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Hearing on the Current System for Providing Long-Term Services and Supports
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Introduction

Chairman Chernof, Vice-Chairman Warshawsky, and Members of the Commission, my name is Kirsten J. Colello, and I am a Specialist in Health and Aging Policy at the Congressional Research Service (CRS). Thank you for the opportunity to appear before the Commission today. As requested by the Commission, my testimony will provide an overview of public financing for long-term care and eligibility for public programs.[1] First I will provide information on who pays, including how much is spent by public and private payers as well as how much is spent by payers across settings. Next, I will focus on those public programs that provide financing for care, eligibility for these programs, and the types of services that are covered.

Throughout my discussion of this topic, I will use the term "long-term services and supports (LTSS)" rather than "long-term care (LTC)." LTSS is a term that is more commonly used by researchers and policymakers to better describe the types of assistance that are provided to persons with disability and the frail elderly.[2] However, at times I may refer to long-term care, as these terms can be used interchangeably.

It is also important to note that the range and variation in settings and services that may be considered LTSS create significant challenges for researchers and policymakers in establishing a common definition for the purpose of evaluating expenditures and determining policy. For example, some argue that Medicare expenditures for skilled nursing facilities and home health services are post-acute services of limited duration and scope, and should not be categorized as LTSS. Others argue that Medicare is an important payer in the continuum of LTSS, since many nursing facility residents start with Medicare paying for the cost of the service; but after the Medicare coverage period ends, Medicaid may pay for these expenditures.

My testimony includes Medicare freestanding and hospital-based skilled nursing facility and home health expenditures as part of LTSS. It does not discuss indirect long-term care benefits through federal and/or

[1] My written testimony is largely excerpted from the following: CRS Report R42345, *Long-Term Services and Supports: Overview and Financing*, April 4, 2013 and CRS Memorandum, *Financial Requirements for Determining Eligibility for Medicaid Long-Term Services and Supports,* Kirsten J. Colello, May 15, 2013.

[2] The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), uses the term LTSS and defines the term to include certain institutionally-based and non-institutionally-based long-term services and supports [Section. 10202(f)(1)].

state tax deductions for LTSS expenditures. Furthermore, it does not address the economic value of informal caregiving.[3]

Financing for Long-Term Services and Supports

Total U.S. spending on formal LTSS is a significant component of all personal health care spending.[4] In 2011, an estimated $317.1 billion was spent on LTSS; representing 13.9% of the $2.3 trillion spent on personal health expenditures in the U.S.[5] There is disagreement among policy analysts as to whether LTSS spending should include Medicare. Excluding Medicare spending on home health and skilled nursing facilities, total LTSS spending was $241.7 billion or 10.6% of U.S. personal health expenditures in 2011.

Formal LTSS are paid by a variety of public and private sources. **Figure 1** shows LTSS spending by payer for 2011. In addition to each payer source, the figure also provides total public and private funding amounts. Public sources accounted for the majority (72.8%) of LTSS spending. These sources include Medicaid, Medicare, and other public programs. The remaining 27.2% was paid by private sources including private health and long-term care insurance policies, out-of-pocket expenditures, and other private sources. For 2011, Medicaid (combined federal and state spending) was the single largest payer at $133.5 billion, or 42.1%, of LTSS spending. Medicare represented the next largest share of spending at $75.4 billion, or 23.8%, of all LTSS expenditures in 2011. Other public sources of funding, such as the Veterans Health Administration (VHA) and the State Children's Health Insurance Program (CHIP), and other state and local financing for LTSS paid $22.1 billion, or 7.0%, of the total.

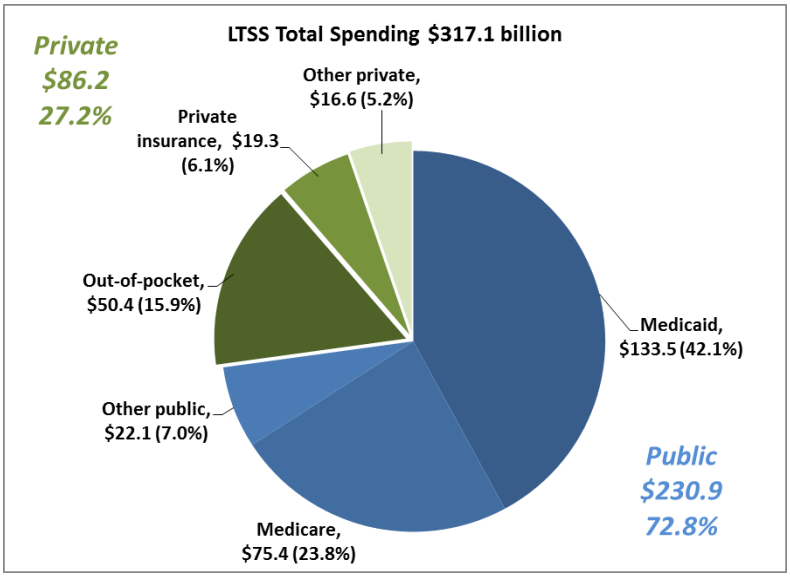
[3] For information on the economic value and costs of caregiving, see CRS Report RL34123, *Family Caregiving to the Older Population: Background, Federal Programs, and Issues for Congress*, by Kirsten J. Colello.

[4] LTSS expenditure data are from the National Health Expenditure Accounts (NHEA) published annually by the U.S. Department of Health and Human Services (HHS). NHEA data represent aggregate health care spending. Data reported are for 2011 and are for personal health expenditures, which is a subcategory of national health expenditures, and exclude the following expenditure categories: government administration, net cost of health insurance, government public health activities, and investment. LTSS personal care expenditures by payer and setting for 2011 were obtained through personal communication with the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

[5] Based on CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

Figure 1. Long-Term Services and Supports (LTSS) Spending, by Payer, 2011

(in billions)



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

LTSS spending is distributed between three types of settings—nursing care facilities; home care; and other residential facilities for persons with intellectual and developmental disabilities, mental health conditions, and substance abuse issues. **Table 1** shows LTSS spending in 2011 for each of these settings by payer. For 2011, about half of LTSS spending (49.3%) was for care provided in nursing facilities, totaling $156.5 billion, while more than one-third of LTSS (36.7%) was for LTSS in the home and 13.9% was for LTSS in residential facilities. Across all settings, public payers were the predominant source of LTSS spending. Public spending accounted for a substantial share of home care (90.0%) but less so among residential and nursing facilities (62.9% and 62.8%, respectively). Looking at aggregate LTSS spending in all three settings, Medicaid was the predominant public source of payment, while private payments represent a smaller share of LTSS spending within each setting.

Table 1. Long-Term Services and Supports (LTSS) Spending Among Payers, by Setting, 2011

(in billions)

	Nursing Facilities		Home Care		Residential Facilities	
Public Payers	**$98.3**	**62.8%**	**$104.8**	**90.0%**	**$27.8**	**62.9%**
Medicaid	50.4	32.2	67.6	58.0	15.4	34.9
Medicare[a]	40.4	25.8	35.0	30.0	—	—
Other Public[b]	7.4	4.7	2.3	2.0	12.4	28.0
Private Payers	**$58.2**	**37.2%**	**$11.6**	**10.0%**	**$16.4**	**37.1%**
Out-of-Pocket	39.9	25.5	5.6	4.8	4.9	11.1
Private Insurance	12.4	7.9	5.1	4.4	1.7	3.9
Other Private[c]	5.9	3.8	0.9	0.8	9.7	22.0
Total	**$156.5**	**100.0%**	**$116.5**	**100.0%**	**$44.2**	**100.0%**
Total as % of LTSS Spending	**49.3%**		**36.7%**		**13.9%**	

Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

Notes: Amounts may not sum to total due to rounding.

a. Medicare expenditures include estimated shares of Medicare Advantage (Medicare Part C) capitated payments attributable to skilled nursing facility care, home health care, and hospice care provided by home health agencies.

b. Includes LTSS expenditures from the Veterans Health Administration, the State Children's Health Insurance Program, state and local programs, general assistance programs (e.g., State Pharmaceutical Assistance Programs), and Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities.

c. Includes philanthropic support from individuals and charitable organizations.

Public Sources of Financing for Long-Term Services and Supports

As previously indicated, public sources account for the majority of LTSS spending. Medicaid and Medicare are the first and second largest public payers, respectively, and accounted for nearly two-thirds (65.9%) of all LTSS spending nationwide in 2011 (see **Figure 1**). Other public programs that finance LTSS for specific populations provide a much smaller share of total LTSS funding (7.0%). These public sources of funding include LTSS funding through the VHA and CHIP, among others.[6] It is important to note that the eligibility requirements and benefits provided by these public programs vary widely.[7] Moreover, among the various public sources of LTSS financing, none is designed to cover the full range of services and supports that may be desired by individuals with long-term care needs.

The following describes these public LTSS payers—Medicare, Medicaid, and other public sources. The majority of my testimony is focused on the Medicaid program, and specifically Medicaid eligibility, as it is the largest public payer that specifically covers LTSS. Additionally, the rules for determining Medicaid financial eligibility for persons who need LTSS under the Medicaid program are complex.

My discussion of these programs does not specifically address "dual-eligible beneficiaries," who are individuals eligible to receive benefits from both the Medicare and Medicaid programs at the same time. According to CBO, in 2009, the federal and state governments spent more than $250 billion on health care benefits for the 9 million low-income elderly or disabled people who are jointly enrolled in Medicare and Medicaid.[8]

[6] Data from the National Health Expenditure Accounts (NHEA) do not include federal discretionary funding for LTSS provided under the Older Americans Act (OAA) or Title XX of the Social Security Act (SSA), the Social Services Block Grant Program (SSBG). OAA nutrition services programs, such as congregate and home-delivered meals (also referred to as "Meals on Wheels,") are excluded from the NHEA because these programs are viewed as nutrition programs rather than health service programs. For information on these programs see CRS Report RL33880, *Funding for the Older Americans Act and Other Aging Services Programs*, by Angela Napili and Kirsten J. Colello and CRS Report 94-953, *Social Services Block Grant: Background and Funding*, by Karen E. Lynch.

[7] For further information about these programs, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz; CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga; CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview*, by Elicia J. Herz and Evelyne P. Baumrucker, CRS Report R41944, *Veterans' Medical Care: FY2012 Appropriations*, by Sidath Viranga Panangala.

[8] CBO, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies*, June 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308_DualEligibles.pdf

Medicare

Medicare is a federal program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act to provide health insurance to individuals 65 and older, and has been expanded over the years to include permanently disabled individuals under 65.

Medicare consists of four distinct parts:

- Part A (Hospital Insurance, or HI) covers inpatient hospital services, skilled nursing care, hospice care, and some home health services. The HI trust fund is mainly funded by a dedicated payroll tax of 2.9% of earnings, shared equally between employers and workers.
- Part B (Supplementary Medical Insurance, or SMI) covers physician services, outpatient services, and some home health and preventive services. The SMI trust fund is funded through beneficiary premiums (set at 25% of estimated program costs for the aged) and general revenues (the remaining amount, approximately 75%).
- Part C (Medicare Advantage, or MA) is a private plan option for beneficiaries that covers all Parts A and B services, except hospice. Individuals choosing to enroll in Part C must also enroll in Part B. Part C is funded through the HI and SMI trust funds.
- Part D covers outpatient prescription drug benefits. Funding is included in the SMI trust fund and is financed through beneficiary premiums, general revenues, and state transfer payments.

Medicare serves approximately one in six Americans and virtually all of the population aged 65 and over. In 2013, the program will cover an estimated 52 million persons (43 million aged and 9 million disabled). The Congressional Budget Office (CBO)[9] estimates that total Medicare spending in 2013 will be about $598 billion; of this amount, close to $580 billion will be spent on benefits.

Medicare Eligibility[10]

Most persons aged 65 or older are automatically entitled to premium-free Part A because they or their spouse paid Medicare payroll taxes for at least 40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement systems. Persons under age 65 who receive cash disability benefits from Social Security or the Railroad Retirement systems for at least 24 months are also entitled to Part A. (Since there is a five-month waiting period for cash payments, the Medicare waiting period is effectively 29 months.)[11] The 24-month waiting period is waived for persons with amyotrophic lateral sclerosis (ALS, "Lou Gehrig's disease"). Individuals of any age with ESRD who receive dialysis on a regular basis or a kidney transplant are eligible for Medicare. Medicare coverage for individuals with ESRD usually starts the first day of the fourth month of dialysis treatments. In addition, individuals with one or more specified lung diseases or types of cancer who lived for six months during a specified period prior to diagnosis in an area subject to a public health emergency declaration by the Environmental Protection Agency (EPA) as of June 17, 2009, are also deemed entitled to benefits under Part A and eligible to enroll in Part B.

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[9] CBO February 2013 Medicare Baseline, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43894_Medicare2.pdf.

[10] The following testimony is excerpted from CRS Report R40425, Medicare Primer, coordinated by Patricia A. Davis and Scott R. Talaga.

[11] For more information, see CRS Report RS22195, Social Security Disability Insurance (SSDI) and Medicare: The 24-Month Waiting Period for SSDI Beneficiaries Under Age 65, by Scott Szymendera.

Persons over age 65 who are not entitled to premium-free Part A may obtain coverage by paying a monthly premium ($441 in 2013) or, for persons with at least 30 quarters of covered employment, a reduced monthly premium ($243 in 2013). In addition, disabled persons who lose their cash benefits solely because of higher earnings, and subsequently lose their extended Medicare coverage, may continue their Medicare enrollment by paying a premium, subject to limitations.

Generally, enrollment in Medicare Part B is voluntary. All persons entitled to Part A (and persons over 65 not entitled to premium-free Part A) may enroll in Part B by paying a monthly premium.[12] For most Part B enrollees, the 2013 monthly premium is $104.90. Higher income enrollees pay higher premiums. While enrollment in Part B is voluntary for most individuals, in most cases, those who voluntarily enroll in Part A must also enroll in Part B. Additionally, ESRD beneficiaries and Medicare Advantage enrollees (discussed below) must also enroll in Part B.

Together, Parts A and B of Medicare comprise "original Medicare," which covers benefits on a fee-for-service (FFS) basis. Beneficiaries have another option for coverage through private plans, called the Medicare Advantage (MA or Part C) program. When beneficiaries first become eligible for Medicare, they may choose either original Medicare or they may enroll in a private MA plan.

Finally, each individual enrolled in either Part A or Part B is also entitled to obtain qualified prescription drug coverage through enrollment in a Part D prescription drug plan. Similar to Part B, enrollment in Part D is voluntary and the beneficiary pays a monthly premium. Beginning in 2011, some higher-income enrollees pay higher premiums, similar to enrollees in Part B. Generally, beneficiaries enrolled in an MA plan providing qualified prescription drug coverage (MA-PD plan) must obtain their prescription drug coverage through that plan.[13]

Medicare Coverage of LTSS

Medicare covers primarily acute care benefits; however, it also provides *some* coverage for two types of LTSS—skilled nursing facility (SNF) services and home health services. These benefits provide limited access to personal care services both in home care settings and in skilled nursing facilities for certain beneficiaries on a short-term basis.

In 2011, Medicare spent $75.4 billion on SNF and home health services combined, which was over one-fifth (23.8%) of all LTSS spending. These expenditures include Medicare Parts A and B (also referred to as "Original Medicare") and estimated Medicare Part C (Medicare Advantage) payments attributable to skilled nursing facility care and home health care.[14] Of total Medicare LTSS spending in 2011, 46.4%, or $35.0 billion, was paid to home health agencies, and 53.6%, or $40.4 billion, was paid to SNFs. **Figure 2** shows the share of home health and SNF expenditures as a proportion of all Medicare LTSS spending for selected years since 1995. The change in Medicare home health expenditures between 1995 and 2000 can be attributed to the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). BBA 97 implemented an interim

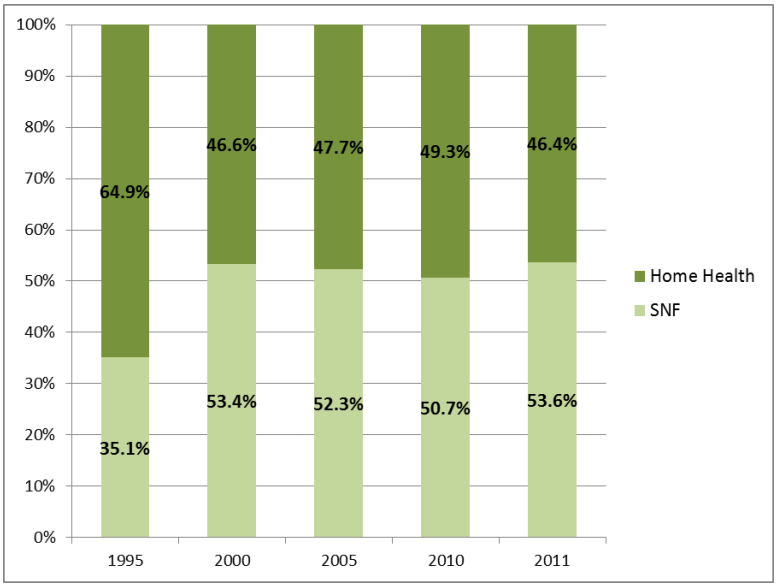
[12] See CRS Report R40082, Medicare: Part B Premiums, by Patricia A. Davis.

[13] If a Medicare beneficiary enrolls in a Private Fee-for-Service (PFFS) plan that does not provide drug coverage, he or she may enroll in a stand-alone Prescription Drug Plan (PDP). However, enrollees in other types of MA plans who want Part D prescription drug coverage must choose a Medicare Advantage Prescription Drug (MA-PD) plan, which is an MA plan that provides all Medicare required parts A, B, and D benefits. If a Medicare beneficiary enrolls in a local HMO or regional PPO that does not offer drug coverage, he or she does not have the option to enroll in a stand-alone PDP plan.

[14] In this report, "Original Medicare" home health expenditures include payments to home health agencies for hospice services.

payment system and limited the number of home health visits that could be reimbursed by Medicare, subsequently reducing Medicare expenditures on home health. Since 1995, Medicare expenditures for LTSS have grown at an average annual rate of 6.5% (from $27.4 billion). For 2011, Medicare LTSS spending increased 9.8% over the previous year ($68.7 billion in FY2010), largely driven by an increase in Medicare SNF expenditures.

Figure 2. Proportion of Medicare Long-Term Services and Supports (LTSS) Spending, by Service, 1995-2011



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

Significant confusion and debate has ensued among policymakers and stakeholders over the classification of these Medicare benefits into post-acute and/or LTSS benefit categories. This is likely due to the fact that Medicare and Medicaid both cover stays in nursing homes as well as visits by home health agencies, yet the service type and scope of coverage are generally different. Moreover, Medicare, unlike Medicaid, is not intended to be a primary funding source for LTSS. While Medicaid nursing facility and home health benefits are available to eligible beneficiaries for as long as they qualify, Medicare's skilled nursing facility and home health benefits, in general, are limited in their duration. In addition, Medicare skilled nursing facility and home health benefits include coverage of rehabilitation services that will, presumably, improve the beneficiary's physical condition or functional status.

Skilled Nursing Facility Services

The Medicare SNF benefit covers up to 100 days of post-hospital care for persons needing continuous skilled nursing or rehabilitation services on a daily basis.[15] As of 2010, the average length of stay for a Medicare beneficiary receiving SNF services was 27.1 days.[16] The SNF stay must be preceded by an inpatient hospital stay of at least three days, and the transfer to the SNF must occur within 30 days of the

[15] For more information on Medicare's coverage of skilled nursing facilities, see CRS Report R42401, *Medicare's Skilled Nursing Facility Primer: Benefit Basics and Issues*, by Scott R. Talaga.

[16] Medicare Payment Advisory Commission, *Report to the Congress*, Medicare Payment Policy, March 2012, p. 179, http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

hospital discharge. Unlike Medicaid, Medicare does not cover nursing facility care if only personal care, sometimes referred to as custodial care, is needed (e.g., when a person needs assistance with bathing, walking, or transferring from a bed to a chair). To be eligible for Medicare-covered SNF care, a physician must certify that the beneficiary needs daily skilled nursing care or other skilled rehabilitation services that are related to the hospitalization, and that these services, as a practical matter, can be provided only on an inpatient basis. Examples of skilled nursing care and rehabilitation that a beneficiary could receive are: intravenous injections; administration and replacement of catheters; administration of prescription medications; supervision of bowel and bladder training programs; therapeutic exercises; and range-of-motion exercises. There is no beneficiary cost-sharing for the first 20 days. Days 21 to 100 are subject to daily coinsurance charges ($148 in 2013).

Since 1995, Medicare expenditures for SNFs have grown at an average annual rate of 9.4%. The average annual growth in Medicare SNF spending since 1995 was higher than the overall growth in Medicare LTSS spending over the same time period. For 2011, Medicare SNF spending increased 16.1% over the previous year. This large increase is most likely attributable to the implementation of a new payment classification system and accompanying beneficiary assessment in 2011. The updated classification system is intended to achieve greater accuracy in assigning Medicare payments to actual SNF beneficiary costs than its predecessor. However, according to the HHS Office of Inspector General, unanticipated provider behavior with the new classification system and assessment resulted in a Medicare overpayment of approximately $4 billion.[17] Additionally, the rate in SNF spending in the previous year (2010) was higher than the overall growth in Medicare LTSS spending.

Home Health Services

Medicare covers 60 days of home health agency visits per episode when such services are required because an individual is confined to his or her home and needs skilled nursing care on an intermittent basis or is in need of physical or occupational therapy, or speech-language pathology services.[18] Also, a beneficiary could be eligible for additional 60-day episodes if a continued need for occupational therapy exists. Covered services include part-time or intermittent nursing care, physical therapy, occupational therapy, speech/language therapy, medical social services, home health aide services, medical supplies, and durable medical equipment. The services must be provided under a personalized plan of care established by a physician, and the plan must be reviewed and updated by the physician at least every 60 days. The average number of home heath visits for Medicare beneficiaries receiving home health services was 36 in 2010.[19] There is no beneficiary cost-sharing for home health services (though some other Part B services provided in connection with the visit, such as durable medical equipment, are subject to cost-sharing charges). Since 1995, Medicare expenditures to home health agencies have grown at an average annual rate of 4.3%. For 2011, Medicare reimbursements to home health agencies increased 3.2% over the previous year (from $33.9 billion). The average annual growth in Medicare reimbursements to home health agencies since 1995 was lower than the overall growth in Medicare LTSS spending over the same time period. Also, the rate in Medicare home health spending for the previous year (2010) was lower than the overall growth in Medicare LTSS spending.

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[17] Stuart Wright, Changes in Skilled Nursing Facilities Billing in Fiscal Year 2011, Health & Human Services Office of Inspector General, OEI-02-09-00204, Washington, DC, July 8, 2011.

[18] CRS Report R42998, *Medicare Home Health Benefit Primer: Benefit Basics and Issues*, by Scott R. Talaga.

[19] Medicare Payment Advisory Commission, *Report to the Congress*, Medicare Payment Policy, March 2012, p. 214, http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

Medicaid

Medicaid is a means-tested entitlement program which finances the delivery of health care and LTSS to certain eligible low-income individuals. Established under Title XIX of the Social Security Act (SSA), the Medicaid program is state-operated within broad federal guidelines, and is funded by both state and federal revenues.

The federal match rate for Medicaid expenditures varies from state-to-state. For FY2013, the federal medical assistance percentage (FMAP) ranges from 50% to 74%, with the federal contribution covering about 57% of the total cost of Medicaid in a typical year.[20] Due to the temporary FMAP increase provided through the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and extended through P.L. 111-226, on average the federal government paid about 64% while states paid the remaining 36% in 2011.[21] Medicaid funds are used to pay for a variety of health care services and LTSS, including inpatient and outpatient hospital care, physician services, family planning, certain screening and diagnostic services, nursing facility care, and home health care. Each state designs and administers its own program within broad federal guidelines.

As stated previously, Medicaid is the largest single payer of LTSS in the United States; in 2011, the program paid 42.1% of all LTSS expenditures at $133.5 billion. Since 1995, Medicaid LTSS expenditures have grown at an average annual rate of 6.2%. For 2011, Medicaid LTSS spending increased 1.6% over the previous year. Even though the growth rate for 2011 is slower than the average annual rate since 1995, some policymakers are still concerned with growth in LTSS spending, given that such spending is high relative to the number of people served. In 2011, Medicaid LTSS accounted for over one-third (35.6%) of all Medicaid spending (see **Table 2**) despite the fact that LTSS recipients represent a relatively small share of the total Medicaid population. The most recent data available estimated that 6.7% of Medicaid recipients (or 4.2 million beneficiaries) received LTSS in 2009.[22] In other words, 6.7% of beneficiaries account for over one-third of the costs. Out of concern over future growth and ability to better predict spending, some states are re-examining their Medicaid programs in an effort to control state spending. However, since 1995, the share of Medicaid LTSS spending relative to total Medicaid spending has remained relatively constant, as shown in **Table 2**.

Table 2. Medicaid Total and Long-Term Services and Supports (LTSS) Spending, 1995-2011

(in billions, nominal dollars)

Total U.S. (50 states and D.C.)	1995	2000	2005	2010	2011
Total Medicaid spending	$136.3	$186.9	$287.7	$371.6	$374.5

[20] See CRS Report RL32950, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2013*, by Alison Mitchell and Evelyne P. Baumrucker.

[21] Christopher J. Truffer, John D. Klemm, Christian J. Wolfe, et al., *2012 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, 2012. For FY2009 through FY2011, the federal share of Medicaid expenditures was higher than usual due to the temporary FMAP increase provided to states from October 1, 2008 through June 30, 2011. The temporary FMAP increase was originally provided through the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and extended through June 30, 2011 by P.L. 111-226.

[22] Medicaid and CHIP Payment and Access Commission (MACPAC), *Overview of Medicaid and CHIP*, January 31, 2013, pg. 67.

Total U.S. (50 states and D.C.)	1995	2000	2005	2010	2011
Medicaid LTSS spending	$51.0	$72.8	$102.5	$131.3	$133.5
Medicaid LTSS spending as a % of total Medicaid spending	37.4%	38.9%	35.6%	35.3%	35.6%

Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

Eligibility for Medicaid Long-Term Services and Supports

Historically, to qualify for Medicaid individuals must meet certain categorical and financial requirements. To qualify for Medicaid LTSS, individuals must also meet state-based functional eligibility criteria.[23] Federal Medicaid law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups). It is important to note that the federal Medicaid statute defines over 50 distinct groups that are potentially eligible for medical assistance. Such groups have their own categorical and financial requirements.[24] Thus, there is no single test of income and resources that can be applied to all individuals for determining financial eligibility for Medicaid.[25]

Generally, individuals must have assets that are equal to or below established thresholds to be considered eligible for Medicaid. While these financial eligibility rules vary by state, states must set these limits in accordance with certain federal requirements. Under federal Medicaid law, states are required to provide coverage to aged, blind, and disabled (ABD) persons receiving cash-assistance through the Supplemental Security Income (SSI) program. As a result, the Medicaid program relies on SSI program rules for

[23] State-based functional eligibility criteria generally measure an applicant's functional limitations and may include determining an individual's ability to perform certain Activities of Daily Living (ADLs) such as eating, bathing, dressing, walking or performing certain Instrumental Activities of Daily Living (IADLs) that allow an individual to live independently in the community, which include shopping, housework, meal preparation.

[24] For more information on population groups eligible for Medicaid, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

[25] The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) created a new Medicaid eligibility group for all non-elderly, non-pregnant individuals (e.g., childless adults, certain parents, certain people with disabilities) who are not otherwise eligible for Medicaid and are also not entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B. The income eligibility threshold for this new "adult" group is up to 133% of FPL based on modified adjusted gross income (MAGI), providing an effective income eligibility threshold up to 138% FPL. There are no additional asset or resource requirements for this eligibility group (i.e., no resource test will apply). On June 28, 2012, the U.S. Supreme Court issued a decision in *National Federation of Independent Business v. Sebelius*. The Court held that the federal government cannot terminate current Medicaid program federal matching funds if a state does not expand its Medicaid program, effectively making the ACA expansion for this new "adult" group optional. As a result, some states may choose not to expand their Medicaid programs. A final CMS rule regarding eligibility changes under ACA specifies how MAGI rules apply to individuals with disabilities and individuals who need LTSS. The rule enables individuals who are eligible under the new eligibility pathway, as well as other optional eligibility pathways, to choose to enroll under an optional eligibility pathway which better meets their needs. Centers for Medicare & Medicaid Services, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," 77 *Federal Register* 17194 and 17208, March 23, 2012.

determining financial eligibility for aged and disabled individuals who may also need LTSS. However, federal law gives states the option to use financial eligibility criteria that are more restrictive than SSI. States that use this alternative to SSI program rules are typically referred to as "209(b) states."[26] These SSI coverage requirements and alternative 209(b) requirements are collectively referred to as SSI-related mandatory eligibility groups. For 2013, the SSI rules specify that recipients must have monthly income at or below $710 for an individual (or $1,066 for a couple), about 75% of the federal poverty level (FPL).[27] SSI rules also limit the countable resources individuals may have to $2,000 for an individual (or $3,000 for a couple).[28]

States may also extend Medicaid coverage to other population groups, referred to as optional eligibility groups. For elderly and disabled individuals potentially eligible for Medicaid LTSS coverage through these optional eligibility groups, states may use more liberal standards for determining financial eligibility than those specified under SSI program rules. Section 1902(r)(2) of the SSA gives states flexibility to modify SSI program rules with respect to counting assets for the purposes of determining Medicaid eligibility. Most states use these Medicaid statutory provisions to ignore or disregard certain types of income and/or resources, thereby extending Medicaid to ABD individuals with assets too high to otherwise qualify for coverage. For example, states may extend Medicaid coverage to individuals who have income up to three times the basic SSI payment level (referred to as the 300% rule) and reside in a nursing facility or other institution.

In general, an individual with LTSS needs can meet financial requirements for Medicaid eligibility in one of three ways. First, individuals may have assets equal to or below the state-specified limits for their eligibility pathway and thus qualify for Medicaid by meeting the financial requirements at the time of application. Second, individuals who have assets above specified limits, but who would otherwise qualify for Medicaid absent these financial requirements may, over time, deplete these assets to specified limits by paying out-of-pocket for the cost of their care (a process known as "spending down"). Finally, those individuals who have assets above specified limits, may divest their resources for purposes other than spending out-of-pocket for the cost of their care. This third group of individuals are of particular interest to policy makers because they may divest resources in an effort to protect them (e.g., preserve them for a family member), thereby meeting financial requirements for Medicaid and any applicable LTSS.

Congress has enacted several laws over the years aimed at limiting the ability of individuals to divest financial resources in order to become eligible for Medicaid LTSS. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, P.L. 97-248) was the first such legislation enacted to limit the actions of individuals who divest resources for this purpose. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93, P.L. 103-66) included several provisions to restrict access to Medicaid LTSS to only those individuals who were low-income or to those who applied their assets toward the cost of their care. The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) was the most recent action taken by Congress to amend the SSA by further limiting the ability of individuals to divest their assets for the purpose of qualifying for Medicaid LTSS.

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[26] The term "209(b)" refers to the statutory authority in the Social Security Amendments of 1972 (SSA 72, P.L. 92-603), which allows states to use more restrictive eligibility criteria than the SSI program, but no more restrictive than those criteria in effect on January 1, 1972. In these states, SSI receipt does not guarantee Medicaid eligibility. There are eleven 209(b) states: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

[27] CMS, *2013 SSI and Spousal Impoverishment Standards*.

[28] The SSI resource limit is not subject to annual increases and has not changed since 1989.

The following describes federal statute as well as selected regulations and guidance regarding these financial eligibility requirements, including rules related to spousal impoverishment, asset transfers, treatment of certain assets, post-eligibility treatment of income, and estate recovery.

General Asset Rules

Assessment of an applicant's assets for the purposes of determining Medicaid eligibility can be complicated, depending on how much and what type of assets an individual possesses. Under the Medicaid program, assets fall into one of two categories: (1) income, or (2) resources. In general, income includes *earned* income such as wages, self-employment earnings, royalties, as well as *unearned* income, which includes payments from annuities, pensions, and trusts. Resources are generally defined as cash and other liquid assets or personal property that an individual (or a spouse) owns and could convert to cash.[29] States have the flexibility to determine income and resource requirements for different Medicaid eligibility groups within broad federal guidelines. For the SSI-related mandatory eligibility groups, states rely on SSI program rules for determining financial eligibility, with options to use more restrictive requirements in 209(b) states. States have further flexibility to modify SSI program rules in determining income and resource requirements for other optional eligibility groups.

Under SSI program rules, resources may be (1) counted based on their entire value, (2) excluded for their entire value, or (3) excluded for part of their value.[30] Resources that are counted for their entire value generally include liquid assets that the individual owns and could convert to cash to be used to support his or her maintenance (e.g., money in bank accounts, stocks and bonds, mutual fund investments, and certificates of deposit). Resources excluded for their entire value include a primary residence, personal and household items (e.g., furniture, appliances, personal computers, personal jewelry, personal care items, or items of cultural or religious significance), certain property essential to income-producing activity, and the value of a burial space. Further, one automobile, regardless of value, is excluded so long as it is used for transportation of the beneficiary or a member of the beneficiary's household. Resources that are excluded for part of their value include burial funds (up to $1,500).

While a primary residence, regardless of value, is not a countable resource for the purposes of Medicaid eligibility under SSI program rules, the equity value of a home may affect whether or not an individual may receive Medicaid covered LTSS. For beneficiaries applying for Medicaid coverage for nursing facility services or home and community-based services, federal Medicaid law restricts eligibility if the applicant's equity interest in the home exceeds a statutorily determined amount ($536,000 in 2013).[31] At state option, this threshold could be higher (up to $802,000 in 2013).[32] Such thresholds do not apply to individuals who have a spouse, child under the age of 21, or a child who is blind or permanently disabled of any age residing in the home. Also, states can choose not to apply this rule if it is determined that doing so would cause an undue hardship in a given case.

[29] 20 CFR 416.1201.

[30] Section 1613 of the SSA specifies items that are excluded from resource counting rules. Federal regulation 20 CFR 416.1210 further clarifies under what conditions resources may be excluded.

[31] The equity interest in a home is the fair market value of the home (i.e., what an individual could sell the home for on the open market) minus the amount of any outstanding debts, such as a mortgage or home equity loan.

[32] Section 1917(f) of the SSA. Through 2010, federal law limited eligibility for Medicaid LTSS if the applicant's equity interest in the home was greater than $500,000. At state option, this threshold could be as high as $750,000. Starting in 2011, these thresholds increase each year based on the percentage increase in the consumer price index for all urban consumers (CPI-U), rounded to the nearest $1,000.

For purposes of qualifying for Medicaid LTSS, individuals who have home equity above the state-specified threshold could use a reverse mortgage or home equity loan to reduce their total equity interest in the home. In order for the proceeds of a reverse mortgage or home equity loan to be excluded from countable resources for the purposes of obtaining Medicaid coverage, federal guidance specifies that the Medicaid beneficiary must either spend the amount of the transaction or repay the amount to the lender in the month the amount is received.[33] Any amounts not spent or repaid in the following month are counted as resources against the state's threshold; therefore, the amount would have to be depleted before qualifying for Medicaid LTSS.

Spousal Impoverishment Protections

Adding to the complexity of determining financial eligibility for Medicaid LTSS is the treatment of the assets of a couple, when one spouse needs institutional care (the institutional spouse) and the other is able to remain in the community (the community spouse). Medicaid specifies rules for equitably allocating how much income and resources, as well as which resources, are to be credited to each spouse for the purposes of determining Medicaid LTSS eligibility. Commonly referred to as *spousal impoverishment* rules, they are intended to prevent the impoverishment of the spouse remaining in the community.[34] In general, states must establish minimum income and resource allowances within federal limits that a community spouse may hold that may not be applied toward the institutional spouse's Medicaid eligibility determination or LTSS costs.

Regarding income, federal Medicaid law exempts all of a community spouse's income in his or her name from being considered available to the other spouse. That is, for any month the institutionalized spouse is residing in an institution, income solely attributable to the community spouse is not considered available to the institutionalized spouse.[35] For community spouses with limited income, federal law allows institutionalized spouses to transfer income to the community spouse up to a state-determined minimum monthly income threshold, referred to as the minimum monthly maintenance needs allowance, that is set within federal limits. In 2013, the community spouse's minimum monthly maintenance needs allowance must be at least $1,891, but no more than $2,898.[36] Following a hearing requested by either the institutionalized or community spouse, states may raise the minimum amount on income that a community spouse may retain in cases of severe hardship. Finally, Medicaid provides for additional income allowances for excess housing costs and when dependent individuals live with the community spouse.[37]

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[33] In determining the value of home equity, states follow SSI program rules. With respect to guidance on SSI loan policy, see SSR 92-8p: Policy Interpretation Ruling Title XVI: SSI Loan Policy, Including its Applicability to Advances of Food and/or Shelter, http://www.socialsecurity.gov/OP_Home/rulings/ssi/03/SSR92-08-ssi-03.html.

[34] As per, Section 1924 of the SSA.

[35] In some cases, income that is jointly held may be attributable to the institutionalized spouse. For example, if a payment of non-trust income is made in the names of both the institutional spouse and the community spouse, half of the income is attributable to each spouse. If the income is paid from a trust, the income is considered available to each spouse depending on provisions of the trust. In the case where no provision is made on how trust income is divided and payment of income from the trust is made to each spouse, half of the income is deemed available to each spouse.

[36] CMS, *2013 SSI and Spousal Impoverishment Standards*.

[37] The minimum income threshold is increased to include an excess shelter allowance if the community spouse's cost of rent or mortgage payment, taxes, insurance, and utilities exceeds 30% of the amount of the minimum

In terms of resources, federal Medicaid law allows states to select the amount of resources a community spouse may be allowed to retain within federal limits. For 2013, this threshold must be at least $23,184 but no more than $115,920.[38] For purposes of determining the amount of resources the community spouse can retain, all resources of the couple are combined, counted, and split in half, regardless of which of the two spouses has ownership of the individual resources. If the community spouse's resources are less than the state threshold, then the Medicaid beneficiary must transfer his or her share of the resources to the community spouse until the community spouse's share reaches the threshold. All other non-exempt resources tied to the applicant must be depleted before the applicant can qualify for Medicaid. Similar to the treatment of income, no resources of the community spouse are considered available to the institutionalized spouse once the institutionalized spouse is determined to be eligible for Medicaid.

Prior to enactment of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), spousal impoverishment rules only applied in situations where the Medicaid recipient was receiving LTSS in an institutional setting, such as a nursing facility. Section 2404 of the ACA requires states to extend spousal impoverishment rules to beneficiaries receiving certain home and community-based services (HCBS).[39] Beginning in 2014, the expansion of spousal impoverishment rules will apply to individuals who: (1) receive HCBS through SSA waiver authorities such as Section 1115 Research and Demonstration waivers, Section 1915(c) HCBS waivers, and the Section 1915(d) HCBS waivers for the elderly; (2) receive services through the Section 1915(i) state plan amendment option to provide HCBS; (3) are determined "medically needy;"[40] or (4) receive personal attendant services under the Community First Choice Option under Section 1915(k).[41] This provision remains in effect for the 5-year period beginning on January 1, 2014.

Asset Transfers

For persons seeking Medicaid LTSS eligibility, federal Medicaid law requires states to apply rules regarding the transfer of assets prior to qualifying for Medicaid.[42] These rules attempt to ensure that Medicaid applicants apply their assets toward the cost of their care and do not divest them to gain Medicaid eligibility sooner than they otherwise would. Specifically, Medicaid may require states to delay Medicaid eligibility for applicants seeking institutional and certain home and community-based LTSS

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monthly maintenance needs allowance. A community spouse may retain additional income for every dependent family member who resides with the community spouse, so long as each family member's income is less than the minimum income threshold.

[38] CMS, *2013 SSI and Spousal Impoverishment Standards*.

[39] For the purposes of spousal impoverishment rules, Section 2404 of ACA redefines an "institutionalized individual" under Section 1924(h) of the SSA to include persons receiving home and community-based services (HCBS) for the five-year period beginning on Jan. 1, 2014.

[40] The medically needy include individuals eligible for medical assistance under Section 1902(a)(10)(C) of the SSA. States may offer the medically needy pathway to individuals who are aged, blind, or disabled and have high medical expenses (including LTSS expenses) who deplete their income to specified levels.

[41] Section 2301 of ACA creates a new optional Medicaid state plan benefit for personal care attendant services under Section 1915(k) of the SSA. States that choose to provide the optional service receive an additional Federal Medical Assistance Percentage (FMAP) match of six percentage points above each state's applicable FMAP.

[42] See Section 1917(c) of the SSA for requirements regarding the transfer of assets for less than fair market value.

who have disposed of certain assets for less than fair market value (FMV) on or after a "look-back" period, or period of time prior to application for services. This look-back period is five years prior to application for Medicaid.[43] In other words, transfers for less than FMV may be, but are not always, prohibited during the 5-year period prior to application for Medicaid. Federal Medicaid law also prohibits spouses of applicants from transferring assets for less than FMV during this same period.

In order to determine whether a transfer for less than FMV occurred, applicants are first asked whether they made any transfers of monetary value during the 5-year "look-back" period. If at least one transfer has occurred during this period, the state must determine whether the transfer was made for FMV. If the transfer was made for less than FMV (often referred to as an improper transfer), a penalty is imposed on the beneficiary in the form of months of ineligibility. To calculate the penalty period, the monetary value of the transfer, or portion of the transfer, that was made for less than FMV is divided by the average monthly private pay rate for nursing facility services in the state (or at state option, the rate in the community in which the individual resides). For example, an improper transfer of $20,000 divided by an average monthly private pay rate in a nursing facility of $5,000 results in a 4-month period of ineligibility for Medicaid LTSS.

The penalty period begins on the first day of the month in which assets have been transferred for less than FMV, or the date on which the individual is eligible for Medicaid and would otherwise be receiving an institutional level of care, whichever is later. Additionally, states may waive penalties for asset transfers if the applicant can demonstrate to the state that he or she either: (1) intended to transfer assets for FMV; (2) transferred assets for a purpose other than to qualify for medical assistance; or (3) recovered the assets that had been previously transferred. Also, ineligibility for Medicaid coverage is limited to certain LTSS, and individuals may still be eligible for other Medicaid health care services.[44]

Not all asset transfers during the 5-year look back period are subject to penalties.[45] For example, asset transfers for FMV, transfers to spouses of any value, and certain transfers to other individuals, such as children with disabilities are not subject to penalties. Also, a home may be excluded from asset transfer penalties if it is transferred to certain individuals, including a spouse, a child under the age of 21, a child who is blind or permanently and totally disabled, or a son or daughter who has resided in the home for at least two years immediately before the date the individual enters an institutional facility and has provided care that permitted the individual to delay institutionalization. These rules are intended to ensure that certain family members would not be without shelter or lose their homes in order for another family member to obtain Medicaid coverage.

[43] The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) lengthened the look-back period from three years to five years for all asset transfers that occurred on or after the date of enactment (February 8, 2006).

[44] The services for which the penalty applies in the form of ineligible months for institutionalized individuals include nursing facility services; services provided in any institution in which the level of care is equivalent to those provided by a nursing facility; and Sections 1915(c) and (d) HCBS waiver services. For non-institutionalized individuals, states may extend asset transfer penalties to other state LTSS available under the state plan.

[45] Exceptions are made for transfers to a third-party by the applicant's spouse for the sole benefit of the spouse or transfers to a disabled or blind child for the sole benefit of the disabled or blind child. These transfers may include the establishment of a trust, such as a special needs trust or a pooled trust, for a disabled or blind child. These exceptions allow a spouse or parent of a disabled child to retain a source of financial support for another spouse or disabled child. States may waive asset transfer penalties for persons who would suffer undue hardship as a result of the penalty, according to criteria established by the HHS Secretary.

Treatment of Certain Types of Assets

For the purposes of Medicaid asset transfer rules, all resources (and income) of an individual or couple are evaluated to determine whether the establishment, purchase, sale, or transfer of an asset has occurred for less than FMV. Generally, states follow SSI program rules concerning the treatment of most types of assets that individuals possess at the time of application to Medicaid. Although Medicaid law does not contain provisions specifying how *all* assets should be treated, it does include special rules about how states must treat *certain* types of assets, such as annuities, fees for Continuing Care Retirement Communities (CCRCs), life estates, promissory notes, loans, mortgages, and trusts. Also, the Secretary of the Department of Health and Human Services (HHS) has the authority to issue guidance to states on other categories of transactions that may be treated as transfers of assets for less than FMV.

Annuities

An annuity is a financial product that provides the investor with the right to receive fixed, periodic payments, either for life or for a specified term of years. For the purposes of determining Medicaid eligibility, federal Medicaid law describes when annuities should be treated as countable resources and when they should not.[46] In general, annuities are treated as transfers for less than FMV, and thus subject to penalties, except when the state is named as a beneficiary of the annuity for at least the amounts paid by Medicaid for certain LTSS (or as a secondary beneficiary after the community spouse, or minor or disabled child and such spouse or representative of the child does not dispose of the remainder of the annuity for less than FMV). Certain annuities may be excluded from penalties if they: (1) are irrevocable and non-assignable, actuarially sound, and provide for payments in equal amounts during the term of the annuity (with no deferral and no balloon payments); or (2) fall into certain categories specified in Section 408 of the Internal Revenue Service Code of 1986 (IRC). Annuities that are defined as individual retirement accounts under federal tax code or purchased with the proceeds of certain retirement accounts and meet certain federal tax code requirements are not considered transfers for less than FMV if purchased by or on the behalf of an individual who applied for Medicaid coverage for LTSS.

Individuals seeking Medicaid LTSS are required to submit a financial disclosure statement of any interest the individual (or community spouse, if applicable) has in an annuity or similar financial product, regardless of whether the annuity meets the criteria for exclusion from countable resources.[47] All annuities are penalized as transfers for less than FMV if the applicant fails to file the necessary disclosure documentation from the financial institution, employer, or employer association that issued the annuity.[48]

Fees for Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) or life care communities offer a range of housing and health services, including LTSS, to older individuals as their care needs change over time. Generally, CCRCs provide housing with various levels of LTSS arrangements such as independent living, assisted living, and nursing facility care. CCRCs are paid primarily with private funds, but a number also accept Medicaid payments for certain services, such as nursing facility care. Residents of CCRCs or life care communities are required to spend their resources, declared when applying for admission, on their care before they apply for Medicaid. Federal Medicaid law requires states to consider certain entrance fees for

[46] DRA amended Section 1917(c)(1)(F) and (G) of the SSA to specify when the purchase of annuities should not be treated as a disposal of assets for less than FMV.

[47] Section 1917(e) of the SSA.

[48] State Medicaid Directors Letter SMDL #06-018, Centers for Medicaid and State Operations, Department of Health and Human Services, July 27, 2006, http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD072706b.pdf.

CCRCs or life care communities as countable resources for the purposes of determining an individual's eligibility for Medicaid.[49]

Life Estates

Generally, a life estate entitles an individual to possess, use, and obtain profits from a property for as long as he or she lives, even though the actual ownership of a property has passed on to another. With respect to Medicaid asset transfer rules, a life estate is at issue when the individual who owns property transfers ownership to another individual while retaining, for the rest of his or her life (or the life of another individual), certain rights to that property.[50] A transfer for less than FMV, which is subject to an asset transfer penalty, occurs when the value of the transferred asset is greater that the value of the rights conferred by the life estate. The purchase of a life estate interest in another individual's home is considered a transfer of assets for less than FMV unless the purchaser resides in the home for at least one year after the date of purchase.[51]

Promissory Notes, Loans, and Mortgages

Funds used to purchase a promissory note, loan, or mortgage are considered a transfer of assets for less than FMV unless the repayment terms are: (1) actuarially sound; (2) provide for payments to be made in equal amounts during the term of the loan (with no deferral or balloon payments); and (3) prohibit the cancellation of the balance upon the death of the lender.[52] Should the promissory note, loan, or mortgage not satisfy the above requirements, the penalty amount is the amount of the outstanding balance due at the time the individual applies for Medicaid.

Trusts

Most trusts are considered assets available to the individual for the cost of their care, and, if transferred, could be considered assets that have been transferred for less than FMV.[53] An individual is considered to have established a trust if the individual's assets were used to form all or part of the trust and if certain persons established the trust, including the individual, the individual's spouse, or a person with legal authority to act on behalf of the individual or spouse. Medicaid law establishes rules for the treatment of assets in two types of trusts: *revocable* and *irrevocable*.

A *revocable* trust can be altered after it is established (i.e., assets may be added or new beneficiaries may be named), whereas an *irrevocable* trust cannot be altered once it is established. In the case of a *revocable* trust, the assets used to establish the trust are deemed resources available to the individual. Payments from the trust to or for the benefit of the individual must be considered income of the individual. Any other payments from the trust are considered assets disposed of by the individual and subject to asset transfer rules. In the case of an *irrevocable* trust, if there are any circumstances under which payments can be

[49] Section 1917(g) of the SSA.

[50] Section 3258.9 of the State Medicaid Manual, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

[51] The DRA amended Section 1917(c)(1)(J) of the SSA to specify the treatment of life estates for the purposes of Medicaid asset transfer rules.

[52] Section 1917(c)(1)(I) of the SSA.

[53] Section 1917(d) of the SSA. Exemptions to asset transfer rules apply to trusts that contain the assets of a disabled individual under age 65, an income-only trust that is applied to the cost of the beneficiary's Medicaid care and for which the state is the beneficiary, and pooled trusts for disabled persons.

made from the trust for the benefit of the individual, then the assets used to establish the trust and payments from the trust are considered income and resources of the individual. Any other payments from the trust are considered assets disposed of by the individual and subject to asset transfer rules. An irrevocable trust from which no portion of the trust could be considered payment to the individual shall be subject to asset transfer rules, as of the date of the trust's establishment or date on which payment occurred, whichever is later. States are required to establish procedures for waiving the application of these rules in cases of undue hardship.

Post-Eligibility Treatment of Income

Medicaid has another set of rules for the treatment of income after a person has become eligible for coverage and is either living in an institution, such as a nursing facility, or is receiving Section 1915(c) HCBS waiver services while living in the community. These rules are commonly referred to as the *post-eligibility treatment of income* rules. In general, beneficiaries qualifying through certain eligibility groups are required to apply their income exceeding specified amounts toward the cost of their care. Within federal guidelines, a beneficiary may retain a certain amount of income for personal use based on the services one receives. The amounts a beneficiary may retain vary by care setting.

For beneficiaries receiving Medicaid LTSS in an institutional facility, a monthly personal needs allowance (PNA) is permitted.[54] The PNA is an amount that is considered reasonable to cover various personal care items not included in the institution's basic charge. Beneficiaries may retain a monthly PNA from their income for clothing and other personal expenses. The beneficiary then applies the remainder of his or her income toward the cost of care. When receiving nursing facility services, Medicaid statute requires states to allow individuals to retain a minimum PNA of at least $30 per month for an institutionalized individual, though the amount can be higher and varies by state.

For beneficiaries living in the community and enrolled in Section 1915(c) HCBS waivers, a monthly maintenance needs allowance (MMNA) is permitted.[55] The MMNA is an amount that is considered reasonable to cover various living expenses in the community. Beneficiaries may retain an MMNA from their income for housing, food, and other personal expenses. The beneficiary then applies the rest of his or her income toward the cost of care. Federal regulations require states to set a maximum amount for the MMNA based on a reasonable assessment of need.[56] In 2009, the most recent year for which data are available, this amount ranged from $600 to $2,022 per month across states.[57]

Estate Recovery

Other provisions in Medicaid seek to recover Medicaid LTSS costs through estate recovery programs. Federal Medicaid law requires states to recover from beneficiary estates any amounts paid for certain LTSS and other related services upon a beneficiary's death.[58] Specifically, states must pursue the estates of those who were receiving services in a nursing facility or intermediate care facility for the developmentally disabled (ICF/DD) regardless of age, and also the estates of individuals age 55 and older

[54] Section 1902(q) of the SSA.

[55] Section 1915(c) of the SSA.

[56] 42 CFR 435.735.

[57] CRS Report R41899, *Medicaid Eligibility for Persons Age 65+ and Individuals with Disabilities: 2009 State Profiles*, by Kirsten J. Colello and Scott R. Talaga.

[58] Section 1917(b) of the SSA describes estate recovery provisions.

who received Medicaid assistance in nursing facilities, HCBS, and related hospital and prescription drug services. States also have the option to recover funds spent on other items or services covered under the Medicaid state plan for individuals ages 55 and older.

Estate recovery is limited to the amounts paid by Medicaid for services received by an individual and is limited to only those assets owned by the beneficiary at the time of recovery. As a result, estate recovery is generally applied to a beneficiary's home, if available, and certain other assets within a beneficiary's estate. For purposes of these estate recovery requirements, Medicaid statute defines an estate as all real and personal property subject to a state's probate law. Under certain circumstances, annuities are included in this definition.[59] States may expand the definition of estate to include other real or personal property and other assets to which the Medicaid beneficiary has legal title or interest at the time of death.[60] Estate recovery may only be made after the death of the individual and his or her surviving spouse, if any, and only at a time when there is neither a surviving child under age 21 nor a child, of any age, who is blind or permanently and totally disabled.

To aid in estate recovery, states are authorized to impose liens on the property of certain beneficiaries prior to or after the beneficiary's death.[61] Liens may only be imposed when the individual resides in a nursing facility, ICF/DD, or other medical institution determined by the state; after notice of and opportunity for a hearing is given; and it is determined that the individual cannot reasonably be expected to return to the home. Liens may also be placed on property when, based on a court's judgment, Medicaid payments have been improperly paid on behalf of the individual. States are prohibited from pursuing liens under certain circumstances. For example, the state cannot place a lien on an individual's home if any of the following individuals reside in the home: a surviving spouse; a child under the age of 21 or a blind or permanently disabled child of any age; or a sibling of the individual who has equity interest in the property and has resided in the home at least one year prior to the individual entering an institution. Medicaid law also requires states to dissolve any lien placed on a home if the individual is discharged from the institution and returns home.

Furthermore, federal Medicaid law provides for exemptions from estate recovery in situations when such recovery would create undue hardship. Medicaid guidance allows for state flexibility in establishing procedures for an undue hardship waiver.[62] In addition to exemptions for undue hardship, Medicaid permits states to forgo estate recovery in cases where it would not be cost-effective.[63] Federal Medicaid law also prohibits estate recovery in cases when a lien has been placed on the home when certain individuals reside in the home. Such instances include: (1) a sibling of an individual who has resided in the home at least one year prior to the individual entering an institution, and (2) an adult child who has

[59] Annuities are exempt from the definition of estate if issued by a financial institution or other business that sells annuities as part of its regular business.

[60] A person's legal title or interest includes assets conveyed to a survivor, heir, or through the assignment of joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangements.

[61] Section 1917(a) of the SSA and Section 3810.F of the State Medicaid Manual describe circumstances in which a lien may be imposed on the property of certain beneficiaries, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

[62] Section 3810.C of the State Medicaid Manual, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

[63] Section 3810.E of the State Medicaid Manual, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

resided in the home for at least two years prior to the parent's institutionalization, has resided there continuously since that time, and can establish to the state's satisfaction that the adult child provided care to the parent that delayed the need for nursing facility services. Special provisions apply to persons who become eligible for Medicaid under a more liberal asset standard used in certain states for those who purchase long-term care insurance.[64]

Coverage of Medicaid Long-Term Services and Supports

Once enrolled, Medicaid beneficiaries, in general, are entitled to those services that are either required or otherwise made available, at state's option, under the Medicaid state plan. In addition to categorical and financial requirements, individuals in need of LTSS may be required to meet level-of-care eligibility criteria that may include, but are not limited to, the need for the level of care provided in an institution, such as a nursing facility or a hospital. These level-of-care criteria are often measured by an individual's functional limitations in activities of daily living (ADLs) or instrumental activities of daily living (IADLs) and/or limitations in cognitive capacity and the need for supervision to carry out ADLs and IADLs.[65]

A variety of acute care services and LTSS are available under Medicaid. With respect to LTSS, Medicaid funds services for beneficiaries in both institutional and home and community-based settings, though the portfolio of services offered differs substantially by state. Federal law requires state Medicaid programs to cover nursing facility services for certain Medicaid beneficiaries, while states have the option to cover services for other beneficiaries and in other institutional settings (e.g., intermediate care facilities for individuals with mental retardation, ICFs/MR). States also have the option of offering home and community-based services (HCBS). This flexibility under Medicaid law has led to widespread variation in state Medicaid benefit packages offered to elderly, disabled and blind individuals. Medicaid law also offers states two broad authorities under which to offer HCBS to Medicaid beneficiaries, either as a benefit under the Medicaid state plan or through a waiver program which permits states to waive certain Medicaid requirements in the provision of these services (for more details see the section entitled "Home and Community-Based Care").

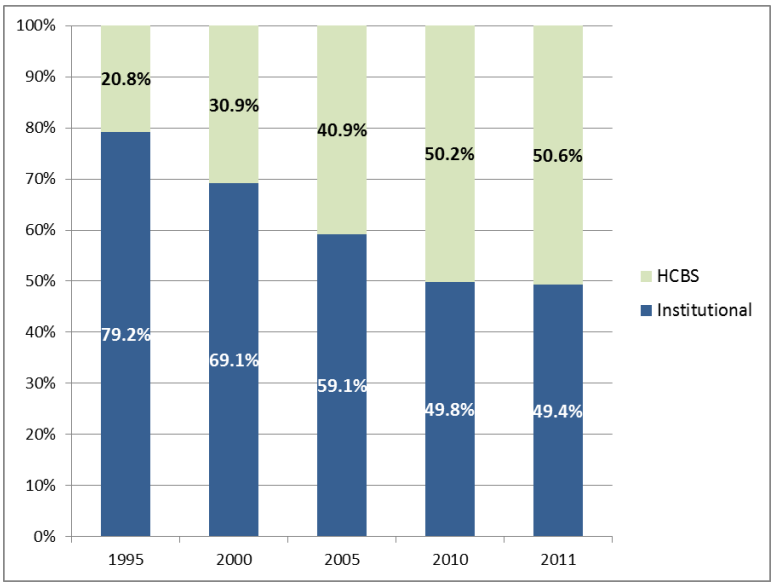
An important debate for Medicaid spending involves its perceived "institutional bias." That is, states are required to cover nursing facility services for eligible Medicaid beneficiaries, but coverage of most HCBS is optional. **Figure 3** shows the share of institutional care and home and community-based care spending

[64] DRA expanded exemptions from estate recovery for those who received benefits under the Medicaid Long-Term Care Insurance Partnership Program as per Section 1917(b)(1)(C) of the SSA. Such a private long-term care insurance policy under the Partnership program provides a predetermined amount of assets that are disregarded, for the purposes of determining Medicaid eligibility, in the event that the lifetime benefit of the insurance plan is depleted. For instance, an individual who had a dollar-for-dollar Partnership policy whose lifetime benefit is $100,000 would, upon exhausting the benefit, have $100,000 in resources exempt from Medicaid resource limits and estate recovery upon applying for Medicaid LTSS. Some Partnership policies in the original partnership states of Indiana and New York have offered policies that have total asset protection. Such policies disregard all assets of any value for the purposes of Medicaid eligibility and exempt all assets from estate recovery.

[65] Persons must also meet certain citizenship and state residence criteria. Additionally, recipients may retain an allowance depending on setting. For example, nursing home residents may retain a personal needs allowance, while residents in home and community-based settings may retain a monthly maintenance needs allowance. Beyond these allowances, Medicaid beneficiaries must apply their income toward the cost of care. For more information, see CRS Report R41899, *Medicaid Eligibility for Persons Age 65+ and Individuals with Disabilities: 2009 State Profiles*, by Kirsten J. Colello and Scott R. Talaga.

as a proportion of Medicaid LTSS spending for selected years since 1995. In 1995, more than three-quarters (79.2%) of all Medicaid LTSS spending was for institutional care. Since then, expanded federal legislative authorities and additional administrative activities have allowed states to further the provision of HCBS under Medicaid. These federal activities were, in part, prompted by the U.S. Supreme Court decision in *Olmstead v. L.C.*,[66] which held that the institutionalization of people who could be cared for in community settings was a violation of Title II of the Americans with Disabilities Act (ADA). As a result, the share of Medicaid LTSS spending for HCBS has increased steadily, from about 20.8% of Medicaid LTSS spending in 1995 to just over half (50.6%) of total Medicaid LTSS spending in 2011. As shown in **Figure 3**, Medicaid LTSS spending in 2010 marked a significant shift. In 2010 and 2011, HCBS spending was a greater proportion of Medicaid LTSS spending than institutional care spending. Therefore, over the same time period, the percentage of spending for institutional care as a proportion of Medicaid LTSS dropped steadily, to just under half.

Figure 3. Proportion of Medicaid Long-Term Services and Supports (LTSS) Spending, by Setting, 1995-2011



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

Institutional Care

Medicaid LTSS spending for institutional care covers nursing facility care and other types of institutional care. Federal Medicaid statute (Title XIX of the Social Security Act, SSA) requires states to provide nursing facility care to certain Medicaid recipients aged 21 and older. However, states may also offer nursing facility care to eligible Medicaid recipients under age 21. States may also offer other types of institutional care including services in ICFs/MR and inpatient hospital services for persons aged 65 or older in Institutions for Mental Diseases (IMDs). Since 1995, Medicaid expenditures for institutional care have grown at an average annual rate of 3.1% (from $40.3 billion). For 2011, Medicaid institutional spending increased 0.8% over the previous year. These growth rates are slower than the growth in overall Medicaid LTSS spending since 1995, on average (6.2%), and for 2010 to 2011 (1.6%). **Table 3** provides additional details about institutional care under Medicaid.

[66] 527 U.S. 581 (1999). For further information on *Olmstead v. L.C.,* see CRS Report R40106, *Olmstead v. L.C.: Judicial and Legislative Developments in the Law of Deinstitutionalization*.

Table 3. Medicaid Long-Term Services and Supports (LTSS) Institutional Care Services

Service	Benefit Type	Description
Nursing Facility	Mandatory for ages 21 and over; Optional for ages under 21	States are required to cover nursing facility services for beneficiaries ages 21 and over under a state's Medicaid plan. States have the option to cover nursing facility services for those under age 21. Beneficiaries must meet nursing home eligibility criteria, referred to as level of care criteria. Services include room and board, skilled nursing care and related services, rehabilitation, and health-related care. States may also cover therapeutic services, such as physical therapy, occupational therapy, and speech pathology and audiology services.
Intermediate Care Facilities for People with Mental Retardation (ICFs/MR)	Optional	States may provide ICF/MR services for those beneficiaries with mental retardation and developmental disabilities under a state's Medicaid Plan. Services include room and board and a wide range of specialized health and rehabilitative services to assist recipients to function at optimal levels.
Inpatient Hospital Care and Nursing Facility Care for Persons in Institutions for Mental Diseases (IMD)[a]	Optional	States may provide inpatient hospital and nursing facility services for certain beneficiaries aged 65 and over with mental diseases that are in IMDs under a state's Medicaid Plan. Services include diagnosis and medical treatment, as well as nursing care and related services under the direction of a physician.

Source: Compiled by CRS.

a. This type of service includes the provision of acute health care services, thus it is not specifically an LTSS service.

Home and Community-Based Care

Medicaid LTSS spending on home and community-based care includes home health care services, personal care services and a range of home and community-based services (HCBS) typically funded under one or more waiver programs. The majority of HCBS services and program offerings are optional for states. The exception is home health services, which is a federally required benefit under a state's Medicaid state plan. Home health must be offered to individuals entitled to nursing facility coverage and must be deemed medically necessary and authorized by a physician as part of a written care plan. States, at their option, may offer other HCBS services such as personal care, respiratory care for persons who are ventilator-dependent, and case management and/or targeted case management. Since 1995, Medicaid expenditures for home and community-based care have grown at an average annual rate of 12.3% (from $10.6 billion). For 2011, Medicaid home care spending increased 2.4% over the previous year. These growth rates are faster than the growth in overall Medicaid LTSS spending since 1995, on average (6.2%), and for 2010 to 2011 (1.6%). **Table 4** provides additional information on these home and community-based services.

Table 4. Selected Medicaid Home and Community-Based Services (HCBS)

Services	Benefit Type	Description
Home Health[a]	Mandatory for ages 21 and over; Optional for ages under 21	States are required to provide home health services to beneficiaries entitled to nursing facility care under a state's Medicaid plan.[a] Services vary by state, and may include intermittent or part-time nursing services, home health aide services, medical supplies, medical equipment, and appliances suitable for use in the home.

Services	Benefit Type	Description
Transportation to and from providers[b]	Mandatory	States are required to ensure necessary transportation to and from providers, in general. States have the option to provide such transportation as a state plan service or as an administrative expense, with either option eligible for federal Medicaid matching funds.
Case Management Services or Targeted Case Management[b]	Optional	States may provide case management services under a state's Medicaid plan or waiver program to assist beneficiaries residing in community-settings gain access to needed medical, social, educational, or other services. Services include development and implementation of a care plan and comprehensive assessment, and periodic reassessment, of needs. Targeted case management provides case management services to specific Medicaid beneficiary groups or individuals who reside in state-designated geographic areas.
Personal Care	Optional[c]	States may provide services to beneficiaries who need assistance with ADLs or IADLs under a state's Medicaid plan or waiver program. Services are furnished in a non-institutional setting, such as an individual's home. Services may include assistance with ADLs such as bathing, dressing, eating, toileting, personal hygiene, or assistance with IADLs such as light housework, laundry, meal preparation, and shopping, among others.
Respiratory Care for Persons Who Are Ventilator-Dependent[b]	Optional	States may provide respiratory care to beneficiaries who are dependent on a ventilator for life support at least six hours per day, under a state's Medicaid plan. Services include respiratory care by a respiratory therapist or a health professional trained in respiratory therapy in the recipient's home.

Source: Compiled by CRS. For more information on Medicaid HCBS see, CRS Report R41600, *Home and Community-Based Services Under Medicaid*, by Kirsten J. Colello and Scott R. Talaga.

Notes: ADLs = Activities of Daily Living; IADLs = Independent Activities of Daily Living; HCBS = Home and Community-Based Services.

a. The coverage criterion for home health services is linked to the coverage criterion for nursing facility services. The phrase "entitled to nursing facility care" means that beneficiaries must meet a state's nursing facility level-of-care criteria in order to receive the home health benefit.

b. This type of service includes the provision of acute health care services, thus it is not specifically a LTSS service.

c. States have the option to cover personal care services, including options for self-directed personal care, under several optional statutory authorities under the Social Security Act such as: (1) the personal care state plan option; (2) the self-directed personal care state plan option under Section 1915(j); and (3) the home and community-based services state plan option under Section 1915(i). States may also use waivers [HCBS waivers under Sections 1915(c), (d), and (e) and research and demonstration wavier authority under Section 1115] to offer personal care. Finally, established under the ACA, the Community First Choice Option under Section 1915(k) allows states to offer consumer-directed personal care services and receive an increased federal match rate of 6 percentage points for doing so, among other benefit requirements. CMS issued a final rule for this program on May 7, 2012, "Medicaid Program; Community First Choice Option," 77 *Federal Register* 26828-26902.

States often use waivers to extend HCBS to individuals with disabilities of all ages residing in home and community-based settings. Such waivers are referred to by their SSA statutory reference, including Sections 1915(b), (c), (d), and (e), and Section 1115 (research and demonstration waivers). These waiver authorities allow states to provide HCBS services to certain targeted populations and limit the number of individuals served. Waivers permit states to waive certain Medicaid requirements so that states can provide HCBS services to a limited geographic area (e.g., "statedwideness" requirement) and/or provide services that are not necessarily comparable in amount, duration, or scope for selected eligibility

categories (e.g., "comparability" requirement).[67] Waiver programs may include services such as: case management, personal care, homemaker/ home health aide, adult day health, habilitation, respite care, day treatment or other partial hospitalization, psychosocial rehabilitation, and clinic services for individuals with chronic mental illness. Depending on the waiver authority, states may have the flexibility to offer additional services approved by the Secretary of Health and Human Services (HHS).

States may also use state plan authority to provide HCBS to Medicaid beneficiaries with LTSS needs. For example, states may use the HCBS State Plan Option under Section 1915(i) of the SSA to provide HCBS to certain Medicaid beneficiaries who meet financial and functional needs-based criteria. The HCBS State Plan Option authorizes states to extend HCBS to certain Medicaid beneficiaries without requiring a Secretary-approved waiver for this purpose. States may also use Section 1915(j) authority, also referred to as the "Community First Choice (CFC) Option," to offer home and community-based attendant services to certain Medicaid beneficiaries under the state plan. Established under the ACA, the CFC option became available on October 1, 2011 and provides a 6% increase in federal matching payments to states for expenditures related to this option. States may also use Section 1929 authority to provide HCBS for functionally disabled Medicaid beneficiaries age 65 and over who meet certain income and resource requirements or are eligible for a state's medically needy program.

Other authorized programs that provide HCBS include the Program for All-Inclusive Care for the Elderly (PACE).[68] PACE combines Medicare and Medicaid services under one common administrative/clinical provider, often at adult day or community centers, but also includes home service referrals. Services provided under PACE include homemaker/home health aide, personal care, adult day health, habilitation, respite care, day treatment and other partial hospitalization services, psychosocial rehabilitation services, and clinical services for individuals with chronic mental illness.

Other Public Payers

Of all LTSS expenditures in the United States, only a small portion of the costs are paid for with public funds other than Medicare or Medicaid. Collectively, these payers covered 7.0% of all LTSS expenditures in 2011, totaling $22.1 billion. Over half (56.1%) of this spending was for LTSS provided in residential care facilities for individuals with intellectual and developmental disabilities, mental health conditions, and substance abuse issues, followed by spending for nursing facility and home health care (See **Table 5**). Spending in this category also includes spending for LTSS that are paid for or operated by VHA. Other public payers include other state and local LTSS programs, general assistance, and federal and state funding for nursing facilities and home health under the State Children's Health Insurance Program (CHIP).

Table 5. Long-Term Services and Supports (LTSS) Spending by Other Public Payers, 2011

(in billions)

Other Public Payers		
Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities[a]	$12.4	56.1%
Veterans Health Administration (VHA)	5.2	23.6

[67] For more information about these waiver authorities in the context of Medicaid HCBS, see CRS Report R41600, *Home and Community-Based Services Under Medicaid*, by Kirsten J. Colello and Scott R. Talaga.

[68] §1934 of the Social Security Act.

Other Public Payers		
Other State and Local Programs	3.9	17.5
General Assistance[b]	0.6	2.5
State Children's Health Insurance Program (CHIP)	0.03	0.1
Other Federal Programs[c]	0.03	0.1
Total	**$22.1**	**100.0%**

Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012.

Notes: Amounts may not sum to total due to rounding. LTSS spending by other public payers includes federal and state funding for VHA and CHIP; federal and state funding for residential care facilities for individuals with intellectual and developmental disabilities, mental health conditions, and substance abuse issues; and other state and local funding. It does not include federal funding for Medicare and state and/or federal funding for Medicaid.

a. Public funding for Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities may include state and local funding and/or federal discretionary funding from grant programs.

b. General Assistance includes two types of programs: General Assistance programs that are often modeled after Medicaid, and the State Pharmaceutical Assistance Programs that provide low-income and medically needy senior citizens and individuals with disabilities financial assistance for prescription drugs.

c. Other Federal Programs include two types of programs: Federal General Hospital and Medical expenditures which capture federal health care funds and grants budgeted to various federal agencies and Pre-existing Conditions Insurance Plans.