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## Serving Low-Income Seniors Where They Live: Medicaid's Role in Providing Community-Based Long-Term Services and Supports

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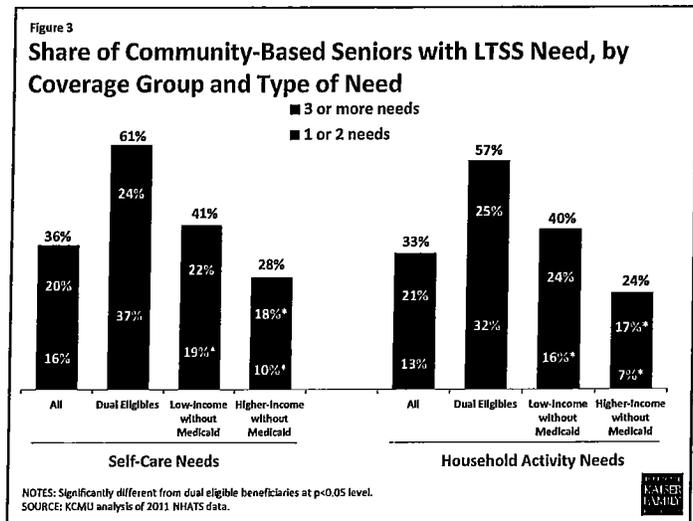
Seniors managing chronic health conditions or experiencing an age-related decline in physical or cognitive functioning may need long-term services and supports (LTSS) to complete daily self-care activities (such as eating, bathing or dressing) or household activities (such as preparing meals or doing laundry). LTSS include a range of services, including adult day health care programs, home health aide services, personal care services, and case management services, among others.<sup>1</sup> LTSS needs may be met through both paid services and unpaid services provided by friends or family members. While some people who need LTSS choose or require care based in nursing facilities, most people with LTSS needs live in the community.

Medicare is the primary source of health insurance for nearly all seniors, but the program does not cover LTSS, and few Medicare beneficiaries have private insurance that covers these services. For some low-income Medicare beneficiaries (called "dual eligible beneficiaries"), Medicaid fills this gap by providing wraparound coverage for a range of services, including LTSS. Helping these individuals remain in the community rather than reside in a nursing facility is a goal of both beneficiaries and states, in part due to the Americans with Disabilities Act's community integration mandate.<sup>2</sup> Understanding the community-based LTSS population served by Medicaid is important for designing effective care delivery systems, particularly as states are increasingly developing new systems of integrated and managed care for this population, and because Medicaid is the nation's primary payer for LTSS.<sup>3</sup>

In addition, other low-income seniors may have LTSS needs but may not meet Medicaid eligibility criteria or be enrolled in the program. Some Medicaid waiver programs that provide home and community-based LTSS have waiting lists for coverage.<sup>4</sup> Since many of these people may become eligible for Medicaid should they ever need institutional-based LTSS, it is important to understand the needs and characteristics of this population as well as that already served by Medicaid.

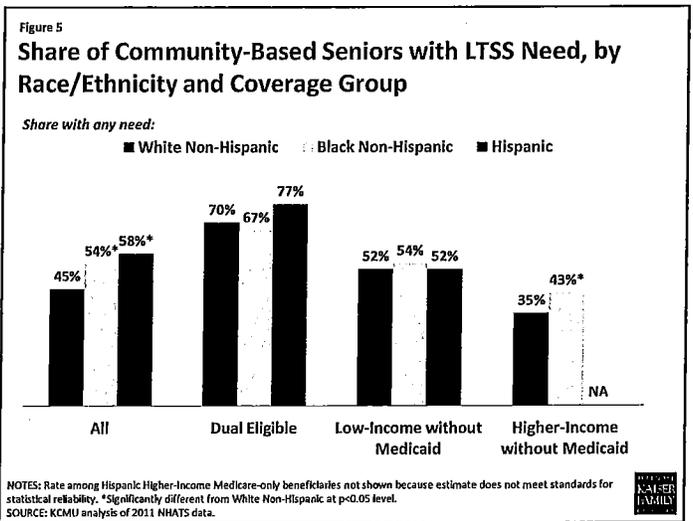
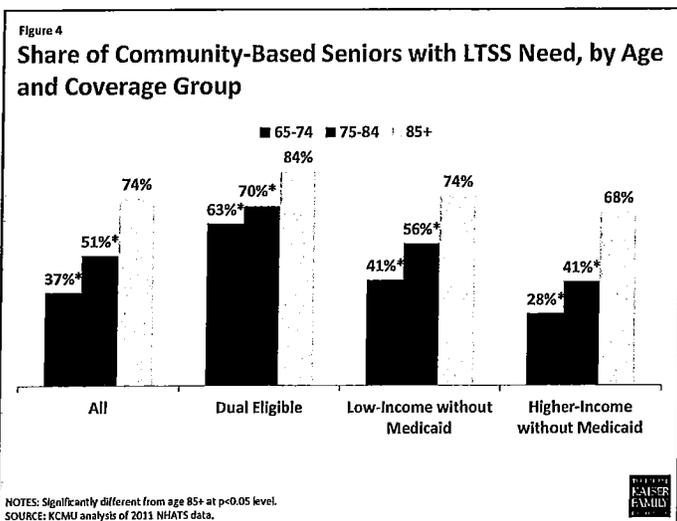
To better understand the low-income population with LTSS needs, including those covered by Medicaid and those who are not, this issue brief examines the need for LTSS among seniors who live in the community<sup>5</sup> and need LTSS. We use the 2011 National Health and Aging Trends Study (NHATS) to examine rates of need for LTSS and detail the characteristics of seniors who need these services. Throughout the brief, we compare dual eligible beneficiaries to low-income seniors without Medicaid. We also examine a third group, higher income seniors without Medicaid, to understand the role of income. Because LTSS needs increase with age, we also

The need for LTSS is more common among some groups of seniors than others. Dual eligible seniors are more likely to have an LTSS need than low-income seniors who do not have Medicaid. Almost seven in ten dual eligible beneficiaries reported an LTSS need, a significantly higher rate than among low-income seniors without Medicaid (52%) or higher-income seniors without Medicaid (36%) (data not shown). This pattern holds across different types (household and self-care) of need (Figure 3). Dual eligible beneficiaries also are more likely than other seniors to report having three or more LTSS needs. This finding in part reflects Medicaid eligibility policy: seniors may become eligible for Medicaid



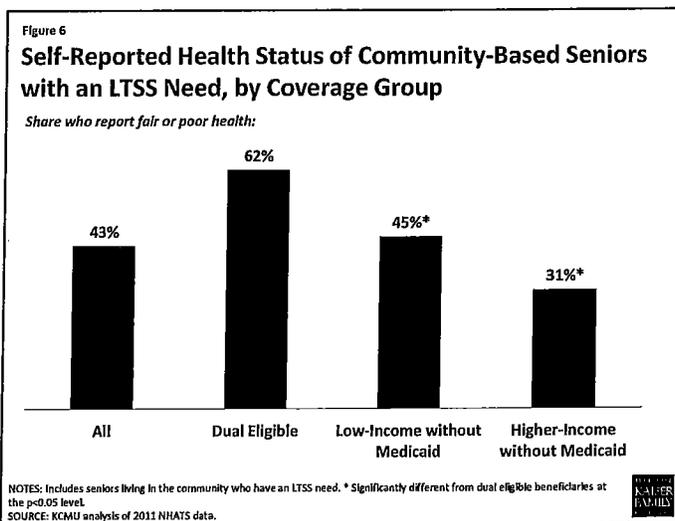
LTSS coverage based on their low income and functional needs or by “spending down” their income and resources to cover medical and LTSS expenses. However, many low-income seniors who do not have Medicaid also need LTSS. Unless these individuals have private insurance coverage for LTSS, they must pay out-of-pocket for services, rely on family or friends, or go without needed services. For low-income seniors without Medicaid, accessing needed services may be particularly difficult, given limited resources.

Not surprisingly, older seniors are most likely to need LTSS. Compared to 37% of seniors aged 65 to 74 and about half of those aged 75-84, nearly three quarters (74%) of those aged 85 and older have an LTSS need (Figure 4 and Table 1). This pattern is expected given that functioning declines with age, but it also demonstrates high levels of need among the “very old” (age 85+) who may face additional challenges in accessing needed services (such as transportation or mobility limitations). It also indicates that, as the population ages, overall rates of need for LTSS may increase. Differences in rates of need by age exist among both dual eligible beneficiaries and seniors without Medicaid, though dual eligible beneficiaries at all ages are more likely to need LTSS than both other low-income and higher-income seniors without Medicaid. Again, different rates of need by coverage group reflect Medicaid’s role in providing assistance to those with LTSS needs.

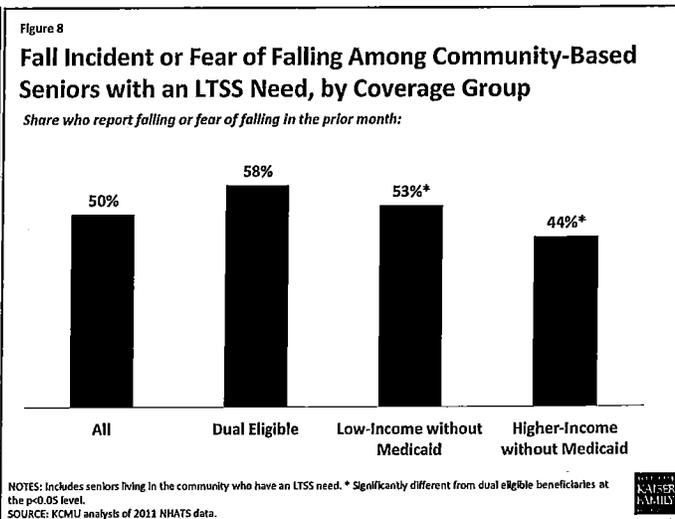
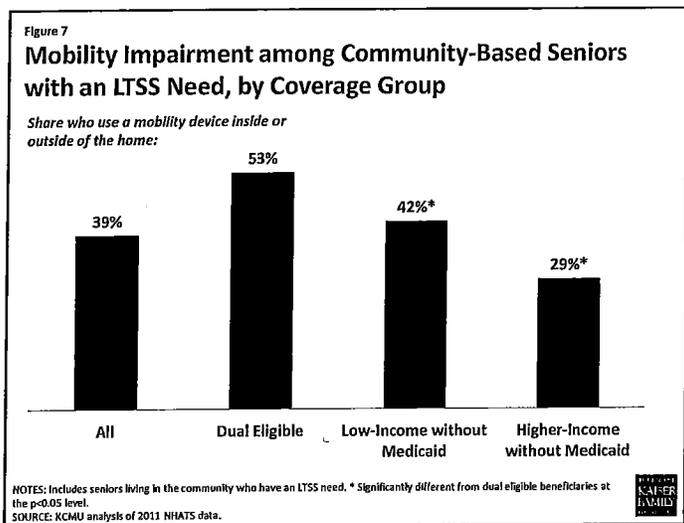


## HEALTH STATUS AND MOBILITY LIMITATIONS

Poor health and the need for LTSS are closely related. Overall, over half (57%) of seniors with an LTSS need live with at least three chronic conditions (such as high blood pressure, arthritis, osteoporosis, diabetes, or heart disease<sup>6</sup>), and this rate is similarly high among dual eligible beneficiaries and low-income seniors without Medicaid with an LTSS need (Table 2). While not surprising, these patterns show a strong relationship between physical illness and LTSS needs. Similarly, many (43%) seniors with an LTSS need say their overall health is fair or poor, though dual eligible beneficiaries are more likely than low-income seniors without Medicaid to say that their overall health is fair or poor (Figure 6). This difference may reflect dual eligible beneficiaries having more complex health needs or comorbidities than seniors without Medicaid.



Mobility problems are also common among seniors with LTSS needs. Overall, nearly four in ten (39%) seniors with an LTSS need use a mobility device (cane, wheelchair, walker or scooter) either inside or outside their home. Among dual eligible beneficiaries with an LTSS need, however, rates are higher, with more than half (53%) requiring a mobility device in or outside the home (Figure 7). Though older (age 85+) beneficiaries in all coverage/income groups are more likely to use a mobility device than younger seniors, the pattern of dual eligible beneficiaries being more likely to use mobility devices holds across age groups (Table 2). This finding may point to a need for special transportation programs for dual eligible beneficiaries, particularly if they require health or social services outside the home.

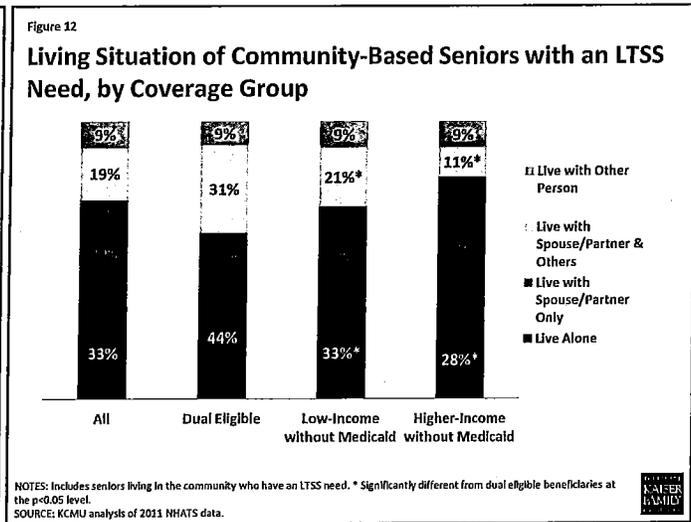
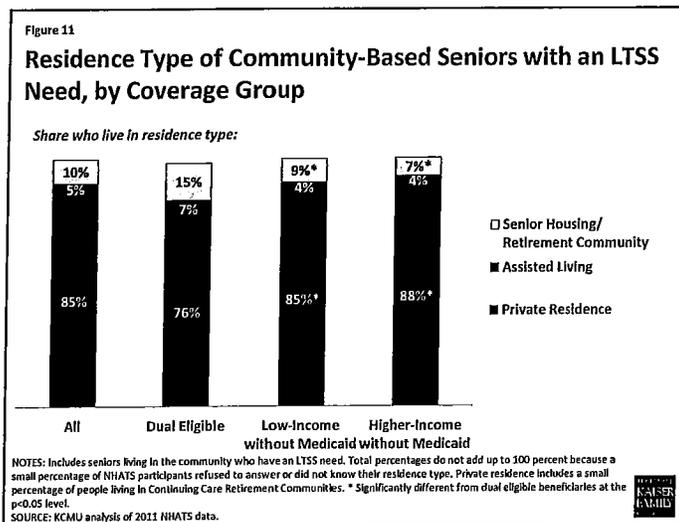


Falls are a serious problem among older adults, occurring frequently and leading to serious injury or even death; fear of falls is also common and can lead to self-imposed restrictions on activity that in turn contribute to mobility impairment.<sup>7</sup> Indeed, corresponding to mobility impairments, half of seniors with an LTSS need

In addition to maintaining self-sufficiency and promoting independence, delivering care in the least-restrictive setting, and lowering long-term care costs, a central goal of helping people with LTSS needs remain in the community is to preserve social networks and community integration. Notably, among seniors with an LTSS need, only 6 percent say they have no one to talk to about important things—a proxy for social isolation. These rates are low across all coverage/income groups. When looking at specific age groups, however, younger (age 65-74) dual eligible beneficiaries are particularly likely to report not having someone to talk to (12%, versus 5% for seniors without Medicaid in the same age range) (Table 2). The higher rate among this group may indicate barriers to being integrated into the community and a need for more social interaction for this population.

## HOUSING TYPE AND CONDITION

People who live in assisted living or senior housing/retirement communities may have access to more social or supportive services than those who do not live in such places. Overall, the majority (85%) of seniors with an LTSS need live in a private residence, versus an assisted living facility or senior housing/retirement community. However, dual eligible beneficiaries are less likely than seniors without Medicaid to live in a private residence and are more likely to live in senior housing or a retirement community (Figure 11), perhaps reflecting a greater level of need among dual eligible beneficiaries. These differences decrease at older ages (Table 2).



In addition, dual eligible beneficiaries with LTSS needs are more likely than seniors without Medicaid to live alone (Figure 12). This pattern holds for those ages 65 to 84, but differences decrease at older ages (Table 2). Notably, much of the low-income LTSS population without Medicaid lives alone. While people who live alone but have Medicaid coverage may receive personal care services to help them with day-to-day tasks, those who live alone, need LTSS, and do not have Medicaid must either pay for help out-of-pocket or rely on someone to come to their home daily to help them. Some people with LTSS needs live with someone else, in addition to a spouse or partner, perhaps because they select living arrangements that enable them to receive assistance from extended family or friends. Dual eligible beneficiaries are more likely than seniors without Medicaid to live with someone besides a spouse or partner, though many low-income seniors without Medicaid also have such living arrangements.

and behavioral health services could allow these beneficiaries' needs to be met in a more holistic manner while potentially improving health outcomes and lowering costs. As of October 2014, 19 states had waivers to operate capitated managed long-term services and supports programs, most of which require beneficiaries to enroll in a Medicaid managed care organization to receive services, and as of July 2015, 12 states were implementing demonstrations seeking to better integrate services and align financing for dual eligible beneficiaries. Many of these programs aim to increase access to community-based services, and most integrate LTSS with acute and primary care as well as behavioral health services.<sup>14</sup> Work is ongoing to measure how well these programs are meeting their goals and the needs of beneficiaries.<sup>15</sup>

States can select from among a variety of optional services to meet Medicaid beneficiaries' LTSS needs, many of which allow beneficiaries to self-direct their services by selecting their personal care provider and/or administering their services budget. In recent years, new and expanded options to provide Medicaid LTSS have become available, although some programs are time-limited and set to expire.<sup>16</sup> For example, the Affordable Care Act provides new Medicaid state plan options, with enhanced federal funding, for states to cover attendant care services and supports through the Community First Choice program and health home services to improve care coordination for beneficiaries with chronic conditions.<sup>17</sup> As of July, 2015, five states had adopted the Community First Choice option,<sup>18</sup> and as of June, 2015, 19 states had adopted the Medicaid health homes option.<sup>19</sup> States have the flexibility to choose among various optional Medicaid services to design programs that best meet the needs of beneficiaries, and a better understanding of the characteristics of this population can assist those efforts.

In addition, the complexity of needs among the Medicaid population may indicate a role for LTSS to prevent deterioration in health status that could result in more costly long-term institutional care. With dual eligible beneficiaries more likely to live alone, these seniors may have less access to natural supports (such as a family caregiver) that could delay the need for formal LTSS. At the same time, supports may be needed to address the social determinants of health. For example, many dual eligible beneficiaries with LTSS needs live in a home in need of repairs. Investments to remediate these conditions, such as pests or tripping hazards, while not medical in nature, might help to avoid future health care costs arising from injuries or medical exacerbations stemming from these conditions if they remain unaddressed. While Medicaid does not cover home repairs, states may encourage their Medicaid managed care organizations to offer medically appropriate alternative services as cost-effective substitutes in lieu of services covered under the Medicaid state plan.<sup>20</sup>

While Medicaid is serving many seniors with LTSS needs, many low-income seniors who do not have Medicaid also have LTSS needs. This population still has notable rates of physical and mental health comorbidity, and many live in housing situations that may make it difficult to meet their needs in addition to lacking financial resources to pay for care out-of-pocket. Providing LTSS to meet this population's needs may be cost-effective over the long-term as unmet needs may worsen and require more costly services to address in the future. In the absence of other public or private sources of LTSS coverage, Medicaid remains the nation's primary payer for these services. States have a number of options to expand Medicaid eligibility to offer services to those in need of LTSS where medically necessary. For example, the Affordable Care Act expanded the § 1915(i) state plan option to create a new Medicaid eligibility pathway, including access to home and community-based services.<sup>21</sup> Through this option, states can choose to cover (1) people who are not otherwise eligible for Medicaid with

## Methods

This analysis uses data from the National Health and Aging Trends Study (NHATS), a longitudinal survey of Medicare beneficiaries ages 65 and older.<sup>†</sup> Participants are drawn from a nationally representative sample of Medicare beneficiaries and interviewed annually in-person. To keep the sample as large as possible, we used NHATS Round 1 data, reflecting the Medicare population in 2011. We subset the data to include only those who lived outside nursing facilities and completed the interview.

We stratified the analysis by age categories of 65-74, 75-84, and 85 and over. Within each age category, we further stratified the analysis into dual eligibility/income groups, which included (i) dual eligible beneficiaries with income below 300% of the 2011 Supplemental Security Income (SSI) federal benefit rate (FBR), (ii) non-dual eligible beneficiaries with incomes below 300% SSI, who we call “low-income without Medicaid” throughout the analysis, and (iii) beneficiaries with incomes at or above 300% SSI, who we call “higher-income without Medicaid” throughout the analysis. We chose to use the 300% SSI break for income to reflect policy rules about which individuals may be eligible for Medicaid long-term care assistance. Note that dual eligible beneficiaries account for a small share (<2%) of the higher income group, but we do not stratify the higher income group by dual eligibility status.

NHATS collects information about different sources of income as well as total income; for respondents who do not know or refuse to provide income information, the survey includes imputed income. If a person is single, does not live with a partner, or is separated, income includes only the respondent’s own income; if a person is married or living with a partner, income includes both the respondent’s income and their spouse’s/partner’s income. We randomly selected the variable `ia1toincim5` from the 5 generated income variables and compared it to the 2011 monthly SSI FBR (\$2,022 for an individual and \$3,033 for a couple).

We excluded respondents who either refused or did not know if they were married because we were unable to ascertain which income threshold (single or married) to use in comparing their incomes to the 2011 SSI FBR. We also excluded participants who did not know or refused to answer their Medicaid enrollment status. The total number of respondents who could not be categorized into an income or coverage group due to missing data was 217, leading to a final sample size of 7,395.

First, we analyzed which participants have any LTSS need by looking at self-care/mobility and household activities. We identified participants as having an LTSS need if they reported having difficulty completing an activity or receiving help with an activity (for household activities help due to a health or functioning reason). Self-care/mobility activities include bathing, dressing, toileting, eating, getting out of bed, getting around inside, and getting outside. Household activities include laundry, shopping, meal preparation, banking, and medication management.

We then looked at socio-demographic characteristics and health status among those who had any LTSS need. All percentages in Tables 1 and 2 are from the non-nursing facility sample with any self-care or household activity need, except for “interior or exterior of the home needs repair/service/attention” and “has no one to talk to.” The former percentage is from the subset of non-nursing facility participants with an LTSS need whose home the interviewer observed. The latter is from the subset of non-nursing facility participants with an LTSS need who completed the survey themselves, rather than through a proxy.

<sup>†</sup> Jill Montaquila, Vicki A. Freedman, Brad Edwards and Judith D. Kasper. 2012. National Health and Aging Trends Study Round 1 Sample Design and Selection. NHATS Technical Paper #1. Baltimore: Johns Hopkins University School of Public Health, <http://www.nhats.org/scripts/sampleDesign.htm>.

**Table 2: Characteristics of Seniors with a Need for LTSS, by Health Status and Quality of Life, by Age and Coverage Group, 2011**

Household type	All Ages				Age 65-74				Age 75-84				Age 85+			
	All Ages/ Coverage Groups	Dual Eligible	Low- Income without Medicaid	Higher- Income without Medicaid												
Live alone	33%	44%	33%*	28%*	44%	25%*^	18%*^	41%	32%*^	31%*^	51%	48%	49%			
Live with spouse/partner	39%	16%	36%*	52%*	18% <sup>^</sup>	45%*^	61%*^	18% <sup>^</sup>	38%*^	50%*^	--	18%*	29%*			
Live with other person (not spouse/partner)	9%	9%	9%	9%	10%	14% <sup>^</sup>	12% <sup>^</sup>	9%	10% <sup>^</sup>	8%	--	3%	6%			
Live with spouse/partner and other(s)	19%	31%	21%*	11%*	28% <sup>^</sup>	17%*^	8%*^	32%	20%*^	11%*^	38%	30%	16%*			
<b>Residence type</b>																
Private residence or Continuing Care Retirement Community	85%	76%	85%*	88%*	76%	90%*^	94%*^	79%	87%*^	89%*^	70%	77%	73%			
Assisted living	5%	7%	4%	4%	--	--	0%	--	3% <sup>^</sup>	--	13%	10%	15%			
Retirement community/senior housing	10%	15%	9%*	7%*	15%	8%*	6%*	16%	9%*	7%*	12%	11%	10%			
<b>Condition of residence</b>																
Interior or exterior of the home needs repair/service/attention	26%	37%	27%*	19%*	39% <sup>^</sup>	28%*	20%*	41% <sup>^</sup>	27%*	21%*	27%	24%	16%*			
<b>Health status &amp; mobility</b>																
Self-reported fair or poor health	43%	62%	45%*	31%*	69% <sup>^</sup>	47%*^	31%*	58%	46%*^	31%*	55%	39%*	31%*			
Has 3 or more chronic conditions	57%	63%	58%	51%*	63%	57%	49%*	64%	61%	55%*	60%	56%	51%*			
Uses mobility device inside or outside	39%	53%	42%*	29%*	43% <sup>^</sup>	27%*^	19%*^	55% <sup>^</sup>	42%*^	30%*^	75%	63%*	56%*			
Had a fall or worried about falling in the last month	50%	58%	53%*	44%*	58%	48%*^	37%*^	58%	55%	50%	58%	57%	54%			
<b>Cognitive impairment &amp; mental health</b>																
Probable or possible dementia	32%	47%	36%*	21%*	36% <sup>^</sup>	20%*^	12%*^	52% <sup>^</sup>	39%*^	23%*^	64%	58%	42%*			
Felt down, depressed, hopeless or nervous, anxious, or on edge	61%	69%	62%*	56%*	71%	64%	55%*	67%	62%	56%*	65%	59%	56%			
Has no one to talk to	6%	9%	7%	5%*	12%	5%*	5%*	6%	9%	5%	--	7%	5%			

NOTES: Dual eligible includes people who receive Medicare and Medicaid and have income below 300% SSI. Low-income without Medicaid includes Medicare beneficiaries without Medicaid and income below 300% SSI. Higher-income without Medicaid includes people with income at or above 300% SSI. Dual eligible beneficiaries comprise a small share (<2%) of the ≥300% SSI comparison group population. See methods appendix for more detail.  
 \* Significantly different from dual eligible beneficiaries within the same age group at the p<0.05 level. ^ Significantly different from beneficiaries age 85+ within the same coverage group at the p<0.05 level. -- Estimates with relative standard errors greater than 30% are not provided.  
 SOURCE: KCMU analysis of 2011 NHATS data.

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<sup>17</sup> Molly O'Malley Watts et al. *How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports Today? State Adoption of Six LTSS Options* (April 2013), Washington, DC: Kaiser Family Foundation, available at <http://kff.org/medicaid/issue-brief/how-is-the-affordable-care-act-leading-to-changes-in-medicaid-long-term-services-and-supports-ltss-today-state-adoption-of-six-ltss-options/>. Kaiser Family Foundation State Health Facts, *Health Home State Plan Option*, available at <http://kff.org/medicaid/state-indicator/health-home-state-plan-option/>.

<sup>18</sup> Kaiser Family Foundation, *Section 1915(k) Community First Choice State Plan Option*, available at <http://kff.org/medicaid/state-indicator/section-1915k-community-first-choice-state-plan-option/>.

<sup>19</sup> Kaiser Family Foundation State Health Facts, *Health Home State Plan Option*, available at <http://kff.org/medicaid/state-indicator/health-home-state-plan-option/>.

<sup>20</sup> CMS, *Providing Long Term Services and Supports in a Managed Care Delivery System, Enrollment Authorities and Rate Setting Techniques: Strategies States May Employ to Offer Managed HCBS, CMS Review Processes and Quality Requirements* (Dec. 2009), available at <http://www.pasrrassist.org/sites/default/files/attachments/10-07-23/ManagedLTSS.pdf>.

<sup>21</sup> Section 1915(i) allows states to offer the same categories of home and community-based services under their Medicaid state plans as are available under waivers. States may target services to specific populations. Section 1915(i) services must be provided statewide and waiting lists are not permitted, although states can further restrict functional eligibility criteria for future beneficiaries if the state exceeds its projected number of beneficiaries served under this option. Molly O'Malley Watts et al. *How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports Today? State Adoption of Six LTSS Options* (April 2013), Washington, DC: Kaiser Family Foundation, available at <http://kff.org/medicaid/issue-brief/how-is-the-affordable-care-act-leading-to-changes-in-medicaid-long-term-services-and-supports-ltss-today-state-adoption-of-six-ltss-options/>. Kaiser Family Foundation State Health Facts, *Health Home State Plan Option*, available at <http://kff.org/medicaid/state-indicator/health-home-state-plan-option/>.

<sup>22</sup> Kaiser Family Foundation State Health Facts, *Section 1915(i) Home and Community-Based Services State Plan Option*, available at <http://kff.org/medicaid/state-indicator/section-1915i-home-and-community-based-services-state-plan-option/>.

<sup>23</sup> Terence Ng et al. *Medicaid Home and Community-Based Services Programs: 2011 Data Update* (Dec. 2014), Washington, DC: Kaiser Family Foundation, available at <http://kff.org/report-section/medicaid-home-and-community-based-services-programs-2011-data-update-eligibility-and-cost-containment-policies-used-in-medicaid-hcbs-programs/>.

<sup>24</sup> *Ibid.*, at Table 14.