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Medicaid's Role in Meeting Seniors' Long-Term Services and Supports Needs

Although nearly all of the nation's 46 million seniors have health insurance through Medicare, that program does not cover the long-term services and supports (LTSS) that many seniors need. Nearly half of seniors residing in the community have an LTSS need[1] due to a cognitive or physical limitation. For example, people with dementia,[2] mobility or coordination problems due to stroke, severe vision loss, or significant pain that prevents movement may require LTSS. LTSS provide assistance with routine self-care tasks, such as eating, bathing, and dressing, and household activities, such as preparing meals, managing medication, and doing laundry. LTSS are expensive, with a median annual cost of over $90,000 for nursing facility care, more than $40,000 for homemaker or home health services, and nearly $20,000 for adult day health care in 2015.[3] At the same time, many seniors are living in poverty (10%) or near poverty (22%)[4] and unlikely to be able to afford paid help, and few have private long-term care insurance to meet their needs. People over age 85 are most likely to need LTSS,[5] and the number of individuals in this age group is expected to increase by almost 70 percent over the next two decades.[6] The need for LTSS varies by state (Table 1), but all states have a substantial share of their population that currently or may soon need LTSS. Medicaid plays a key role in financing LTSS for many low-income seniors, and its role will grow as the population ages. This fact sheet describes how seniors become eligible for Medicaid LTSS, what LTSS Medicaid covers, and how much Medicaid spends for those services, and highlights key policy issues in Medicaid and LTSS.

How Do Seniors Qualify for Medicaid LTSS?

Not all seniors who need LTSS qualify for Medicaid; they must have low incomes and limited assets. States generally must provide Medicaid to seniors who receive federal Supplemental Security Income (SSI) benefits and may extend Medicaid eligibility to seniors with relatively higher incomes (up to 300% of SSI, or $2,199 per month for an individual in 2016). At state option, seniors who incur health care expenses may "spend down" to the state's financial eligibility threshold. After qualifying for Medicaid, often after entering a nursing facility and exhausting their savings, seniors must allocate all of their income except for a small personal needs allowance toward the cost of their health and long-term care services. In 2015, the median monthly personal needs allowance is $50 for those receiving institutional care and $1,962 for community-based care, reflecting that those living in the community face additional costs to maintain housing.[7] Seniors also generally must meet asset limits to qualify for Medicaid, typically at SSI levels ($2,000 for an individual and $3,000 for a couple).

In addition to meeting financial eligibility criteria, seniors also must qualify for Medicaid LTSS based on their functional needs. Functional eligibility for LTSS is commonly assessed by determining a person's need for assistance with one or more self-care or household activities. Other functional eligibility criteria may include the presence of certain medical conditions or evidence of cognitive impairment. Traditionally, beneficiaries have been required to have functional limitations that would otherwise meet an institutional level of care to qualify for Medicaid home and community-based services (HCBS). However, the Deficit Reduction Act of 2005 gives states the option, expanded by the Affordable Care Act (ACA), to provide Medicaid HCBS to people with functional limitations that do not yet rise to an institutional level of care,[8] and states are increasingly offering HCBS to this population to prevent or delay the need for more intensive and costly future care.

Which LTSS Does Medicaid Cover?

States have considerable flexibility in designing their Medicaid benefit packages but generally must provide nursing facility and home health services to adult beneficiaries. All other LTSS, particularly most HCBS, are optional for states. Examples of Medicaid HCBS include homemaker/home health aide services, personal care or attendant services, adult day health services, case management, habilitation, respite care, home modifications, and home delivered meals.

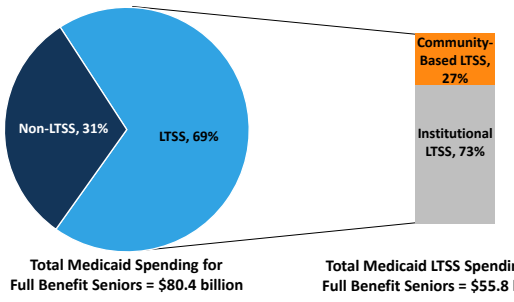
LTSS may be provided in the community or in an institution such as a nursing facility. Over the last thirty years, there has been a shift toward serving more people in the community rather than institutions due in large part to the growth in beneficiary preferences for HCBS and states' obligations under the Supreme Court's *Olmstead* decision, which found that the unjustified institutionalization of persons with disabilities violates the Americans with Disabilities Act.[9] Still, some people with extensive medical and LTSS needs may require around-the-clock care that is provided in an institutional setting such as a nursing facility. Almost all states (46 states in both fiscal year (FY) 2015 and 2016) continue to focus on expanding beneficiary access to Medicaid HCBS.[10]

How Much Does Medicaid Spend to Cover Seniors' LTSS Needs?

Most Medicaid spending on behalf of seniors is for LTSS. Of the $80.4 billion[11] Medicaid spent on care for full-benefit[12] seniors in FY 2011, over two-thirds ($55.8 billion, or 69%) was devoted to LTSS (Figure 1). LTSS spending for seniors as a share of all Medicaid spending for seniors varies by state, with some states spending a little over half of their total Medicaid expenditures for this population on LTSS, and others spending more than 90% (Table 2). This variation reflects differences in both the needs of states' elderly beneficiaries and the structure of state Medicaid programs. For example, some states may provide a broader scope of acute care (e.g., dental) services to seniors, while others may provide a broader scope of LTSS. In addition, some states rely on comprehensive risk-based managed care organizations to deliver LTSS, with LTSS spending combined with acute care spending under a single capitation rate.

Figure 1

LTSS account for the majority of Medicaid expenditures for seniors with full benefits.



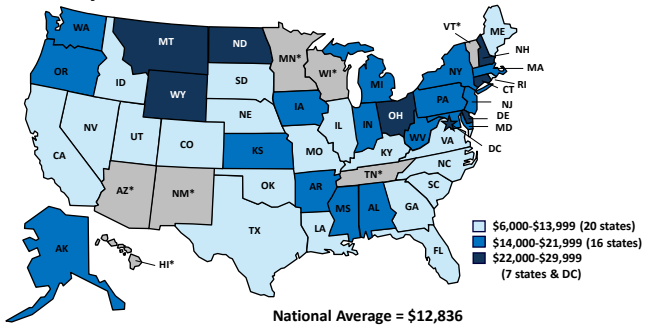
NOTE: MLTSS programs for seniors were in place in AZ, HI, MN, TN, VT, and WI, and as a result, we may not be capturing all LTSS spending.
SOURCE: KCMU and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports. Because 2011 data were unavailable, 2010 data was used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT. For total spending in these states, it was then adjusted to 2011 CMS-64 spending levels.

Nationally, Medicaid spent more than $12,000 per full-benefit senior enrollee on LTSS in FY 2011. Medicaid LTSS spending per senior enrollee varied across states, from $6,427 in California to $28,130 in North Dakota (Figure 2 and Table 2). This variation was due in part to differences in the mix of LTSS services used across states and variation in provider reimbursement rates.

Nearly three-quarters (73%) of national Medicaid LTSS spending for seniors funds institutional services, with just over one-quarter (27%) going toward community-based services as of FY 2011 (Figure 1). The split between community-based and institutional Medicaid LTSS spending for seniors in Medicaid varies at the state level, ranging from 7 percent (Florida) to 60 percent (Alaska) in FY 2011 (Figure 3 and Table 2). While all states provide some Medicaid HCBS to seniors, the size and scope of these programs varies, and because many of these services are offered through waivers, enrollment can be capped. In 2014, there were 78 Medicaid HCBS waivers in 46 states targeted to seniors or seniors and non-elderly people with physical disabilities, with nearly 156,000 individuals on a waiting list for waiver services.[13] Waiting list enrollment also varies by state.

Figure 2

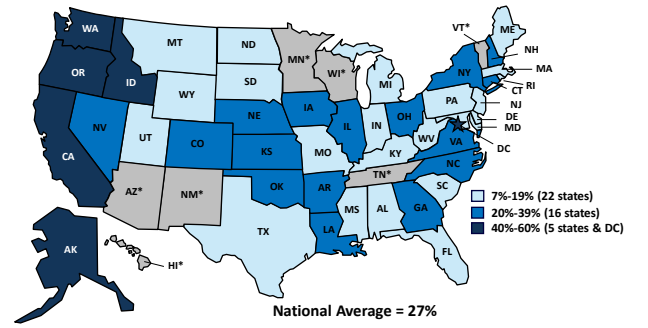
Medicaid LTSS spending per full-benefit senior enrollee varies by state.



NOTE: *MLTSS programs for seniors were in place in AZ, HI, MN, TN, VT, and WI. Because of the way the MLTSS data are categorized, we were unable to calculate reliable spending per enrollee estimates for these states. We were also unable to report spending for New Mexico, due to a spending data reliability issue for senior enrollees in the New Mexico CoLTS program. These states were withheld from the national spending per full-benefit senior enrollee calculation.
SOURCE:KCMU and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports. Because 2011 data were unavailable, 2010 data was used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT.

Figure 3

The share of Medicaid LTSS spending for full-benefit seniors devoted to HCBS varies by state.



NOTE: *MLTSS programs for seniors were in place in AZ, HI, MN, TN, VT, and WI. Because of the way the MLTSS data are categorized, we were unable to calculate reliable HCBS shares of LTSS spending for these states. We were also unable to report HCBS shares for New Mexico, due to a spending data reliability issue for senior enrollees in the New Mexico CoLTS program. These states were withheld from the national HCBS share of LTSS spending calculation.
SOURCE: KCMU and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports. Because 2011 data were unavailable, 2010 data was used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT and adjusted to 2011 CMS-64 spending levels.

What are the Current Policy Issues in LTSS for Seniors?

Given that an estimated 70 percent of Americans turning 65 today will use some form of LTSS in their lifetime,[14] ensuring adequate access to affordable LTSS for seniors is likely to remain a topic of discussion among policymakers and other stakeholders in the coming decades. While the majority of Americans age 40 and older anticipate needing LTSS as they age and have done some planning, 38 percent expect that Medicare will cover their LTSS expenses; however, while Medicare covers acute and post-acute services, it does not cover LTSS. Just 20 percent of those surveyed identified Medicaid as a potential source of LTSS coverage, suggesting there are opportunities to educate the public about current LTSS financing options.[15] With Medicaid likely to continue to play a primary role in financing LTSS, policymakers have begun discussing how to streamline the existing Medicaid HCBS authorities, which can be complex for states to administer and difficult for seniors who need LTSS to navigate.[16]

Policymakers also continue to focus on ways to increase access to community-based services as opposed to institutional care. The vast majority of Americans age 40 and over would prefer to receive LTSS in a home or community-based setting rather than in an institution.[17] Over the last several decades, total Medicaid LTSS spending (for both seniors and people with disabilities) has been increasingly devoted to HCBS instead of institutional care, surpassing 50% in FY 2013, and reaching 53% in FY 2014.[18] However,

disparities in access to community-based services remain: among Medicaid beneficiaries receiving LTSS, only half of seniors lived in the community in 2011, compared to 80% of non-elderly people with disabilities.[19] To support seniors' desire to "age in place," policymakers will continue to draw on the Medicaid options to provide HCBS, including those added and expanded by the ACA, while also considering how to increase the supply of community-based providers and affordable housing.

LTSS delivery system reforms are another area of recent policy focus, with an increasing number of states pursuing models that seek to integrate LTSS with physical and behavioral health services. Some states are implementing risk-based capitated managed care models, while others are pursuing managed fee-for-service options, such as Medicaid health homes for beneficiaries with chronic conditions. Some states are focused on Medicaid LTSS delivery system reforms, while others also are examining how to better coordinate Medicare and Medicaid services for beneficiaries who are eligible for both programs. As evaluation results and data from these models become available, policymakers may be able to identify promising practices to improve health outcomes and increase access to community-based care while preventing or delaying unnecessary institutional care.

Looking Ahead

Many of the nation's 76 million baby boomers will develop chronic health conditions or experience functional impairments with advancing age, leading to a need for LTSS. Improving access to LTSS for seniors is likely to remain a major public health issue as federal and state policymakers, seniors and their families, and other stakeholders consider cost-effective options to best meet the needs of this growing population. Medicaid is the nation's primary payer for LTSS for people with low incomes and is likely to continue to play a key role as LTSS financing reforms are considered. In the years ahead, policymakers will be challenged to meet the growing need for LTSS for our nation's seniors in a manner that promotes community integration and autonomy, supports caregivers, and provides adequate access to needed care while managing costs.

Table 1: Senior Population (Age 65+), by State					
State	Number of Residents Age 65+, 2014[a]	Share of State Population Age 65+, 2014[a]	Share of Senior Population <200% of Poverty, 2014[a]	Share of Senior Population Age 85+, 2014[a]	Share of Senior Population with an ADL Difficulty, 2012[b]
United States	**45,994,000**	**15%**	**32%**	**12%**	**9%**
Alabama	716,000	15%	43%	7%	11%
Alaska	66,700	10%	28%	N/A	10%
Arizona	965,700	15%	36%	10%	7%
Arkansas	462,100	16%	37%	7%	10%
California	4,888,100	13%	32%	13%	11%
Colorado	736,600	14%	24%	16%	7%
Connecticut	495,200	14%	30%	15%	7%
Delaware	153,400	17%	24%	7%	7%
District of Columbia	75,800	12%	36%	9%	8%
Florida	3,524,900	18%	38%	12%	8%
Georgia	1,269,500	13%	36%	9%	10%
Hawaii	223,200	16%	27%	14%	8%
Idaho	210,200	13%	28%	13%	8%
Illinois	1,886,900	15%	32%	16%	8%
Indiana	973,300	15%	26%	13%	8%
Iowa	484,600	16%	32%	17%	7%
Kansas	390,700	14%	28%	17%	7%
Kentucky	682,300	16%	39%	11%	10%
Louisiana	556,600	12%	53%	8%	11%
Maine	241,600	19%	29%	11%	6%
Maryland	798,300	13%	27%	12%	8%
Massachusetts	1,040,200	16%	36%	16%	8%
Michigan	1,482,100	15%	30%	10%	9%
Minnesota	818,900	15%	21%	12%	7%
Mississippi	391,600	13%	49%	11%	12%
Missouri	935,300	16%	28%	12%	8%
Montana	158,500	16%	32%	10%	7%
Nebraska	262,700	14%	31%	14%	6%
Nevada	402,100	14%	33%	11%	7%
New Hampshire	205,000	16%	24%	9%	6%
New Jersey	1,280,300	14%	21%	12%	8%
New Mexico	331,300	16%	39%	N/A	10%
New York	3,044,400	15%	36%	14%	9%
North Carolina	1,441,400	15%	35%	9%	9%
North Dakota	95,300	13%	32%	16%	6%
Ohio	1,852,000	16%	31%	13%	8%
Oklahoma	539,800	14%	31%	9%	9%
Oregon	717,400	18%	24%	13%	9%
Pennsylvania	2,152,000	17%	28%	14%	8%
Rhode Island	152,900	15%	34%	14%	6%
South Carolina	744,900	16%	39%	9%	9%
South Dakota	134,000	16%	32%	15%	6%
Tennessee	1,027,400	16%	41%	12%	10%
Texas	3,162,800	12%	32%	11%	10%
Utah	317,100	11%	27%	6%	7%
Vermont	101,500	16%	24%	10%	7%
Virginia	1,109,500	13%	26%	12%	9%
Washington	1,014,600	14%	30%	10%	8%
West Virginia	320,900	18%	44%	10%	11%
Wisconsin	882,400	15%	27%	11%	7%
Wyoming	73,900	13%	25%	9%	6%

NOTES: N/A: Sample size too small for reliable estimate. In 2014, 200% of poverty was $22,708 for an individual and $28,618 for a couple.
SOURCES: a Kaiser Family Foundation analysis of Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2015; b Susan C. Reinhard, Enid Kassner, Ari Houser, Kathleen Ujvari, Robert Mollica, and Leslie Henderickson, Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers 92, Exhibit A22 (Washington, DC: AARP Public Policy Institute and The Commonwealth Fund and Long Beach, CA: The SCAN Foundation), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2014/raising-expectations-2014-AARP-ppi-ltc.pdf.

Table 2: Medicaid Enrollment and Expenditures for Full-Benefit Enrollees Age ≥65, FY2011						
State	Total Number of Full-Benefit Medicaid Enrollees Age 65+	Total Medicaid Spending for Full-Benefit Enrollees Age 65+ (Millions)	Medicaid LTSS Spending for Full-Benefit Enrollees Age 65+			Share of LTSS Spending for Full-Benefit Enrollees Age 65+ that is for HCBS
			Total LTSS Spending (Millions)	LTSS Spending as a Share of Total Spending (%)	Spending Per Enrollee	
United States	**4,568,680**	**$80,433**	**$55,775**	**69%**	**$12,836**	**27%**
Alabama	50,040	$924	$803	87%	$16,050	11%
Alaska	9,065	$220	$176	80%	$19,380	60%
Arizona	65,702	$1,061	N/A	N/A	N/A	N/A
Arkansas	42,536	$871	$662	76%	$15,571	21%
California	978,708	$11,763	$6,290	53%	$6,427	48%
Colorado	46,962	$868	$609	70%	$12,965	29%
Connecticut	50,259	$1,536	$1,369	89%	$27,230	22%
Delaware	7,000	$194	$161	83%	$23,050	13%
District of Columbia	13,493	$369	$304	82%	$22,499	44%
Florida	267,634	$3,929	$2,615	67%	$9,642	7%
Georgia	92,530	$1,309	$1,127	86%	$12,180	20%
Hawaii	22,773	$420	N/A	N/A	N/A	N/A
Idaho	12,308	$191	$160	84%	$13,006	54%
Illinois	193,215	$2,209	$1,564	71%	$8,096	32%
Indiana	62,199	$1,323	$1,105	84%	$17,770	13%
Iowa	32,521	$688	$583	85%	$17,932	22%
Kansas	27,607	$563	$471	84%	$15,311	27%
Kentucky	57,398	$904	$769	85%	$13,390	8%
Louisiana	60,558	$938	$766	82%	$12,650	24%
Maine	28,387	$546	$309	57%	$11,643	9%
Maryland	52,423	$1,282	$1,047	82%	$19,398	19%
Massachusetts	118,782	$3,232	$1,953	60%	$16,440	15%
Michigan	121,615	$2,140	$1,770	83%	$14,550	14%
Minnesota	65,902	$1,650	N/A	N/A	N/A	N/A
Mississippi	46,484	$864	$705	82%	$15,176	12%
Missouri	80,807	$1,375	$961	70%	$11,897	19%
Montana	9,275	$255	$232	91%	$24,233	19%
Nebraska	24,268	$364	$290	80%	$11,942	21%
Nevada	15,950	$211	$169	80%	$10,590	27%
New Hampshire	10,763	$288	$263	91%	$24,465	21%
New Jersey	115,038	$2,256	$1,636	73%	$14,262	13%
New Mexico	24,347	N/A	N/A	N/A	N/A	N/A
New York	458,594	$12,995	$9,690	75%	$21,129	38%
North Carolina	123,764	$1,302	$1,047	80%	$8,459	38%
North Dakota	7,162	$223	$201	90%	$28,130	9%
Ohio	124,501	$3,423	$2,838	83%	$22,796	22%
Oklahoma	53,893	$655	$526	80%	$10,054	25%
Oregon	39,497	$958	$841	88%	$21,281	45%
Pennsylvania	190,599	$4,073	$3,562	87%	$18,689	16%
Rhode Island	16,221	$276	$151	55%	$9,309	13%
South Carolina	71,978	$882	$707	80%	$9,824	17%
South Dakota	8,273	$135	$116	85%	$13,998	11%
Tennessee	77,730	$1,224	N/A	N/A	N/A	N/A
Texas	263,460	$4,005	$2,379	59%	$8,964	19%
Utah	14,835	$177	$119	68%	$8,141	10%
Vermont	9,305	$133	N/A	N/A	N/A	N/A
Virginia	73,709	$1,206	$976	81%	$13,242	26%
Washington	68,338	$1,106	$989	89%	$14,468	58%
West Virginia	25,596	$595	$542	91%	$21,175	17%
Wisconsin	131,047	$2,142	N/A	N/A	N/A	N/A
Wyoming	3,629	$117	$91	78%	$25,139	19%

NOTES: Enrollees were identified as having full benefits if for each month they were enrolled in Medicaid they also received full benefits or received Medicaid benefits through an alternative package of benchmark equivalent coverage. Data include full-benefit enrollees who participated in Medicaid for any length of time during the federal fiscal year. MLTSS programs for seniors were in place in AZ, HI, MN, TN, VT, and WI. Because of the way the MLTSS data are categorized, we were unable to calculate reliable LTSS numbers for these states, as represented with "N/A." We were also unable to report spending for New Mexico, due to a spending data reliability issue for senior enrollees in the New Mexico CoLTS program.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports. Because 2011 data were unavailable, 2010 data was used for Florida, Kansas, Maine, Maryland, Montana, New Mexico, New Jersey, Oklahoma, Texas, and Utah. For total spending in these states, it was then adjusted to 2011 CMS-64 spending levels. For spending per enrollee in these states it was adjusted to 2010 CMS-64 spending levels.

Endnotes

[1] Rachel Garfield, Katherine Young, MaryBeth Musumeci, Erica L. Reaves, and Judy Kasper, *Serving Low-Income Seniors Where They Live: Medicaid's Role in Providing Community-Based Long-Term Services and Supports* (Washington, DC: KCMU, September 2015), http://kff.org/medicaid/issue-brief/serving-low-income-seniors-where-they-live-medicaids-role-in-providing-community-based-long-term-services-and-supports/.

[2] Rachel Garfield, MaryBeth Musumeci, Erica L. Reaves, and Anthony Damico. *Medicaid's Role for People with Dementia*. (Washington, DC: KCMU, October 2015), http://kff.org/medicaid/issue-brief/medicaids-role-for-people-with-dementia/.

[3] Genworth, *Cost of Care Survey 2016, Summary of 2016 Survey Findings* (Richmond, VA: Genworth Financial, Inc., May 2016), https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/131168_050516.pdf.

[4] Kaiser Commission of Medicaid and the Uninsured analysis of Current Population Survey, Annual Social and Economic Supplement, 2015.

[5] Rachel Garfield, Katherine Young, MaryBeth Musumeci, Erica L. Reaves, and Judy Kasper, *Serving Low-Income Seniors Where They Live: Medicaid's Role in Providing Community-Based Long-Term Services and Supports* (Washington, DC: KCMU, September 2015), http://kff.org/medicaid/issue-brief/serving-low-income-seniors-where-they-live-medicaids-role-in-providing-community-based-long-term-services-and-supports/.

[6] Ari Houser, Wendy Fox-Grage, and Kathleen Ujvari, *Across the States 2012: Profiles of Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, September 2012), http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html.

[7] Molly O'Malley Watts, Elizabeth Cornachione, and MaryBeth Musumeci, *Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2016), http://kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015-report/.

[8] 42 U.S.C. § 1396n(i).

[9] *Olmstead v. L.C.* 527 U.S. 581 (1999), http://www.law.cornell.edu/supct/html/98-536.ZS.html.

[10] Vernon K. Smith, Kathleen Gifford and Eileen Ellis, Health Management Associates, Robin Rudowitz, Laura Snyder, and Elizabeth Hinton, *Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2015), http://kff.org/medicaid/report/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016/.

[11] This is likely lower than the actual amount that Medicaid spent on LTSS in FY 2011, because we are unable to capture all spending on managed long-term services and supports (MLTSS) programs. At this time, we are unable to parse out MLTSS from acute care managed care spending.

[12] We restricted analysis to full-benefit Medicaid enrollees because Medicaid does not cover LTSS for enrollees receiving limited or partial benefits. Enrollees were identified as having full benefits if for each month they were enrolled in Medicaid they also received full benefits or received Medicaid benefits through an alternative package of benchmark equivalent coverage. Data include full-benefit enrollees who participated in Medicaid for any length of time during the federal fiscal year.

[13]Terence Ng, Charlene Harrington, MaryBeth Musumeci, and Erica L. Reaves, *Medicaid Home and Community-Based Services Programs: 2012 Data Update* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2015), http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2012-data-update/. Five other states (AZ, HI, RI, TN, and VT) offer Medicaid HCBS to seniors through Section 1115 waiver authority; information about waiting lists in those states is unavailable.

[14] "Who Needs Care?" U.S. Department of Health and Human Services, accessed June 10, 2016, http://longtermcare.gov/the-basics/who-needs-care/.

[15] The Associate Press-NORC Center for Public Affairs Research, *Long-Term Care in America: Expectations and Preferences for Care and Caregiving* (New York, NY: The Associated Press and Chicago, IL: NORC, May 2016), http://www.longtermcarepoll.org/Pages/Polls/long-term-care-in-america-expectations-and-preferences-for-care-and-caregiving.aspx.

[16] Mary Sowers, Henry Claypool, and MaryBeth Musumeci, *Streamlining Medicaid Home and Community-Based Services: Key Policy Questions* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2016), http://kff.org/report-section/streamlining-medicaid-home-and-community-based-services-key-policy-questions-issue-brief/.

[17] The Associate Press-NORC Center for Public Affairs Research, *Long-Term Care in America: Expectations and Preferences for Care and Caregiving* (New York, NY: The Associated Press and Chicago, IL: NORC, May 2016), http://www.longtermcarepoll.org/Pages/Polls/long-term-care-in-america-expectations-and-preferences-for-care-and-caregiving.aspx.

[18] Steven Eiken, Kate Sredl, Brian Burwell and Paul Saucier, *Medicaid Expenditures for Long-Term Services and Supports in FY 2014: Managed LTSS Reached 15 Percent of LTSS Spending* (Truven Health Analytics, April 15, 2016), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-2014.pdf.

[19] Mary Sowers, Henry Claypool, and MaryBeth Musumeci, *Streamlining Medicaid Home and Community-Based Services: Key Policy Questions* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2016), http://kff.org/report-section/streamlining-medicaid-home-and-community-based-services-key-policy-questions-issue-brief/.