
²⁹ For more information about these waiver authorities in the context of Medicaid HCBS, see CRS Report R41600, *Home and Community-Based Services Under Medicaid*, by Kirsten J. Colello and Scott R. Talaga.

³⁰ §1934 of the Social Security Act.

it also provides *some* coverage for two types of LTSS—skilled nursing facility (SNF) services and home health services. These benefits provide limited access to personal care services both in the home care setting and in skilled nursing facilities for certain beneficiaries on a short-term basis.

In 2011, Medicare spent \$75.4 billion on SNF and home health services combined which was over one-fifth (23.8%) of all LTSS spending. These expenditures include Medicare Parts A and B (also referred to as “Original Medicare”) and estimated Medicare Part C (Medicare Advantage) payments attributable to skilled nursing facility care and home health care.³¹ Of the total, 46.4%, or \$35.0 billion, was paid to home health agencies, and 53.6%, or \$40.4 billion, was paid to SNFs. **Figure 3** shows the share of home health and SNF expenditures as a proportion of all Medicare LTSS spending for selected years since 1995. The change in Medicare home health expenditures between 1995 and 2000 can be attributed to the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). BBA 97 implemented an interim payment system and limited the number of home health visits that could be reimbursed by Medicare, subsequently reducing Medicare expenditures on home health. Since 1995, Medicare expenditures for LTSS have grown at an average annual rate of 6.5%. For 2011, Medicare LTSS spending increased 9.8% over the previous year, largely driven by an increase in Medicare SNF expenditures.

Figure 3. Proportion of Medicare Long-Term Services and Supports (LTSS) Spending, by Service, 1995-2011



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

Significant confusion and debate has ensued among policymakers and stakeholders over the classification of these Medicare benefits into post-acute and/or LTSS benefit categories. This is likely due to the fact that Medicare and Medicaid both cover stays in nursing homes as well as visits by home health agencies, yet the service type and scope of coverage are generally different.

³¹ In this report, “Original Medicare” home health expenditures include payments to home health agencies for hospice services.

Moreover, Medicare, unlike Medicaid, is not intended to be a primary funding source for LTSS. While Medicaid nursing facility and home health benefits are available to eligible beneficiaries for as long as they qualify, Medicare's skilled nursing facility and home health benefits, in general, are limited in their duration. In addition, Medicare skilled nursing facility and home health benefits include coverage of rehabilitation services that will, presumably, improve the beneficiary's physical condition or functional status.

Skilled Nursing Facility Services

The Medicare SNF benefit covers up to 100 days of post-hospital care for persons needing continuous skilled nursing or rehabilitation services on a daily basis.³² As of 2010, the average length of stay for a Medicare beneficiary receiving SNF services was 27.1 days.³³ The SNF stay must be preceded by an inpatient hospital stay of at least three days, and the transfer to the SNF must occur within 30 days of the hospital discharge. Unlike Medicaid, Medicare does not cover nursing facility care if exclusively personal care, sometimes referred to as custodial care, is needed (e.g., when a person needs assistance with bathing, walking, or transferring from a bed to a chair). To be eligible for Medicare-covered SNF care, a physician must certify that the beneficiary needs daily skilled nursing care or other skilled rehabilitation services that are related to the hospitalization, and that these services, as a practical matter, can be provided only on an inpatient basis. Examples of skilled nursing care and rehabilitation that a beneficiary could receive are: intravenous injections; administration and replacement of catheters; administration of prescription medications; supervision of bowel and bladder training programs; therapeutic exercises; and range-of-motion exercises. There is no beneficiary cost-sharing for the first 20 days. Days 21 to 100 are subject to daily coinsurance charges (\$148 in 2013).

Since 1995, Medicare expenditures for SNFs have grown at an average annual rate of 9.4%. The average annual growth in Medicare SNF spending since 1995 was higher than the overall growth in Medicare LTSS spending over the same time period. For 2011, Medicare SNF spending increased 16.1% over the previous year. This large increase is most likely attributed to the implementation of a new payment classification system and the accompanying beneficiary assessment in 2011. The updated classification system is intended to achieve greater accuracy in assigning Medicare payments to actual SNF beneficiary costs than its predecessor. However, according to the HHS Office of Inspector General, unanticipated provider behavior with the new classification system and assessment resulted in a Medicare overpayment of approximately \$4 billion.³⁴ Additionally, the rate in SNF spending in the previous year was higher than the overall growth in Medicare LTSS spending.

Home Health Services

Medicare covers 60 days per episode of home health agency visits when such services are required because an individual is confined to his or her home and needs skilled nursing care on an

³² For more information on Medicare's coverage of skilled nursing facilities, see CRS Report R42401, *Medicare's Skilled Nursing Facility Primer: Benefit Basics and Issues*, by Scott R. Talaga.

³³ Medicare Payment Advisory Commission, *Report to the Congress*, Medicare Payment Policy, March 2012, p. 179, http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

³⁴ Stuart Wright, Changes in Skilled Nursing Facilities Billing in Fiscal Year 2011, Health & Human Services Office of Inspector General, OEI-02-09-00204, Washington, DC, July 8, 2011.

intermittent basis or is in need of physical or occupational therapy, or speech-language pathology services.³⁵ Also, a beneficiary could be eligible for additional 60-day episodes if a continued need for occupational therapy exists. Covered services include part-time or intermittent nursing care, physical therapy, occupational therapy, speech/language therapy, medical social services, home health aide services, medical supplies, and durable medical equipment. The services must be provided under a personalized plan of care established by a physician, and the plan must be reviewed and updated by the physician at least every 60 days. The average number of home health visits for Medicare beneficiaries receiving home health services was 36 in 2010.³⁶ There is no beneficiary cost-sharing for home health services (though some other Part B services provided in connection with the visit, such as durable medical equipment, are subject to cost-sharing charges). Since 1995, Medicare expenditures to home health agencies have grown at an average annual rate of 4.3%. For 2011, Medicare reimbursements to home health agencies increased 3.2% over the previous year. The average annual growth in Medicare reimbursements to home health agencies since 1995 was lower than the overall growth in Medicare LTSS spending over the same time period. Also, the rate in Medicare home health spending for the previous year was lower than the overall growth in Medicare LTSS spending.

Other Public Payers

Of all LTSS expenditures in the United States, only a small portion of the costs are paid for with public funds other than Medicare or Medicaid. Collectively, these payers covered 7.0% of all LTSS expenditures in 2011, totaling \$22.1 billion. Over half (56.1%) of this spending was for LTSS provided in residential care facilities for individuals with mental retardation, mental health conditions, and substance abuse issues, followed by spending for nursing facility and home health care. Spending in this category also includes spending for LTSS that are paid for or operated by VHA. Other public payers include other state and local LTSS programs, general assistance,³⁷ and federal and state funding for nursing facilities and home health under CHIP.

Table 7. Long-Term Services and Supports (LTSS) Spending by Other Public Payers, 2011

(in billions)

Other Public Payers		
Residential Mental Retardation, Mental Health, and Substance Abuse Facilities	\$12.4	56.1%
Veterans Health Administration (VHA)	5.2	23.6

³⁵ CRS Report R42998, *Medicare Home Health Benefit Primer: Benefit Basics and Issues*, by Scott R. Talaga.

³⁶ Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy*, March 2012, p. 214, http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

³⁷ General Assistance includes two types of programs: General Assistance programs that are often modeled after Medicaid, and the State Pharmaceutical Assistance Programs that provide low-income and medically needy senior citizens and individuals with disabilities financial assistance for prescription drugs. General assistance refers to direct payments or payments to vendors or on behalf of needy persons who do not qualify for federally financed assistance programs. It is provided by state and local government jurisdictions, and is not financed in whole or part by federal funds.

Other Public Payers		
Other State and Local Programs	3.9	17.5
General Assistance ^a	0.6	2.5
State Children’s Health Insurance Program (CHIP)	0.03	0.1
Other Federal Programs ^b	0.03	0.1
Total	\$22.1	100.0%

Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

Notes: Amounts may not sum to total due to rounding. LTSS spending by other public payers includes federal and state funding for VHA and CHIP; federal and state funding for residential care facilities for individuals with mental retardation, mental health conditions, and substance abuse issues; and other state and local funding. It does not include federal funding for Medicare and state and/or federal funding for Medicaid.

- a. General Assistance includes two types of programs: General Assistance programs that are often modeled after Medicaid, and the State Pharmaceutical Assistance Programs that provide low-income and medically needy senior citizens and individuals with disabilities financial assistance for prescription drugs.
- b. Other Federal Programs include two types of programs: Federal General Hospital and Medical expenditures which capture federal health care funds and grants budgeted to various federal agencies and Pre-existing Conditions Insurance Plans.

Private Sources of Financing for Long-Term Services and Supports

In the absence of public funding for LTSS, individuals must rely on private sources of funding. In 2011, about 27.2% of LTSS expenditures were paid by private sources (see **Figure 1** and **Table 3**). Within private sources of funding, out-of-pocket spending was the largest component (over one-half of all private funding), comprising 15.9% of total LTSS expenditures. Second was private insurance (6.1%) which includes both health and long-term care insurance. Finally, other private sources which largely include philanthropic contributions comprised 5.2% of total LTSS. The following sections discuss these private sources of LTSS funding in greater detail.

Out-of-Pocket Spending

Out-of-pocket expenditures include deductibles and copayments for services that are primarily paid for by another payment source as well as direct payments for LTSS. While there are daily copayments for skilled nursing services after a specified number of days under Medicare, there are no copayments for Medicare’s home health services. In addition, some private health insurance plans may provide limited skilled nursing and home health coverage which may or may not require copayments. Moreover, private long-term care insurance (LTCI) often has an elimination or waiting period for policyholders which requires out-of-pocket payments for services for a specified period of time before benefit payments begin. This elimination period is similar to a deductible. Finally, private LTCI policies can vary in terms of the daily benefit amount and duration of coverage (i.e., number of years of coverage).

Once individuals have exhausted their Medicare and/or private insurance benefits, they must pay the full cost of care directly out-of-pocket. Furthermore, to be eligible for Medicaid LTSS individuals must meet both financial and functional eligibility requirements. Some individuals may not initially be eligible for Medicaid when they begin utilizing LTSS. Those not eligible for Medicaid would have to pay for LTSS directly out-of-pocket. Eventually, these individual may spend down their income and assets over a period of time and meet the financial criteria for Medicaid eligibility. Of the \$50.4 billion paid for LTSS out-of-pocket in 2011, 79.1% was for nursing facility care, 11.1% was for LTSS provided in a home setting, and 9.8% was for LTSS provided in residential facilities (e.g., residential mental retardation, mental health, and substance abuse facilities).

Private Insurance

Private insurance expenditures for LTSS include both health and long-term care insurance (LTCI). Similar to Medicare funding for LTSS, private health insurance funding for LTSS includes payments for some limited home health and skilled nursing services for the purposes of rehabilitation. Private LTCI, on the other hand, is purchased specifically to provide financial protection against the risk of the potentially high costs associated with LTSS.³⁸ Additionally, a number of hybrid products that combine LTCI with either an annuity or a life insurance product has recently emerged. Moreover, the Medicaid Long-Term Care Insurance Partnership Program is also a LTCI product that is linked to Medicaid eligibility. In 2011, 6.1% of total spending for LTSS, or \$19.3 billion, was funded through these private health and long-term care insurance sources.

Long-Term Care Insurance

LTCI covers care in a variety of settings, including nursing homes, community residential care facilities (e.g., assisted living facilities), and care provided in the individual's own home through home care. Policies may also cover respite care for caregivers, homemaker and chore services (e.g., housework or meal preparation), and medical equipment, among other services. LTCI policies pay for specified LTSS for persons who have paid premiums and qualify for benefits. LTCI policy benefits are often triggered when an individual needs assistance with two or more ADLs or has a cognitive impairment and is in need of supervision with ADLs. LTCI policies may be sold to an individual directly or to a group as part of an employer-sponsored plan. The premiums charged for LTCI vary by age of first purchase, with higher premiums charged to those purchasing at older ages. This age differential reflects the higher risk of needing LTSS at advanced ages. In addition, LTCI policies are medically underwritten in that individuals who currently have physical or cognitive impairments or pre-existing medical conditions that may result in increased prevalence of disability may be denied coverage or charged higher premiums.

The relatively low rate of LTCI financing for LTSS in the U.S. reflects two key trends. First, the demand for LTCI has been relatively low over the past few decades. In 2008, the most recent year for which data are available, about 11% of the population aged 55 and older and 12% of the

³⁸ For a more in-depth discussion of LTCI, see CRS Report R40601, *Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress*, by Janemarie Mulvey.

population aged 65 and older owned a LTCI policy.³⁹ Second, for those who do own a LTCI policy, most have not yet reached the age where they may need LTSS.

Factors that primarily affect the demand for LTCI include cost and benefit complexity. Over 85% of potential buyers of LTCI who choose not to purchase a policy cite cost as a “very important” or “important” reason for their decision.⁴⁰ Over the past decade, average LTCI premiums have increased significantly above the overall rate of inflation, largely reflecting increased demand for more comprehensive benefit packages (including inflation protection) and higher daily benefit amounts. In addition, low rates of return on investments and under estimates of lapse (termination) rates have prompted insurers to raise premiums for both current and new policyholders.

Complexity is often cited as another reason for not purchasing a policy. For example, according to the America’s Health Insurance Plans (AHIP), 49% of those who did not buy a LTCI policy when given the opportunity stated that the policy options were “too confusing.”⁴¹ This complexity arises when potential buyers must evaluate the many different possible combinations of LTCI product features available such as services covered (home health care, institutional care or both), dollar amount of coverage, and length or duration of coverage, among other features.

The private LTCI market has undergone significant changes in the past three decades. The employer-sponsored market has grown as a share of total LTCI sales. In addition, the overall market has become more concentrated in terms of the number of companies selling the product. In 2010, the top 10 LTCI companies produced 88% of new sales.⁴² The consolidation of the LTCI industry reflected several factors, including high administrative expenses relative to premiums, lower than expected terminations (i.e., lapse rates) that increased the number of people likely to submit claims, low interest rates that reduced the expected return on investments, and new government regulations limiting direct marketing by telephone.⁴³

Other Long-Term Care Insurance Products

A number of legislative changes have enabled insurers to begin to develop hybrid products that combine LTCI with either an annuity or a life insurance product. The Pension Protection Act of 2006 (P.L. 109-208) simplified tax rules regarding combination products (effective in 2010) and added a tax provision specifying that proceeds from an annuity can be used tax-free to purchase a LTCI policy. LTCI policies can also be combined with a life insurance policy through an accelerated death benefit rider. Circumstances that trigger these accelerated benefits include diagnosis of a terminal illness or a medical condition that would drastically shorten the policyholder’s life span, the need for LTSS, or permanent confinement to a nursing home. Also,

³⁹ R. Johnson and J. Park, “Who Purchases Long-Term Care Insurance,” Urban Institute, Issue Brief, No. 29, March 2011.

⁴⁰ M. Cohen, *Who Buys Long-Term Care Insurance in 2010-2011? A 20-Year Study of Buyers and Non-Buyers (In the Individual Market)*, LifePlans and America’s Health Insurance Plans, 2012.

⁴¹ Ibid.

⁴² C. Pfau, D. Helwig, and A. Schmitz, “2011 Individual Long-Term Care Insurance Survey,” *Broker World Magazine*, July 2011.

⁴³ U.S. Government Accountability Office, “Long-Term Care Insurance: Federal Program Compared Favorably with Other Products, and Analysis of Claims Trend Could Inform Future Decisions,” March 2006.

under the American Homeownership and Economic Opportunity Act of 2000 (P.L. 105-569), proceeds from a reverse mortgage can be used to purchase a LTCI policy.⁴⁴

In addition to the above mentioned hybrid LTCI policies, there is also a LTCI product that is linked to Medicaid eligibility. Under the Medicaid Long-Term Care Insurance Partnership Program (hereinafter referred to as the Partnership Program), individuals who purchase certain LTCI⁴⁵ policies may qualify for Medicaid without the same means-testing requirements that other applicants must meet. Generally, Partnership Program purchasers would seek Medicaid for extended coverage of LTSS after their LTCI benefits have been exhausted. For these individuals, Medicaid means-testing requirements are relaxed at (1) the time of application to Medicaid; and (2) the time of the beneficiary's death when Medicaid estate recovery is generally applied.^{46,47}

The original Partnership Program was established in four states: California, Connecticut, Indiana, and New York in the early 1990s.⁴⁸ The Omnibus Budget Reconciliation Act of 1993 (OBRA 93, P.L. 103-66) prohibited other states from implementing the program. However, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) lifted this prohibition and allowed any state with a Secretary-approved Medicaid state plan amendment to operate a Partnership Program.⁴⁹ As of July 2011, 40 states, including the four original Partnership states, elected to adopt a Partnership Program, while 11 states had yet to adopt a Partnership Program.⁵⁰ There were about 641,000 Partnership Program policies in force, accounting for 9% of all LTCI policies in force.⁵¹

Other Private Funds

Other private funds generally include philanthropic support, which may be directly from individuals or obtained through philanthropic fund-raising organizations such as the United Way. Support may also be obtained from foundations or corporations. Of the \$16.6 billion paid for LTSS by other private sources in 2011, 58.7% was for LTSS provided in residential facilities

⁴⁴ See CRS Report RL33843, *Reverse Mortgages: Background and Issues*, by Bruce E. Foote.

⁴⁵ The insurance product provides persons needing assistance with LTSS with protection against the high cost of LTSS without having to rely on the public sector. This insurance covers a variety of settings, such as nursing home care, assisted living, and services brought to people in their own homes, such as home health, respite care, and personal care, among others.

⁴⁶ The Social Security Act requires states to recover from a beneficiary's estate certain amounts Medicaid paid for LTSS and other services.

⁴⁷ Most Medicaid applicants may protect no more than \$2,000 in assets for an individual and \$3,000 for a married couple. In general, Partnership Program policy owners may protect amounts equivalent to the value of the benefits paid by the LTCI policy purchased (e.g., \$100,000 of nursing home or assisted living benefits paid enables that individual to retain up to \$100,000 in assets and still qualify for Medicaid coverage in that state). This is referred to as the dollar-for-dollar model. Two states have exceptions to this design model. New York uses a total asset protection model in which purchasers with certain state-approved policies may qualify for Medicaid while retaining all of their assets. Indiana uses a hybrid model, offering both dollar-for-dollar and total asset protection.

⁴⁸ Iowa received approval from the Secretary of HHS to operate a program before OBRA 93, but it did not fully do so.

⁴⁹ The DRA also added new minimum federal requirements for LTCI plans to qualify as Partnership policies. Among these requirements are consumer protections related to inflation protection, unintentional lapse, disclosure, and nonforfeiture of benefits.

⁵⁰ Thomson Reuters, *The Long-Term Care Partnership Program: 5 Years After Enactment Under the Deficit Reduction Act*, October 17, 2011. The states that have not yet adopted a DRA Partnership Program as of September 9, 2011, are AK, DE, HI, IL, MA, MI, MS, NM, UT, VT, and WA.

⁵¹ *Ibid.*

(e.g., residential mental retardation, mental health, and substance abuse facilities), another 35.8% was for care provided in nursing facilities, and 5.5% was for LTSS provided in home settings.

Author Contact Information

Kirsten J. Colello
Specialist in Health and Aging Policy
kcolello@crs.loc.gov, 7-7839

Scott R. Talaga
Analyst in Health Care Financing
stalaga@crs.loc.gov, 7-5956

Janemarie Mulvey
Specialist in Health Care Financing
jmulvey@crs.loc.gov, 7-6928

Acknowledgments

Certain sections of this report are drawn from previous CRS reports authored by Karen Tritz and Julie Stone, both former CRS Specialists in Health Care Financing.

Area of Expertise by Author

Area of Expertise	Name	Phone	E-mail
Medicaid long-term services and supports	Kirsten J. Colello	7-7839	kcolello@crs.loc.gov
Private LTC Insurance and tax treatment of LTSS	Janemarie Mulvey	7-6928	jmulvey@crs.loc.gov
Medicare skilled nursing facilities and home health	Scott R. Talaga	7-5956	stalaga@crs.loc.gov