

Chapter 41

Long-Term Care Spending Relevant to U.S. Medicaid Expansion: Medicaid Long-Term Care Spending

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ABSTRACT

The U.S. population is living longer, placing a demand on long-term care services. In the U.S., Medicaid is the primary player 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 facilities toward community care. Facing other funding obligations and recent recessions, not all states expanded their Medicaid long-term care program using the financial incentives. Some states continue to spend more dollars on traditional nursing facility care despite legislation. This chapter explores why some states spend more revenue on nursing facility long-term care despite enhanced federal funding to reform, while others are spending more on home and community-based services. Regression analysis and 50 state-level data is used.

INTRODUCTION

Longevity has increased in high-income countries (World Health Organization, 2014). In the U.S., those 65 years and older are living longer, placing a demand on long-term care services. Nearly 82.3 million seniors are expected in the U.S. by 2040, over twice that in 2000 (U.S. Dept. of Health and Human Services, 2014, p. 3). “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” (Centers for Medicare

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and Medicaid Services [CMS], November 16, 2015, p. 31). Medicaid long-term care service(s) are an option for those American seniors facing poverty, yet, need substantive care (Schmeida & McNeal, 2015).

The history of Medicaid funding for community-based long-term healthcare is over 30 years. In 2010, U.S. legislation in support of Medicaid expanded to fit the needs of many poor population groups, including the fast growing aged poor with long-term care needs. Reforming healthcare, the 2010 Patient Protection and Affordable Care Act (ACA) offers financial incentive for states to increase their Medicaid enrollment including long-term care (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, 2015). The idea of home and community-based long-term care is growing, made “doable” as financial support improves, political ideological values promote, and caregivers make it a realization (Schmeida & McNeal, 2015). In Fiscal Year 2015, Medicaid enrollment increased by 13.8% (on average) across the 50 states, and total Medicaid spending increased 13.9% on average (Kaiser Family Foundation [KFF], October 2015, p. 1).

How states in the U.S. attempt to meet their many financial obligations while addressing a demand for long-term care is becoming a delicate balancing act. There are many issues state leaders consider when providing long-term care including how to best maximize Medicaid dollars. This chapter explores why some states continue to spend more revenue on traditional nursing facility care despite federal incentives to reform, while other states are spending more on home and community-based services. Specifically, what factors (state economic [supply and demand], political, and need/ demand) explain the differences in Medicaid long-term care spending across the 50 states? This chapter answers this question using multivariate regression analysis and 50 state-level data.

POLICY BACKGROUND

A timeline of the 1935 Social Security Act (SSA) and its amendments reveals how U.S. social policies have evolved into the modern day 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 their unemployment compensation laws” and other purposes. It created the “Old-Age Reserve” account, now known as Social Security under its Title II. This was a venue for today’s private nursing home industry by prohibiting social security payout to recipients residing in substandard public poor homes (P.L. 74-271, p. 620-622; KFF, August 2015, p. 1). Since inception, the SSA of 1935 has grown in scope. Once a worker’s “retirement program” is now a family security program (CQ, 2015); nursing homes now receive the medical payments for care not beneficiaries; and Medicare and Medicaid programs were added in 1965 (Public Law 89-97). 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

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