Implications of Ageism on Medicaid Utilization

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Part I: Issues and Facts

Reflection

There is importance regarding the increase of the elderly population and the need for healthcare utilization. Ageism has always been a concern in a historical context but requires more attention in a contemporary view. Rates of older adults (with a chronic illness) 65 years of age and older are increasing at an unprecedented speed and are expected to increase by nearly 25% in the next 40 years (Healthy People, 2020). These older adults require healthcare services to achieve (at a minimum) the opportunity for successful aging outcomes. Ageism is defined as the discrimination of people based on age as well as physical and cognitive ability (Iversen, 2009). One of the most utilized social welfare policies created is Medicaid, designed as a means of providing healthcare for low-income adults (Medicaid.gov, 2020). Over *25 million* older adults fall below the poverty line triggering the need for assistance programs like Medicaid (NCOA, 2019). There is a reason to consider the negative impact of ageism on older adults' utilization of Medicaid, which can negatively impact the outcome of successful aging.

Working in the geriatric field for a short time has provided some insight into policy analysis. Understanding the systematic layout of a policy is important for considering the impact on the geriatric population. I have worked primarily with Medicaid and Medicare which has provided a unique insight regarding the pros and cons of policy utilization. Based on my experience completing physical and cognitive assessments of older adults, I have recognized the importance of assistance programs like Medicaid. Experiencing the positive outcomes of successful utilization gives an alternate perspective when negative aspects of Medicaid policy occur, resulting in an increased need for advocacy. Medicaid is designed to provide for those who are economically insecure, and as a social worker there is value in promoting the dignity

and worth of a person (NASW, 2017). For older adults, the promotion of dignity is vital to the opportunity for successful aging. Older adults are part of a vulnerable population and the effects of ageism are profoundly impactful on healthcare provision. Many of the reasons this policy location is so compelling is because not only do older adults have to work through the challenges of ageism but are also discriminated based on socioeconomic status. Vulnerability from older adults exists due to eligibility and utilization requirements set by federal standards that do not adequately reflect the needs of older adults. There is a significance in considering this population regarding decisions on policy and how that may affect future generations.

Policy Problem

Medicaid was established to provide insurance for low-socioeconomic individuals to support housing and medical expenses (Gruber, 2003). Many people across the country could not afford the cost of daily living and required additional resources for housing and healthcare needs (Gruber, 2003). Older adults who require healthcare services are limited and at the mercy of Medicaid regulations for eligibility and threshold utilization. There is age discrimination taking place under Medicaid that can delay admission into adult homes that are vital to the individuals' health trajectory (Meyer, 2001). Older adults who have community-based Medicaid are financially ineligible for admission, and those who are not enrolled may make too much money to be Medicaid eligible (Meyer, 2001). Medicaid policies, although different in each state can create a large gap in healthcare provision for older adult who require residential placement. Because low income older adults are limited to Medicaid, there is a serious problem with how this policy affects healthcare. Older adults may have to spend-down their assets or transfer them to family to be eligible for Medicaid (Lee, 2006). The result of these policies leaves older adults unable to pay privately and ineligible for Medicaid making necessary residential care

unattainable (Lee, 2006). For those who have the appropriate income amount and are Medicaid active are not free from the effects of ageism. Within residential older adult homes, threshold limits are placed on services like prescription coverage, physical, occupation and speech therapy, transportation, durable medical equipment, dentures, hearing aids…list continues (Sloan, 1993). As part of Medicaid requirements, this negatively impacts older adults who are on a fixed income but are still required to pay out-of-pocket costs for copays and certain nursing services (Sloan, 1993). The geriatric population is increasing and so has the cost of living as well as healthcare costs (NIH, 2016). This is an organic explanation for the cause of issues associated with Medicaid threshold limits.

Assumptions are that Medicaid covers all healthcare costs for older adults, but the reality is quite different (Sloan, 1993). The truth is that Medicaid requires out of pocket payments that older adults cannot afford, if they are even eligible for Medicaid in the first place (Lockhart, 2008). These policies leave Medicaid recipients and ineligible older adults without healthcare insurance coverage which contributes to faster physical decline and higher mortality rates (LaPar, 2010). The Affordable Care Act of Medicaid was designed to make the insurance more attainable and increase eligibility however, the effects of these policies still significantly impact the older adult population because of age requirements and ability to obtain services (Frean, 2016).

What is known about this problem is that there is a disproportionate amount of people who require services but are not eligible, and those who are eligible may not be able to afford the necessary care they need to successfully age (Korenman, 2019). What current research suggests is a need for increasing attainability and service utilization for impoverished older adults (Korenman, 2019). What is unknown is how to adjust Medicaid eligibility and threshold

requirements to be even more attainable for impoverished older adults. Given the results of the affordable care act, it is hard to determine the best course of action to positively impact future generations. Causality is also hard to determine as Medicaid is reimbursed by social security which is funded through federal income tax (Carpenter, 1988). Policies based on income and reimbursement rates fuel eligibility requirements for older adult home recipients, which change on a yearly basis due to increases in the cost of living (Weissert, 1978). Understanding this problem is better interpreted when compared to socioeconomic disparity through an ecological systems perspective. Many of the problems faced by this specific older adult population is similar to what low-income families face (Robert, 1999).

Process of the Problem

When the affordable care act was implemented in 2010 it boosted the utilization of Medicaid resources to nearly 50% of eligible older adult recipients (Sommers, 2012). A reduction in mortality rates was a positive outcome. However, the remaining 50% of ineligible older adults are left with lengthy and cryptic Medicaid threshold requirements such as selling or spending down assets and also navigating supplemental income programs like Social Security Income or State Supplemental Programs to qualify for Medicaid benefits (Sommers, 2012). This is happening to the low-socioeconomic and naturally aging groups which are identified as vulnerable. In this circumstance, it is common for older adults to be admitted to a hospital where they are deemed unsafe to return home. When insurance stops covering for hospital, nursing home, skilled nursing, or home care, assisted or independent living the individual accrues an extremely large bill (Grimmer, 2004). Those who are unwilling to give up their assets (homes, vehicles, savings) are not eligible for Medicaid and are unable to receive health care services (Grimmer, 2004). This is the point where older adults are forced into this Medicaid paradigm

where you either have to sell your home and car or risk dying earlier (Grimmer, 2004). This is were ageism is denoted as older adults who inevitably need assistance have little choice if they fall in a certain income bracket (Norton, 1995). They will either *spend down* their savings or sell or transfer their assets just to be eligible for Medicaid and then may be left unable to afford the cost of services under Medicaid (Norton, 1995). This problem is faced not only by older adults but the social workers who support them during adult care discharges. Medicaid is seen as a savior if it will pay for housing and health care but mortality rates for older adults residing in nursing homes are statistically higher than older adults aging in place who receive compensatory care (Cohen-Mansfield, 1999; Windle, 2006). Mortality rates and data collected on mortality in Medicaid recipients is how this problem was identified, and because this problem has increased with the recent expansion of Medicaid there is little history on this issue (Cohen-Mansfield, 1999; Windle, 2006). Although Medicaid is both state and federally regulated there is similar utilization and eligibility problems present. For older adults who fall in the middle of Medicaid eligibility, they simply cannot afford health care costs, but are viewed by the government as having enough assets to afford care costs. The government does not understand that the cost of daily living and care services surpasses what many older adults can afford, and do not take into consideration that eligibility requirements are disproportionate to the needs of older adults.

Those who receive Social Security Retirement benefits typically benefit from the policies around Medicaid eligibility (Nardi, 2013). These individuals fall above the middle socio-economic class providing and advantage to attaining benefits. This advantage is due to having assets or income that falls within the Medicaid threshold limits set by state and county officials based on local average income rates (Carpenter,1988; Frean, 2016). When compared to low socioeconomic status roughly 30% of the population falls at risk of the effects of Medicaid

policy (Pew, 2019). Within this 30%, 14% of older adults fall in the low socioeconomic range (APA, 2019). This is in part due to the stigma associated with aging, which included poor nutrition, mental health and physical disabilities (APA, 2019).

Navigating the Medicaid system is challenging for most, and because it is set up to provide benefits to a wide variety of demographics, older adults are viewed as unable to manage the application process (Koss, 2007). For younger adults who have a stake in this process acquiring information about the inter-workings of the Medicaid system is more easily attainable and promoted. As for older adults who are often left with little choice, they are lumped into this Medicaid world with little understanding which can create stress that further impacts wellbeing (Koss, 2007). The most identifiable difference between groups affected by Medicaid policies is that many young people can work to supplement their income. Older adults transitioning into older adult homes are often ineligible to work and are unable to supplement their income to afford the co-pays associated with out-of-pocket medical costs not covered under Medicaid (Carpenter, 1988). There is little consideration for the effects of aging and the significance that Medicaid has for approximately 14% of the population, and this literally can be a matter of increased risk of mortality (APA, 2019; Pew, 2019; Grimmer, 2007).

Part Two: Existing Policy

Policy Response

As the older adult population continues to increase, in addition to the cost of living and health care, policy makers are reluctant to address the effects of ageism on healthcare utilization. In response to those with limited income and resources, Medicaid administrators developed the Medicare Savings Programs designed to help low socio-economic individuals afford Medicare

(National Council on Aging, 2020). Older adults who have both Medicaid and Medicare are referred to as *dual eligible*, which is a response to those who cannot afford copays for certain services under Medicare which are still necessary for healthcare reasons (NCOA, 2020). This response suggests that Medicaid officials recognize disproportionate eligibility requirements for health care services covered under Medicare. Services like nursing, physical therapy, occupational therapy, speech therapy, and several others are often a necessity for older adults who would not have access to services the Medicare Savings Program was not implemented (Federman, 2005).

Medicaid policies are aimed at trying to provide services for those who cannot afford payments required by Medicare as well as Medicare which work in tandem under certain healthcare service provisions (NCOA, 2020). The savings program allows those who do not qualify for full Medicaid coverage to have coverage for prescription drugs and certain services under Medicare (NCOA, 2020). This saves a lot of money for older adults as well as the young and disabled and allows for services to be utilized (NCOA, 2020). The nature of the targeted groups is homogeneous meaning older adults fall under a vulnerable population despite differences in gender, race, and ethnicity (Siegel, 1985). Low socio-economic older adults 65 years and older, vary in physical and cognitive condition which is a significant factor in acquiring resources in the form of both Medicare and Medicaid (APA,2019; Siegel, 1985). Medicaid is funded through a reimbursement plan jointly controlled by federal and state expenditures (Mitchell, 2010). Known as The Federal Medical Assistance Percentage, this is the process of state Medicaid expenses being matched and reimbursed by the federal government (Mitchell, 2010). This allows for states to spend what they need for Medicaid while being compensated for the exact amount, this is an effort to reduce spending and costs associated with

Medicaid (Mitchell, 2010). State Medicaid cases are regulated through the county's Department of Health and Human Services (DHHS) who establish eligibility and the activation of Medicaid benefits (Medicaid.gov, 2020). DHHS and The Department of Health (DOH) regulate services provided in residential adult homes, which is dependent on the licensure of the adult home (Medicaid.gov, 2020). Depending on what the facility was granted under Licensed Home Care Services Agencies (LHCSA), independent living/ enriched housing, assisted living/ adult home, skilled nursing facilities, nursing homes, palliative and comfort care vary in services covered by Medicaid (New York State Department of Health , 2020). Medicaid is extremely challenging to navigate and often requires case workers to assist in activating benefits (Clark, 1998). As older adults rely on social workers and case workers to assist in this process it takes away some of the nuances of participating in one's own healthcare further marginalizing older adults (Clark, 1998). Medicaid is often uncharted territory where older adults must place trust in case managers for them to receive services often suggested by doctors (Hurley, 1989). Compared to younger adults who may have sought out and had a higher stake in the Medicaid process, older adults have less investment because of the natural aging process compelling them into the system, furthering inequalities in the lens of agism (Clark, 1998). Services for older adults that are paid for by Medicaid do not create competition for resources ultimately because eligibility requirements vary county to county (Hurley, 1998). Once being accepted into the Medicaid program, services adequately address personal healthcare needs, as eligibility requirements are the most challenging part to navigate (Clark, 1998; Hurley, 1998). Competition grows with the challenge of maintaining quality care and containing costs of Medicaid benefits, and states compete with one another for resource allocation and increased funding (Hurley, 1986). For those who have an

educated introduction into the Medicaid process, services are adequate at providing access to care as long as they are attainable (Long, 2005).

Several inequalities can be recognized within eligibility and utilization requirements, and this can be analyzed on an individual, communal and societal basis. Considering the individual, one of the most prominent challenges of long-term placement for older adults is the restriction of patient inclusion upon discharge from the hospital (Dill, 1995). This is a pivotal point where a doctor can determine if an older adult is unsafe to return home to the community which is referred to as decision-making capacity (Keene, 2015). Here the determination of long-term care is needed which can be paid through private funds or undertaking the Medicaid/ Medicare process (Kaye, 2010). Older adults may have little investment in this process considering that they may be in recovery, might not have a family to advocate for them and or simply may lack decision-making capacity (Dill, 1995; Kaye, 2010; Keene, 2015). The ability for older adults to make these decisions are severely restricted leaving them little option regarding insurance and receiving healthcare. Estimates indicate 14% of older adults who face this challenge without support (Dill, 1995; Pew, 2019; Grimmer, 2004). The aging population is so interconnected that concepts of race, gender, and other intersectionality points, converge raising concerns of agism (CQ Researcher, 2015).

The community-level response to ageism is the implementation of Managed Long-Term Care programs or MLTC's (NY Health Access, 2019). This is an effort to keep older adults in the community while still receiving appropriate health care services under Medicaid (NY Health Access, 2019). The recognition that residential placement of older adults in nursing homes and other long-term care facilities increases the risk of mortality is a profound realization of the current utilization of Medicaid (Cohen-Mansfield, 1999). Noting a significant reduction in risk

factors for older adults using MLTC programs is a mesosystem policy response to agism (Cohen-Mansfield, 1999). This is a way to provide more viable options for older adults and is a more person-centered approach to aging (Feder, 2000). Promoting discussion of ageism can be approached based on the dignity and worth of a person. This is a societal approach to change the way we perceive aging and older adults and the way we care for them. It is common for the general public to have limited knowledge about the long -term care system and how Medicaid/ Medicare interacts with the aging process. Using intersectionality to highlight the importance of older adults emotional and psychological wellbeing is an approach that could be effective at creating policy change to further support this population (Sabik, 2016). There is a need for younger generations to support older adult's health and wellness, because these policies will inevitably affect those younger generations at some point. Intersectionality in this regard is not a conflict but rather an untapped ore of communication between age groups. Furthering the conversation between the young and old about the inadequacies of older adult health care will benefit generations in the future. Connecting policy makers and younger generations can reduce the macro level stigmatization associated with aging. This form of intersectionality can connect divergent groups by highlighting areas of need as we age, placing importance on life domains that were not previously considered in Medicaid policy.

Part Three: Policy Proposal

Improvements

To create long term change regarding the effect of these policies, interventions should be implemented at the federal and state level as well as on a local and community level. Specifically, federal reimbursement or funding to the states included in the Medicaid Expansion should be increased, as this policy increased the demand for resources while denying the funding

to make these services and resources attainable (Snyder, 2016). A steady increase in enrollment over the last decade has challenged the reimbursement rates of Medicaid funded services and, more funding is needed as the aging population continues to increase as well as the demand for services covered under Medicaid (Snyder, 2016). Initially, Medicaid Expansion was successful in terms of making access to healthcare service more attainable and creating a system that is funded more thoroughly helping build on the ideas that were originally proposed during the initial expansion. State leaders and representatives will be a main influence on the proposed interventions for more funding, as they will be able to advocate on behalf of the increased enrollment for Medicaid and service output (Medicaid.gov, 2020). The vulnerability of the older adult population makes supporting interventions like these more challenging, which is why social workers are required for advocacy. Older adults can validate the hardships that occur under Medicaid requirements however for effective and sustainable change social workers are needed to help support and promote these hardships that can be changed through appropriate intervention.

Micro-level and Macro-level changes are needed to create a sustainable Medicaid program for older adults. On a Micro-level, eligibility requirements need to be changed to reach older adults who may not make enough or those who make too much to obtain Medicaid coverage (Meyer, 2001). To support access to Medicaid coverage as an intervention, funding needs to be addressed on a Macro-level to allow these marginalized individuals access to healthcare services. The need for increased federal funding has been promoted by local and state agencies that are negatively affected by low reimbursement rates, and at the start of the 2020 fiscal year a nearly 7% boost in reimbursement rates across states included under Medicaid expansion was implemented due to increased enrollment rates (Center on Budget and Policy

Priorities, 2020). Communication occurs between micro and macro systems when changes need to be addressed regarding funding and demand for services and service provision.

Short term reactions

To bypass financial requirements, individuals have utilized loopholes that need to be closed. Specifically, those who are financially ineligible and those who cannot afford necessary services with out of pocket payments, were forced to find a way to protect their income to remain Medicaid eligible. Trusts are commonly used to protect income and assets from eligibility requirements. Although families can create trusts in the stereotypical capacity, in recent history trusts have been used by families of varying social-economic status to preserve assets or income, to remain eligible for Medicaid (Taylor, 1999). There are dozens of trusts in the world of financial management and determining the appropriate ones for the purpose of Medicaid and service provision is extremely challenging to navigate even for attorneys who work in this field (Palmer, 2007). Loopholes should not be required to attain the necessary insurance for health coverage. This is a reactive solution that helps older adults in the immediate future, but Medicaid policies need to shift regarding eligibility requirements. Medicaid eligibility is based on income and assets, and a change needs to occur and consider personal expectations like social and cognitive engagement which are not services provided under Medicaid (Sommers, 2011). The lack of consideration of these nuances of life is similar to that of nursing home environments that do not consider cognitive and social engagement which can increase the risk of mortality (Cohen-Mansfield, 1999: Sommers, 2011). Medicaid policy should change eligibility requirements to account for the social and cognitive loss that older adults face when transitioning into adult homes. Federal funding should include emotional and cognitive challenges that transitioning to a residential home can evoke.

Inequities

Increased federal funding to states under Medicaid Expansion will help reduce the effects of ageism faced by older adults. Increased funding to states will allow for further consideration of income and asset-based eligibility requirements by providers, creating more financial freedom that promotes a more holistic and engaging aging experience (Foster, 2003). These unintentional eligibility requirements are based on healthcare models and costs associated with service provisions that do not recognize emotional and psychological health. Addressing federal funding policy around Medicaid will create an opportunity for emotional and psychological components of aging to be addressed through wellness and activity department programs (Foster, 2003). It will be challenging to advocate for these changes as older adults are a vulnerable population. If these changes were implemented, it would require community case managers and social workers to advocate for older adults to receive what they are entitled to under Medicaid. The federal government is in the position to determine exact funding measures to directly support and consider the emotional and psychological wellbeing of older adults through the revision of Medicaid funding (Mitchell, 2010). The Federal Medical Assistance Percentage will carry out exact funding measures to directly support older adults in the community and residential settings (Mitchell, 2010). These changes would be effective at the beginning of each new year as Medicaid funding changes yearly to account for increases in the cost of living (Social Security, 2020). These changes will connect policy-makers to those that the policy directly affects which will encourage coalition-building across divergent groups.

Current research has focused on assessing older-adult quality of life in community and residential settings. Emotional and cognitive wellbeing is challenged in the transition to residential care due to a loss of independence and health decline. If Medicaid would consider the

quality of life in an emotional and psychological capacity, funding would impact emotional and psychological wellbeing which accounts for the quality of life through the utilization of wellness programs (Dempster, 2000). Changes to eligibility would take time to measure the impact increased funding would have on quality of life. A longitudinal study on quality of life and mortality rates in a community and residential dwelling for older adults would be required to assess if increased funding would allow the implementation of wellness programs that target quality of life. As a result of policy reform, it would be expected that the quality of life ratings increase over time and mortality rates decrease. The inclusion of emotional and psychological wellbeing in Medicaid policy is important for older adults, and further funding to support these life domains will reduce the effects of ageism.

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