

Medicaid and long-term care

The Medicaid program is the nation's major source of public financing for long-term care, which many people with disabilities need to function daily. Fiscal pressures threaten Medicaid's ability to finance long-term care services, however. The federal and state governments jointly finance the Medicaid program. States have limited budgets and most have balanced budget requirements that create pressure to contain Medicaid spending, which accounts for approximately 18 percent of state spending.¹ In fiscal year 2007, ten states plan to constrain Medicaid long-term care service costs. At the same time, however, 38 states will expand Medicaid-financed long-term care services, primarily home and community-based services, in response to the needs of the population and the growing demand for community-based care options.²

What Is Medicaid's Role in Financing Long-Term Care?

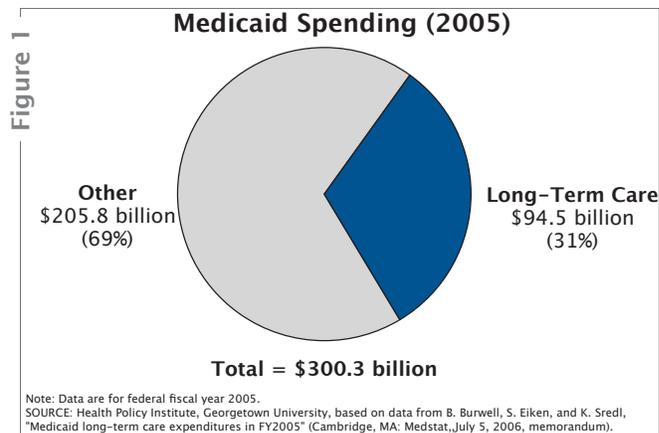
The Medicaid program accounts for 49 percent of the \$194 billion spent in 2004 for long-term care in the United States.³ Between fiscal years 1995 and 2005, Medicaid spending for long-term care increased substantially, after adjusting for inflation, from \$63.4 billion (in 2005 dollars) to \$94.5 billion.⁴ Long-term care services account for almost one-third—31 percent—of Medicaid spending (see Figure 1).

The majority of Medicaid long-term care spending is for care in institutions such as nursing homes. The proportion of Medicaid spending for noninstitutional or home and community-based care, however, has nearly doubled over the last decade, from 19 percent in fiscal year 1995 to 37 percent in fiscal year 2005 (see Figure 2). This spending is expected to continue growing as states respond to consumers' requests for this type of service.

How Do Medicaid Benefits Vary Across States?

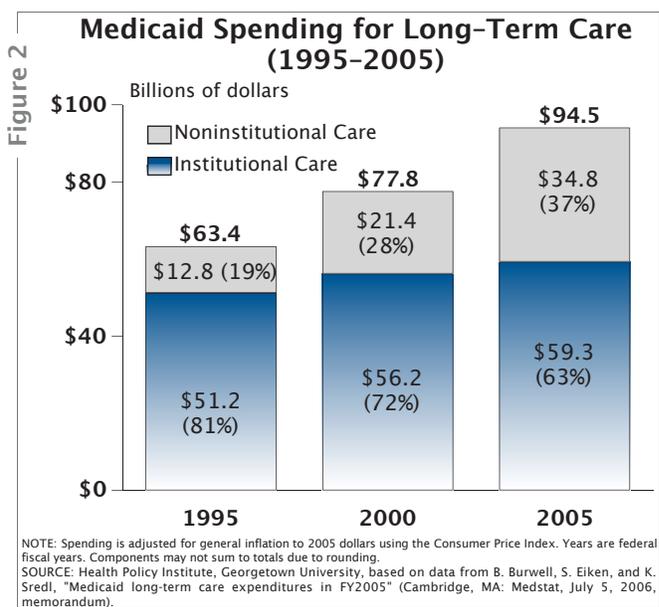
States have such flexibility in designing Medicaid long-term care programs that Medicaid really is not one program but more than 50 programs. The factor that has the most impact on the availability of services is the choices states make regarding the level of resources they are able and willing to devote to long-term care. Per capita spending for Medicaid long-term care in 2004 ranged from \$833 in New York to about \$100 in Utah and Nevada, for example.⁵

One indicator of these choices is variation in program eligibility rules. At a minimum, states must set income eligibility limits for long-term care services at a level



equal to the benefit level for the Supplemental Security Income program (\$603 per month for an individual in 2006), but states may set income limits up to three times as high (\$1,809 per month). The optional Medicaid "medically needy" programs allow individuals to deduct medical expenses from income to qualify for coverage, but 15 states did not use this option in 2003.⁶ Limits on the amount of assets or resources individuals may own also differ, and each state has developed different criteria to determine whether applicants meet functional eligibility requirements. As a result of these differences, the same person might qualify for Medicaid assistance in one state, but not in another.

Individuals who do qualify for Medicaid are not entitled to the same types of services in every state. For example, the proportion of Medicaid long-term care spending devoted to home and community-based care ranges from 70.1 percent in Oregon to 12.7 percent in Mississippi.⁷ Thus, residents of some states are much more likely than residents of other states to have the option of receiving long-term care services at home or in a community setting rather than in an institution.



How Does Medicaid Provide Home and Community-Based Care?

Medicaid pays for some home health services, a mandatory benefit, which must be ordered by a physician based on medical necessity. States may also choose to cover personal care services that people with disabilities need to perform basic tasks. The largest share of Medicaid spending for home and community-based care—65 percent in fiscal year 2005—is for home and community-based waiver programs, also known as 1915(c) waivers.⁸ Waiver programs allow states to deliver care in the community to individuals who otherwise could receive care in institutions. Waivers also allow states to control expenditures for noninstitutional long-term care. States may target the waivers to different groups of people and may set limits on the number of people who can receive services. They are also free to determine what services will be covered, the settings where services will be provided, and the geographic areas where they will be provided. People with mental retardation or developmental disabilities accounted for 39 percent of participants but 73 percent of waiver program expenditures in 2002 (see Figure 3).⁹ Other groups have also been targeted for waiver services, such as people with AIDS (acquired immune deficiency syndrome) or AIDS-related conditions and people with traumatic brain or head injuries. They account for a very small proportion of participants and spending.

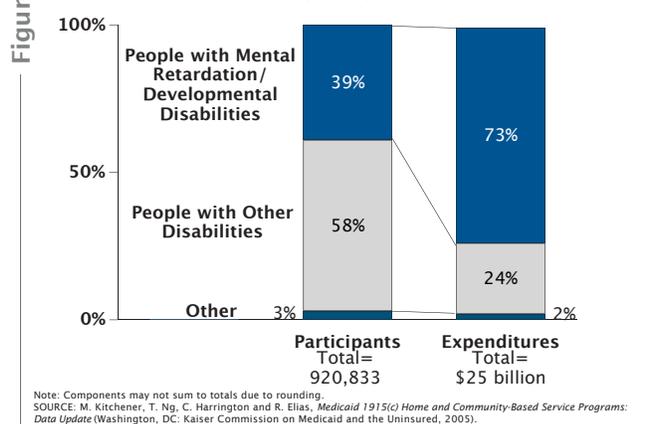
The Deficit Reduction Act of 2005 (DRA) gives states even more flexibility to provide some community-based long-term care services for some beneficiaries through Medicaid state plans. The state plan option differs from waivers in that states can extend benefits even to certain beneficiaries who do not meet the criteria for an institutional level of care. Another important difference is that the requirement for budget neutrality between institutional and home and community-based services does not apply to state plan services as it does under waivers. And, for the first time, states are permitted to cap enrollment and maintain waiting lists for a state plan service. The DRA also permits self-direction of personal assistance services without a waiver.

Options for the delivery of community-based care also are increasing. In 2004, 41 state Medicaid programs paid for services in assisted living facilities for just over 121,000 residents, compared with four years earlier when 29 states were providing these services for about half as many people.¹⁰ The option of paying family or friends to provide personal care services has become more widespread. States continue to test approaches to self-directed care, which may allow individuals to plan their care, to purchase or monitor the services they need, to hire and supervise their caregivers, or to develop their care plans.

How Will the DRA Affect Medicaid's Home and Community-Based Care?

Although new options are available, states are waiting for guidance before committing to major changes in the delivery of community-based care. Some are

Figure 3
Proportions of Home and Community-Based Waiver Participants and Expenditures, by Type of Participant (2002)



hesitant because the state plan option applies only to beneficiaries with incomes that do not exceed 150 percent of the federal poverty level.

A policy of interest is that under the state plan option less stringent eligibility criteria for community services than for institutional services will be required. At issue is whether states will use this as an opportunity to tighten eligibility requirements for institutional care.

In addition, provisions in the law for states to maintain waiting lists and to adjust eligibility criteria if actual enrollment exceeds projections raise questions about the extent to which access to community-based long-term care services may be limited.

Finally, the flexibility afforded by an option for self-direction of services is attractive, but it will be important to monitor the adequacy of budgets for individuals under this option.

Notes

1. V. Smith et al., *Low Medicaid Spending Growth Amid Rebounding State Revenues, Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2006).
2. *Ibid.*
3. H. Komisar and L. Thompson, *National Spending for Long-Term Care* (Washington, DC: Georgetown University Long-Term Care Financing Project, January 2007, fact sheet).
4. B. Burwell, K. Sredl, and S. Eiken, "Medicaid Long-Term Care Expenditures in FY 2005" (Cambridge, MA: Medstat, July 5, 2006, memorandum).
5. E. O'Brien, *Long-Term Care: Understanding Medicaid's Role for the Elderly and Disabled* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2005).
6. J. Crowley, *Medically Needy Programs: An Important Source of Medicaid Coverage* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).
7. Burwell, Sredl, and Eiken, "Medicaid Long-Term Care Expenditures in FY 2005."
8. *Ibid.*
9. M. Kitchener, T. Ng, C. Harrington, and R. Elias, *Medicaid 1915(c) Home and Community-Based Service Programs: Data Update* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2005).
10. R. Mollica, *State Assisted Living Policy, 2004* (Portland, ME: National Academy for State Health Policy, 2005).

