# Background Information for a Presentation On Medicaid and Long-Term Care

by

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to

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*The views expressed herein are the author's; they are not the views of RTI International.*

# Who Needs Long-Term Care?

- Children
- Adolescents
- Working Age Adults
- Retired Adults

# Why Do They Need It?

Functional limitations – typically measured by ability to perform

- Activities of Daily Living (bathing, dressing, eating, toileting, transferring)

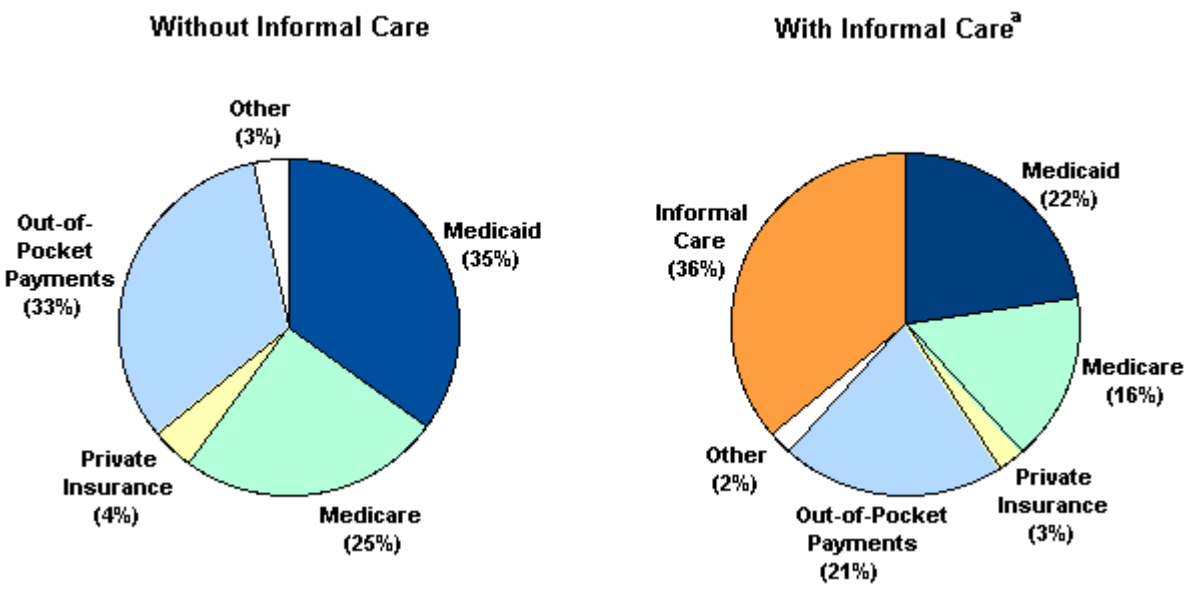
- Instrumental Activities of Daily Living (meal preparation, managing medications, housekeeping/laundry, shopping, using the phone, managing money, using transportation)

# What Causes Functional Limitations?

- Physical impairments (paralysis)
- Mental impairments (cognitive impairment / dementia)
- Chronic illness that impairs functioning (COPD)

* All increase with age
* Not all impairments cause functional limitations
* Not all functional limitations cause disability

# Who Provides and Pays for Long-Term Care?




Source: Congressional Budget Office.

a. Values are calculated on the basis of how much such care would cost if it were provided through formal means. Estimates are from Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Administration on Aging, *Informal Caregiving: Compassion in Action* (June 1998), inflated to 2004 dollars.

# Medicaid Coverage of Long-term Care

**Mandatory Services**: Nursing homes and home health

**Optional Services**: Home and Community Services
(Under State Plan or Waiver)

- Historical institutional bias

- Policy shift to rebalance LTC system to offer more choices and more home and community service options.

- Olmstead decision

# Home and Community Services

- Personal care services
- Homemaker/chore services
- Adult day health services
- Case management
- Services provided in residential care settings
- Psychosocial rehabilitation

# Recent Innovations Aimed at Rebalancing the System

- Consumer Direction
- Cash and Counseling
- Money Follows the Person
- Aging & Disability Resource Centers
- Integration of financing for acute and long term care
- Case management to coordinate primary health care and long-term care
- Deficit Reduction Act 2006: Ability to offer “waiver” home and community services through a state plan amendment.

# Waivers

In 1981, Congress authorized the waiver of certain federal requirements to enable states to cover home and community services (except room and board) to people who would otherwise need institutional care.

## Major Requirements waived:

- Services must be offered statewide
- All eligible persons must receive comparable services

Congress also authorized states to offer a wide range of services in waiver programs not covered under the Medicaid State Plan, in order to prevent institutionalization.

## Deficit Reduction Act

DRA intended to eliminate the need for a waiver to provide the wide range of home and community services generally covered under the waiver, BUT DRA does not waive the federal requirement for comparability.

## Issues

- States are allowed to establish targeting eligibility criteria but the comparability requirement is generally interpreted as requiring the coverage of all services for all Medicaid beneficiary groups.

- States may want to narrowly target services but the comparability requirement may not permit them to do so.

## Issues (cont.)

- To use different eligibility criteria for different disability groups (e.g., persons with mental retardation, AIDS, traumatic brain injury, physical disabilities) states need a waiver of comparability.

- If states are not able to target services as they can through waiver programs, they may not make use of this new option. They may wait to see how CMS regulations address the comparability/targeting issue before deciding whether to offer the new optional benefit.

## Issues (cont.)

- States may find it very difficult to design eligibility criteria for a universal home and community services benefit for beneficiary groups with very different needs.

- If a state offers the new benefit and then tightens up its nursing home level-of-care criteria, it will also tighten up its waiver criteria. But if the state caps the new benefit, the outcome may be a reduction in the entitlement to both nursing home and waiver services for many people who would formerly have been eligible.

- It is possible to use a research and demonstration waiver to use different eligibility criteria for nursing home and waiver services.

# Reforming a Crucial Safety Net Program

Medicaid provides long-term care services to persons with disabilities of all ages who do not have the resources to pay for the care they need.

The program needs to be reconfigured to better meet the needs of the people it serves, and to ensure the long-term financial sustainability of the program.

Reform is difficult because

- The program is extremely complex
- Need to understand the world in which Medicaid operates
- Cannot ignore problems with the Supplemental Security Income (SSI) program for disabled Medicaid beneficiaries.

## Supplemental Security Income (SSI) Program for Disabled Persons

- Medicaid does not pay for housing.

- Not possible to deal with home and community service issues without dealing with housing. Some people are in nursing homes and residential care settings because they can't afford housing.

- In 2000, people with disabilities receiving SSI benefits needed to pay – on a national average – 98 percent of their SSI benefits to rent a modest one-bedroom unit at Fair Market Rent (based on HUD data.)

# Example: Providing Medicaid Services in Residential Care Facilities

**Goal:** Some States want to provide nursing facility residents the option to move to Medicaid-covered assisted living, thereby increasing consumer satisfaction and possibly saving the state money.

**Issues to Consider:**

- Do state's licensing rules for assisted living allow facilities to serve individuals who meet nursing home level of care criteria?

- If a state uses the higher income eligibility standard (e.g., 300 percent of SSI special income rule) for nursing homes but not for the waiver program, then nursing home residents who want to transfer to the community may not be financially eligible for waiver services.

## Issues to Consider (cont.)

- States may choose to provide higher spousal income and asset protection rules for nursing home residents than they have for waiver beneficiaries, creating a disincentive to be served outside the nursing home.

- For SSI beneficiaries, should the state limit room and board payments to the SSI monthly benefit? If they do, will facilities accept this amount to provide room and board? ($603 for an individual /$904 for a couple)

- How will nursing home residents eligible for Medicaid under medically needy provisions afford room and board if their state required spend down obligation in the community exceeds the cost of room and board?

## Issues to Consider (cont.)

- Should the state provide a supplement to the SSI payment for persons living in residential care settings, and limit the amount that can be charged to the SSI + state supplement payment?

- Should the state set the Medicaid personal maintenance allowance high enough to pay for room and board? Persons eligible for the waiver under the 300 percent of SSI income eligibility rule may have incomes up to $1,809 per month. However, not all of this income is available to pay for room and board because waiver clients may be required to contribute toward the cost of services. (Unless the state chooses to disregard a certain amount of income that the waiver beneficiary can use to pay for room and board.)

- Should the state allow family supplementation to increase the funds available for room and board, particularly to pay the difference in cost between a shared and a private room?

# Options for Simplifying Medicaid and Increasing Flexibility in Medicaid and SSI to Meet the 21st Century's Long-Term Care Needs

- Eliminate all provisions tying Medicaid policy to welfare programs, e.g., eliminate federally imposed ceiling on medically needy income levels (currently 133 $^{1/3}$ percent of the highest amount paid to an AFDC family of the same size)

- Eliminate the medically needy provisions that require people on SSDI and those moving from SSI to SSDI to impoverish themselves to the point where they cannot afford to live in the community.

  Instead, require states to use 100 percent of the federal poverty level (FPL) as the Medicaid income threshold for people with disabilities, and permit states to use income disregards and buy-ins to enable those with incomes over 100 percent of poverty to meet financial eligibility criteria. (SSI level is approximately 75 percent of FPL; average SSDI payment is below the FPL.)

## **Options** (cont.)

- Eliminate 1/3 reduction in SSI benefits for people who live with a friends or family members to remove financial disincentive to informal caregiving.

## Connection Between Lack of Health Care and Medicaid Eligibility

Not all people with LTC needs will meet Medicaid's financial eligibility criteria, BUT they will eventually if they are depleting assets and spending down to Medicaid income levels on both medical and LTC costs.

Options to address this:

- Eliminate the 24 month waiting period for Medicare for SSDI beneficiaries.
- Allow SSDI beneficiaries to buy-in to Medicaid for 24 months.
- Eliminate categorical eligibility requirements for Medicaid and allow actuarially based buy-in for people who can't get or can't afford private insurance.

# Points to Consider When Undertaking Reform

- Recognize that present law and policy is incoherent. Present policy is the product of 30+ years of incremental changes to federal law that is based on serving people in institutions.

- A coherent policy for the 21st Century must start with the proposition that people with LTC needs should be supported in their homes and communities and institutional services are a last resort.

- In order for a community-first strategy to succeed, eligibility for LTC must be restructured and simplified.

- Recognize that a community-first strategy must be built on ensuring that people have sufficient income to meet their everyday living expenses. LTC cannot be reformed absent rethinking the interconnections with SSI/SSDI. Medicaid LTC will remain tethered to facility-based services so long as beneficiaries lack the resources to meet everyday living expenses in the community.

- Recognize that some beneficiaries with LTC needs have extensive medical needs and services for both need to be coordinated.
- The Deficit Reduction Act HCBS benefit is possibly a starting point. However, the research and demonstration waivers advanced by Kentucky and Vermont suggest a more coherent framework that avoid some of the defects of the DRA benefit.