

July 2006

Medicaid and Long-Term Care Services

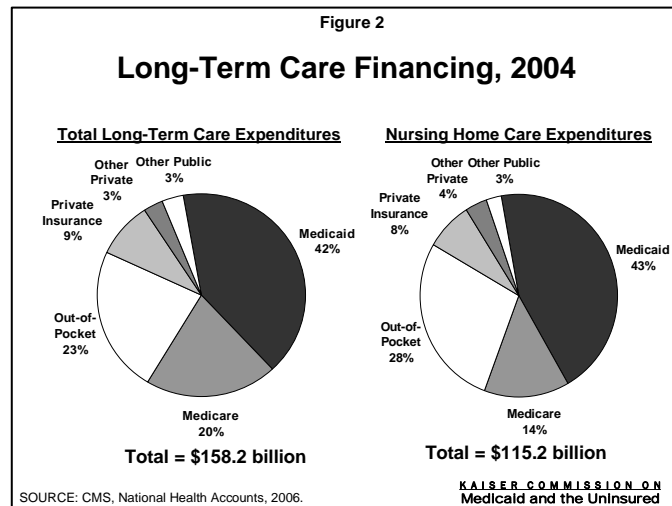
Medicaid is the nation's major source of financing for long-term care services, covering services for both elderly and non-elderly persons in institutional settings and in homes and other community-based settings. Many of these critical services are not covered by Medicare or private insurance. However,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

Who Needs Long-Term Care Services?

Nearly 10 million Americans need long-term care services and supports to assist them in life's daily activities (Figure 1). The majority of beneficiaries who receive long-term care services are age 65 and above while 37 percent are under 65. Long-term care services include a range of services and supports that 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 brain injuries may need care for decades. The elderly often need some long-term services due to decreasing mobility and cognitive functioning that comes with aging and often more extensive services for those disabled by a serious illness.

pocket care spending comprises the next largest payer category, accounting for slightly less than one-quarter in spending. Medicare provides limited post-acute care through its skilled nursing facility benefit and its home health care benefit, accounting for 20% of spending.

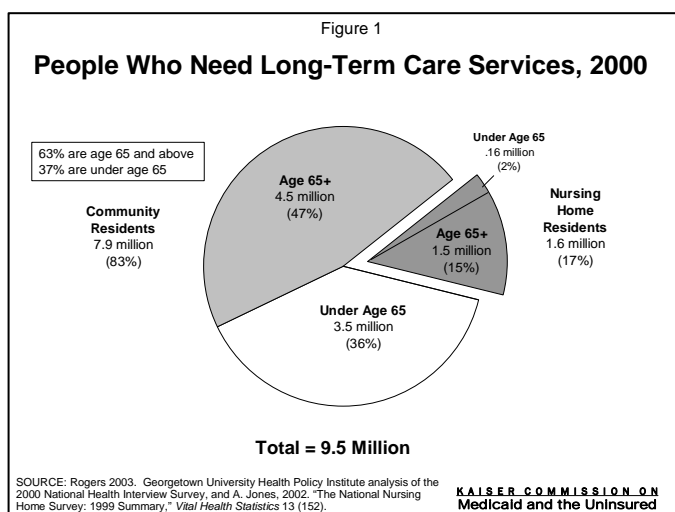


Who Qualifies for Medicaid Long-Term Care Services?

Medicaid is intended to assist low-income individuals and is not available to everyone who needs long-term services. Those who need long-term services must meet both financial and functional eligibility criteria to qualify for Medicaid. For elderly and people with disabilities with long-term care needs, these limits are often tied to the Supplemental Security Income (SSI) program – \$603 per month in 2006 – but states can, and often do set higher limits.

Thirty-three 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, 38 states allow individuals needing nursing home care to qualify under the “300 percent rule”. Under this option, individuals with income up to 300 percent of SSI (\$1,806 per month in 2006) can qualify for Medicaid assistance with institutional care.

Elderly persons who enter nursing homes as private pay clients can exhaust their available life savings and become eligible for Medicaid once they have depleted their assets. After qualifying, most of their monthly income would continue to be applied to the cost of their care. Individuals who apply for Medicaid assistance with long-term care services are subject to a “look back” period of five years for asset transfers during which eligibility may be denied. This is intended to prevent those above the eligibility levels for Medicaid from giving away their resources in order to qualify



Who Pays for Long-Term Care Services?

Although many people who need long-term care rely primarily on unpaid help from family and friends, nearly \$160 billion was spent on long-term services in 2004 (Figure 2). Medicaid accounted for 42% of spending. Direct out-of-

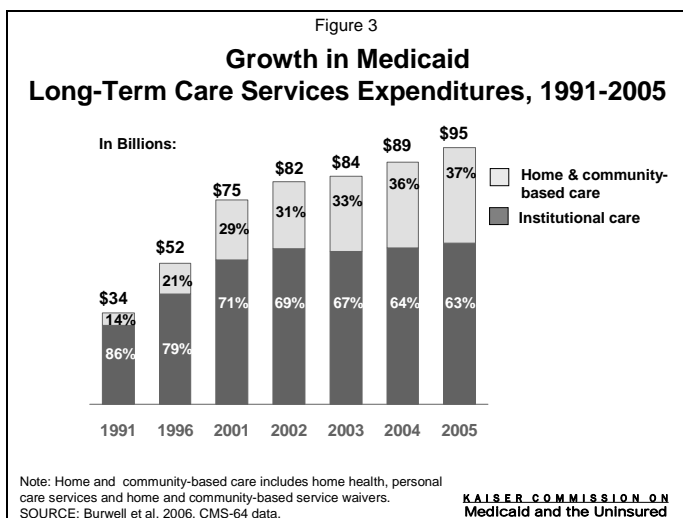
rather than spending down to Medicaid eligibility. Medicaid coverage is excluded for individuals with home equity in excess of \$500,000 (or up to \$750,000 at state option).

Nursing home residents who qualify for Medicaid must apply all their monthly income towards 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 community-based participants.

Almost half (48%) 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 population who have incomes above SSI eligibility. Many individuals who qualify as “optional” beneficiaries are poor and have extensive health and long-term care needs especially the elderly and people with disabilities.

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 services has been growing. In 2005, spending on home and community-based care accounted for 37% (\$35.2 billion) of total Medicaid long-term care services spending up from 14% in 1991 (Figure 3).



Spending on long-term care services varies greatly across states – long-term care services account for more than 50% of Medicaid spending in only 2 states, and less than 30% in 13 states. States also vary in the extent to which they cover community-based long-term care ranging from 13% of total Medicaid long-term care services expenditures in the District of Columbia to 71% in Oregon.

Current Issues in Medicaid Long-Term Care Services

Medicaid is the single largest source of financing for long-term care services, but as states face constant pressure to balance budgets, policymakers seek strategies to reduce Medicaid long-term care spending growth, which accounts for more than a third of Medicaid spending.

In February 2006, Congress passed the Deficit Reduction Act of 2005 (DRA) which made several major changes to Medicaid long-term care services. The DRA is expected to reduce Medicaid spending by \$11.5 billion over the next five years, but includes both spending increases and reductions to Medicaid long-term care services. Key changes to long-term care services include:

- **Asset Transfers:** Limits Medicaid eligibility by lengthening the look back period for asset transfers from 3 to 5 years and excludes coverage for individuals with home equity exceeding more than \$500,000 (or up to \$750,000 at state option).
- **Long-Term Care Partnerships:** Lifts moratorium on states expanding new partnership programs to increase the role of private LTC insurance.
- **Family Opportunity Act:** Creates a new option for families with disabled children with income up to 300% of poverty to “buy-in” to the Medicaid program.
- **Money Follows the Person Demonstration:** Gives states enhanced matching funds to transition beneficiaries from institutional to community-based settings.
- **State Option to Provide HCBS:** Creates a new option to provide all HCBS waiver services without a waiver for seniors and people with disabilities up to 150% of poverty. The provision allows states to cap enrollment, maintain waiting lists, and provide services that are not statewide. It also requires states to establish more stringent eligibility criteria for institutional services.
- **Cash and Counseling Option:** Allows consumer-directed personal assistance services without a waiver.

The impact of the DRA changes on access to long-term care services in Medicaid should be assessed. Few low-income Americans have the resources or the insurance to protect themselves from the high cost of long-term care, and the need for long-term services is projected to increase due to the growth in the disabled and aging populations. Developing a broader based system of financing long-term care would help to alleviate pressure on the Medicaid program.

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