

Long Term Services and Supports (LTSS) in Medicaid

What are Long Term Services and Supports?

In Medicaid, *long term services and supports (LTSS)* refers to the services and supports received by Medicaid enrollees of all ages that help them with functional limitations and/or chronic illnesses, and assistance in performing routine *activities of daily living (ADLs)* like bathing, grooming, dressing, meal preparation, eating, and medication assistance.¹ Services can be provided in a range of settings, including nursing homes, assisted living facilities, convalescent homes, and home and community-based settings.

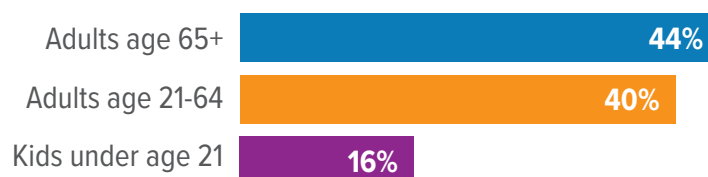
In 2016, combined federal and state Medicaid expenditures for LTSS were \$167 billion – approximately 30 percent of total Medicaid spending. Of total LTSS expenditures, over \$95 billion (57 percent) was spent on *home and community-based services (HCBS)*.² Each year, millions of Medicaid enrollees of all ages utilize the full spectrum of LTSS, from nursing home care to home-based services. It's important to note that medical care and LTSS are very different. LTSS is not curative care; it is a combination of supports and services that help people carry out their daily activities.

Who uses LTSS?

People who use LTSS are elderly and non-elderly individuals with functional impairments, a physical disability, developmental disability, behavioral health diagnosis, or a combination of disabilities.³ Many states offer services through special programs for people with spinal cord or traumatic brain injuries, as well as chronic conditions that result in significant disabilities.

Eligibility requirements for receiving LTSS can be complicated and vary from state to state.⁴ Generally, individuals must require assistance with their ADLs and meet the Medicaid income requirements set by the state.

Figure 1. Who uses LTSS?



Source: Medicaid.gov³

A Brief History of LTSS in Medicaid

When Medicare and Medicaid were created in 1965, state Medicaid programs provided services in nursing homes, convalescent hospitals, and other institutions for older adults and people with disabilities. These services, generally known as “long term care,” were provided in facilities staffed by an array of medical and non-medical professionals who provided basic medical care and ADL supportive services. Medicaid was only required to pay for long term care in institutions and not in a person’s home. This created an *institutional bias* in the program which encouraged placement of people with care needs into nursing facilities. However, over the past 40 years, a number of policy and legal changes have worked to change the landscape of long-term care, reducing the institutional bias in favor of providing care in a person’s home and community.

1 <https://www.hilltopinstitute.org/wpcontent/uploads/publications/LTSSChallengesandOpportunitiesforStatesinDifficultBudgetTimes-December2011.pdf>

2 <https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf>

3 Ibid.

4 <https://fas.org/sgp/crs/misc/R43506.pdf>

While facility-based care is still a mandatory Medicaid benefit in every state, many states now choose to cover HCBS as an optional benefit for some or all of their Medicaid enrollees. States have made significant efforts to *rebalance* the proportions of care provided in individual’s homes and community settings as compared with care provided in nursing homes. In fact, 2013 marked the first year that total U.S. Medicaid expenditures for HCBS exceeded expenditures for facility-based care.

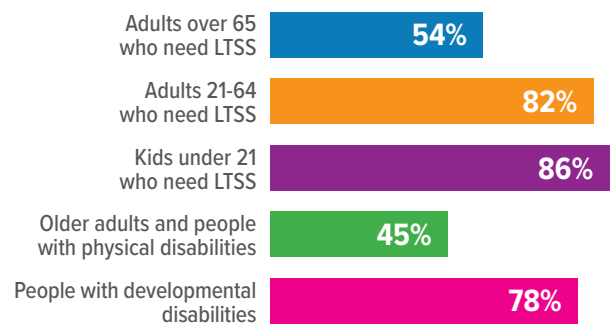
How do States Implement LTSS Programs?

Because the majority of LTSS are optional benefits, states add the services to their Medicaid program through State Plan Amendments (SPAs)⁵ or through waivers. The most common way states add additional LTSS is through a *1915(c) waiver*. Also known as the “Home and Community Based Services” or “HCBS” waiver, the 1915(c) waiver allows individuals⁶ (see Figure 2) to receive a variety of services, including personal care, case management, adult day services, and habilitation while residing in their homes instead of in institutional settings. States can have more than one 1915(c) waiver; in fact, there are more than 300 1915(c) waivers currently in effect serving more than 4.6 million people across the United States.

LTSS and Managed Care

States contract with Medicaid managed care organizations (MCOs) to provide some or all of their Medicaid benefits. In 24 states, some or all LTSS benefits are provided through managed care. MCOs receive a capitation payment (a pre-determined amount paid per member, per month) from the state to cover costs of all the services specified under the contract. States choose to provide LTSS through managed care for a variety of reasons, including improved care management, community inclusion and quality of care. MCOs work with LTSS enrollees and their care teams to ensure that enrollees receive all of the care and services they need in a timely manner. Currently more than 1.7 million people receive LTSS through Medicaid MCOs.⁷

Figure 2. Who uses HCBS?



Source: Medicaid.gov⁷

Opportunities to Improve LTSS

The services provided through LTSS programs are life-saving and life-sustaining. While LTSS programs have evolved significantly over the past 20 years, they have evolved sometimes as patchwork responses to issues faced by various populations. Streamlining LTSS through a holistic, intentionally designed approach, as well as continued advancements that increase the availability of HCBS, will help ensure that people with Medicaid can maintain their independence and quality of life while making smart use of taxpayer dollars.

For more information on Medicaid, please refer to other briefs in AHIP’s Medicaid 101 series

- [Medicaid 101 — Program Overview](#)
- [Medicaid Administration and Financing](#)
- [Medicaid Eligibility and Enrollment](#)
- [Medicaid Prescription Drug Coverage](#)
- [Medicaid Managed Care](#)
- [Children’s Health Insurance Program \(CHIP\)](#)

⁵ Each state has a State Plan that documents details of its Medicaid program for the federal government. State plans are often amended by a State Plan Amendment (SPA) to add to or change elements of the program. SPAs are different than waivers.

⁶ Ibid.

⁷ <https://www.kff.org/other/state-indicator/total-medicaid-enrollment-in-managed-long-term-services-and-supports/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>