Medicaid Expansion: Policy Impact on Home and Community-Based Services

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ABSTRACT

U.S. longevity is placing a demand on long-term care services for the impaired and elderly. Medicaid is the primary insurance program in funding costly long-term care for the aged poor. As a major health reform law, the 2010 Patient Protection and Affordable Care Act, Public Law 111-148, gives financial incentive for states to expand Medicaid, transitioning long-term care services from costly facilities toward home and community-based care. Not all states choose to expand their Medicaid long-term care program despite the financial incentive, but instead they continue spending on nursing facility care despite the less costly option of community care. This article explores why some states have been reluctant to expand long-term care into the community. Regression analysis and 50 state-level data is used.

KEYWORDS

Elderly, Long-Term Care, Medicaid, Patient Protection and Affordable Care Act, United States

INTRODUCTION

As the senior population ages, we expect the need for long-term care to increase. The U.S. Census Bureau reports from 2000 to 2016, residents 65 years and older increased from 35 million to over 49 million or 15.2% of the total U.S. population (U.S. Census Bureau, June 22, 2017). Nearly 82.3 million seniors are expected to be living in the U.S. by 2040, over twice that in 2000 (U.S. Department of Health and Human Services, 2014, p. 3). According to the Centers for Medicare and Medicaid Services (November 2015) “with the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase” (p. 31). Medicaid long-term care service is an option for those seniors facing poverty (Schmeida & McNeal, 2018). Studies have found the Medicaid home and community-based-service (HCBS) program spends less on long-term community care than for institutionalized care (Medicaid and CHIP Payment and Access Commission, June, 2014).

The history of Medicaid funding for community-based long-term healthcare began over 30 years ago. In 2010, U.S. legislation was passed in support of Medicaid expansion to fit the needs of many poor population groups, including the fast-growing aged poor with long-term care needs. The 2010 Patient Protection and Affordable Care Act (ACA) gave the states an opportunity to expand their long-term care community-based services for those under Medicaid Title XIX of the Social Security Act of 1965 (Public Law 111–148, 2010). It builds upon the Deficit Reduction Act of 2005 (Public Law 109-171, 2005) to “rebalance state Medicaid long-term care spending” from nursing
facility care to home and community-based services, allowing the recipient to remain in a beneficial community setting, less costly to government (Mathematica, 2014, p. 2; Public Law 111-148, 2005; Schmeida & McNeal, 2018). ACA’s expansion of the Medicaid home and community-based services (HCBS) for the impaired gives states a financial incentive to change. It is an opportunity to bring beneficiaries out of isolated settings (Medicaid.gov, 2018) and provide long-term care services at cost savings. This idea of HCBS long-term care is made “doable” as financial support improves, political ideological values promote, and caregivers make it a realization (Public Law 111-148, 2010; Schmeida & McNeal, 2018). This paper explores why some states have expanded their Medicaid HCBS while others continue to limit beneficiaries to institutional care. What factors (state economic [supply and demand], political, and need/demand) explain the differences in Medicaid long-term care expansion across the 50 states? Regression analysis and probability estimates are used with 50 state-level data.

POLICY BACKGROUND

An examination of the timeline of the 1935 Social Security Act (SSA) and its amendments reveals how U.S. social policies have evolved into the modern-day health reform effort. Federal benefits for the aged did not become law until the Roosevelt Administration signing of the 1935 Social Security Act (Public Law 74-271, 1935). This Act (SSA) offered federal old age grants, helping states with provisions for “aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of unemployment compensation laws, among other. It created the “Old-Age Reserve” account, now known as Social Security under its Title II. The nursing homes received the medical payments for care, not beneficiaries. This was a venue for today’s private nursing home industry because it prohibited social security money payout directly to recipients even though they were residing in the “poor homes” that were substandard (Public Law 74-271, 1935, pp. 620-622; Kaiser Family Foundation[KFF], August 2015, p. 1). Since inception, the SSA of 1935 has grown in scope. Medicare and Medicaid programs were added in 1965 (Public Law 89-97, 1965). Unlike Medicare that covers medical care for the aged, Medicaid is the U.S. social insurance program for the poor. As a redistributive program, it manipulates the allocation of property rights, wealth, and other value among social classes (Ripley & Franklin, 1980). Medicaid is a federal-state means tested insurance program (CMS, 2014), with the federal government giving states financial assistance (cost sharing) as an incentive to subsidize care and service its residents (Public Law 111-148, 2005). As an open-ended matching program, states must provide services for mandatory “categorically needy” populations, such as the aged, blind, and disabled to receive any federal matching funds (CMS, November 16, 2015, p. 24).

The Social Security Amendments of 1965 biased Medicaid toward institutional nursing home care (Public Law 89-97, 1965; KFF, December 2015), but this bias is changing. In 1981, a SSA amendment (Section 1915c) allowed states to offer HCBS as an alternative to institution nursing care (KFF, August 2015). The state of Oregon was the first to use HCBS waivers (Kane, 2012). In 1999, the Supreme Court in Olmstead v. L.C. ruled it a violation of the Americans with Disability Act of 1990 (requiring the disabled be provided with appropriate accommodations in housing, employment and public service) not to open up HCBS to the disabled (Public Law 101-336, 1990; Kane, 2012). With time, more changes have been made to policies for the aged. Under the George W. Bush Administration, the Deficit Reduction Act of 2005 gave states federal monies to further expand HCBS (Public Law 109-171, 2005), reinforcing the option for states to offer HCBS to residents. According to the Patient Protection and Affordable Care Act of 2010 (Public Law 111–148) the HCBS can cover multiple needs associated with aging and impairment, ranging from intensive “health-related tasks” requiring hands on assistance, to “activities of daily living” for example bathing assistance, to “instrumental activities of daily living” for example assisting with groceries (p. 299). Meanwhile the institutional nursing home from the original 1965 Act remains as the original mandatory back-up. In 2010, the Patient Protection and Affordable Care Act (ACA), considered a key reform law, gave states even
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