

March 2005

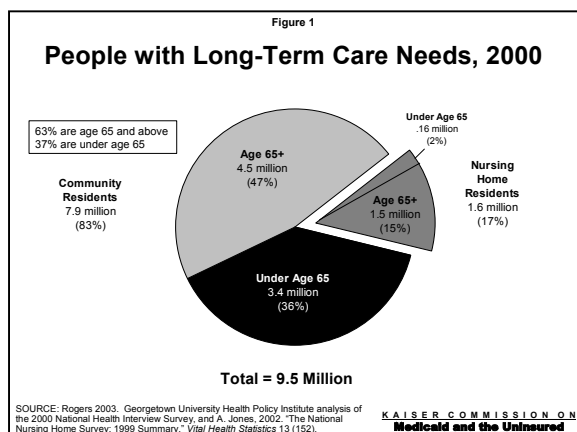
Medicaid and Long-Term Care

Medicaid is the nation's major source of financing for long-term care services, covering services for both elderly and non-elderly persons in institutional settings and in homes and other community-based settings. Many of these critical services are not covered by Medicare or private insurance. However, Medicaid's long-term care protections are limited to those with low-incomes or who incur catastrophic expenditures.

Who Needs Long-Term Care?

Nearly 10 million Americans need long-term care services and supports to assist them in life's daily activities (Figure 1). Long-term care involves providing a range of supportive services that may assist individuals with performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These range from providing assistance with eating, dressing, and toileting, to assisting with managing a home, preparing food, and medication management.

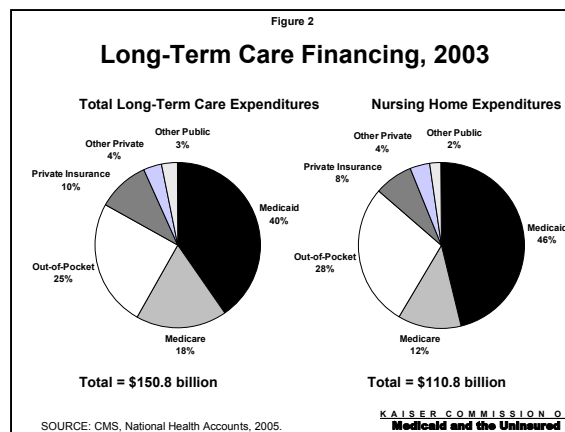
For some people, these are lifetime needs. Children born with severe physical impairments, developmental disabilities, or a degenerative disease often need care throughout their lives. Teenagers and adults who incur traumatic injuries may need care for decades. The elderly often need some long-term care service due to decreasing mobility and cognitive functioning that comes with aging and often more extensive services for those disabled by a serious illness.



Who Pays for Long-Term Care?

Although many people who need long-term care rely primarily on unpaid help from family and friends, over \$150 billion was spent on long-term care in 2003

(Figure 2). Medicaid accounted for 40% of long-term care services (\$61 billion). Direct out-of-pocket spending comprises the next largest payer category, accounting for one-quarter, or \$38 billion, in spending. Medicare provides limited post-acute care through its skilled nursing facility benefit and its home health care benefit, accounting for only 18% of spending.



Who Qualifies for Medicaid Long-term Care Services?

Medicaid is not available to everyone who needs long-term care. To limit public expenditures, those who need long-term care must meet financial and categorical eligibility criteria to qualify for Medicaid. For the elderly and people with disabilities with long-term care needs, these limits are often tied to the Supplemental Security Income (SSI) program—\$579 per month in 2005 – but states can, and often do, set higher limits.

Most states also allow the "medically needy" --those with high medical bills--to spend down to a state-set eligibility standard. In addition, because few people can afford the high cost of nursing home care, 33 states allow individuals needing nursing home care to qualify under the "300 percent rule". Under this option, individuals with income up to 300% of SSI (\$1,737 per month in 2005) can qualify for Medicaid assistance with institutional care.

Many elderly persons enter nursing homes as private pay clients, spend their available life savings, and become eligible for Medicaid once they have depleted their assets. Individuals who apply for Medicaid

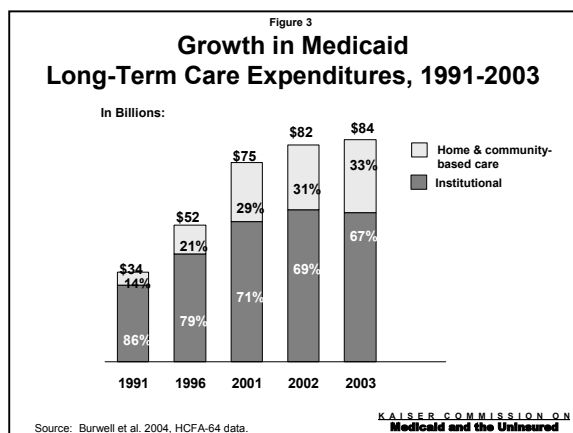
assistance with long-term care needs are subject to a “look-back” period of three years for asset transfers and five years for some types of trusts during which eligibility may be denied. This process is intended to focus public resources on the neediest, but in some cases can be demeaning and burdensome and can result in foregone or delayed assistance for those with long-term care needs.

Nursing home residents who qualify for Medicaid must apply all their monthly income toward the cost of care, except for a small personal needs allowance. Those with spouses living in the community are allowed to disregard a certain amount of income for the support of the community-residing spouse. Medicaid beneficiaries receiving home and community-based services are also required to apply a portion of their income to the cost of care; states are not required to offer spousal impoverishment protections to waiver participants.

Over half (56%) of the elderly who qualify for Medicaid and thus long-term care, qualify through optional eligibility groups, reflecting state decisions to extend coverage to nursing home residents and the medically needy with incomes above SSI eligibility levels. Without Medicaid, many of these individuals would not have access to long-term care services.

What Long-term Care Services Does Medicaid Cover?

Medicaid provides long-term care services in both institutional and home and community-based settings. While many prefer to remain in the community, some individuals with extensive needs require nursing home care. Spending on Medicaid home and community-based care has been growing. In 2003, spending on home and community-based care accounted for 33% (\$28 billion) of total Medicaid long-term care spending up from 15% in 1992 (Figure 3).



Spending on long-term care varies greatly across states -- long-term care accounts for more than 50% of Medicaid spending in 7 states, and less than 30% in 11 states. States also vary in the extent to which they cover community-based long-term care. In some states, a significant share of resources is devoted to home and community-based care. Expenditures for home and community-based care range from 11% of total Medicaid long-term care expenditures in Louisiana to 63% in New Mexico.

Current Issues in Medicaid Long-Term Care

Medicaid is the single largest source of financing for long-term care, but in an era of constrained revenue growth, policymakers are seeking strategies to reduce Medicaid spending growth. Because long-term care accounts for a third of Medicaid spending, it is a target for cost containment actions.

The Administration's FY 2006 budget proposes to reduce Medicaid spending by \$60 billion over 10 years through a number of savings proposals (offset by some program increases), including a proposal to tighten existing rules regarding transfers of assets (\$4.5 billion over 10 years). However, few Americans have insurance to protect them from the high cost of long-term care, leaving Medicaid as the only source of financial assistance for people who deplete their resources paying for long-term care needs.

To meet the diverse situations of people with long-term care needs, states need to finance care in institutional and home and community-based settings. The historic institutional bias in Medicaid spending has been shifting as states have increased the availability of home and community-based services as optional benefits or through waivers. The Administration has promoted independent living through consumer direction and nursing home transition initiatives. Despite these gains, eligibility, enrollment and funding have been limited and many states have long waiting lists for home and community-based services. In addition, quality concerns about care in nursing homes and community-based settings persist.

The need for long-term care is projected to increase due to the growth in the under-65 disabled population as well as the aging of the population. In the absence of broader reform, efforts to assure that Medicaid can continue to finance long-term care coverage for the low-income population, increase the availability of community-based care, and develop better quality-monitoring systems are fundamental to Medicaid's role as the nation's major source of long-term care financing.

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