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Long-Term Care in the United States: A Timeline

Long-term care (LTC) in the United States has evolved over the course of the last century to better serve the needs of seniors and person with disabilities. This timeline outlines the major milestones in LTC from the nursing home era, which created an institutional bias in LTC, to the era of home and community based services (HCBS) and integration, and into the era of health reform and beyond. These milestones include key legislation and court decisions that were instrumental in providing LTC funding; improving the quality of care and safety in nursing homes; and allowing people with LTC needs to stay in their communities. Despite these successes, proposals by commissions and legislators for broader and more comprehensive national LTC policies have not been fully realized; though efforts in this area continue.

THE ERA OF NURSING HOMES

1935

Social Security Act (SSA) enacted. Under the SSA, the Old Age Assistance program makes federal money available to the states to provide financial assistance to poor seniors. The law specifically prohibits making these payments to anyone living in public institutions (poor houses, which had become known for their terrible living conditions), thus spawning the creation of the private nursing home industry.

1950

An amendment to the SSA requires payments for medical care to be made directly to nursing homes rather than beneficiaries of care. Under the amendments, states are also required to license nursing homes in order to participate in the Old Age Assistance program.

1965

Medicare and Medicaid are passed as amendments to the SSA. Medicare's focus is on acute care only and does not provide for long-term care (LTC). Medicaid requires coverage of LTC in institutions but not in the home, creating a bias in favor of institutional LTC. Under this legislation, the federal and state governments become the largest payers for LTC: nursing home utilization increases dramatically, along with government expenditures.

Older Americans Act (OAA) enacted, establishing Administration on Aging within the department of Health, Education and Wellness (HEW).

1967

As a response to public outcry over fraud and abuse in nursing homes, 1967 Amendments to the SSA include a provision for states to govern the licensing of nursing home administrators.

1968

"Moss Amendments" are passed to authorize HEW to standardize the regulations for the Medicare and Medicaid programs and to withhold funding from nursing homes that do not meet those standards, paving the way for comprehensive regulations to improve nursing home care.

THE ERA OF COMMUNITY-BASED SERVICES

1974

1974 SSA amendments authorize federal grants to states for social services programs including homemaker services, protective services, transportation, adult day care, training for employment, nutrition assistance and health support.

Final regulations for skilled nursing facilities are put into effect and enforcement of compliance with standards such as staffing levels, staff qualifications, fire safety, and delivery of services become a requirement for participation in Medicare and Medicaid.

1975

1975 SSA amendments create Title XX, which consolidate the federal assistance to states for social services into a single grant. Under Title XX states are required to prevent or reduce inappropriate institutional care by providing for home and community-based services (HCBS).

1978

The Comprehensive OAA Amendments of 1978 require all states to develop and implement a nursing home ombudsman program and to prioritize community alternatives to LTC.

1980

Mental Health Systems Act of 1980 provides federal funding for ongoing support and development of community mental health programs with an emphasis on deinstitutionalization.

The U.S. Department of Health and Human Services' (HHS) National Long-Term Care Channeling Demonstration to test quality and cost-effectiveness of HCBS for frail seniors is implemented. It runs through 1986.

1981

HCBS waiver program is enacted under Section 1915(c) of the SSA, allowing states to offer home and community-based services that are not strictly medical in nature through Medicaid as an alternative to institutional care.

1982

Established under the Tax Equity and Fiscal Responsibility Act, the Katie Beckett Medicaid state plan option permits states to cover children with disabilities living in the community; previously, these children were eligible for Medicaid only if institutionalized.

1984

Reauthorization of OAA reaffirms role of State Area Agencies on Aging in coordinating HCBS.

1987

Under OBRA-87, The Nursing Home Reform Act imposes quality standards for Medicare and Medicaid-certified nursing homes in response to well-documented quality issues facing seniors in nursing homes. Reauthorization of the OAA adds six additional distinct authorizations of appropriations for services including in-home services for frail seniors; LTC ombudsman; and prevention of elder abuse, neglect and exploitation.

The Robert Wood Johnson Foundation (RWJF) begins support for long-term care public/private partnership programs in four states to encourage people to purchase LTC insurance in order to potentially offset their need for care financed by Medicaid.

1988

Medicare Catastrophic Act of 1988 – Among other things, expands skilled nursing facility (SNF) benefits by removing time limits on most hospital service coverage and establishes protections against spousal impoverishment from nursing home expenses, but still does not pay for long-term custodial nursing home care. It also requires Medicaid to cover Medicare premiums and cost-sharing for Medicare beneficiaries with incomes below 100% FPL and limited assets (Qualified Medicare Beneficiaries, QMBs).

Congress creates the U.S. Bipartisan Commission on Comprehensive Health Care to recommend legislative action on health and long-term care. The Commission is renamed the Pepper Commission in honor of its creator and first chair, Representative Claude Pepper (D-FL).

1989

Repeal of Medicare Catastrophic Act; provisions on spousal impoverishment and QMBs are kept in place.

1990

OBRA-90 – Requires state Medicaid programs to cover premiums for Medicare beneficiaries with incomes between 100-120% FPL. Medicare is expanded to cover partial hospitalization services in community mental health centers.

The Pepper Commission issues report on LTSS financing options, with a set of recommendations on LTC that include an initiative that would establish government or social insurance to keep resources intact for people with severe disabilities at home or with the potential to return home after a short nursing home stay, and would establish a floor of protection against impoverishment for all nursing home users, no matter how long their stay. It also proposes to cover the first 3 months of nursing home care with 20% copayment and coverage of home care services for Medicare elders with 3+ Activity of Daily Living (ADL) impairments. The recommendations are never enacted.

Americans with Disabilities Act (ADA) enacted. The Act emphasizes the importance of integrating people with disabilities into the community and ending exclusion and segregation.

1993

Clinton Health Care Plan includes plans to expand HCBS; improve Medicaid coverage for institutional care; and establish minimum standards to improve the quality of private insurance for LTC and tax incentives to encourage its purchase. The plan is never enacted.

1994

The final rule for OBRA-87 is published, eight years after the law is passed.

1995

As part of a larger attempt to reform Medicaid, the Nursing Home Reform Act is nearly repealed, but through interventions by consumer advocates demonstrating the positive effects of the reform provisions, repeal is averted.

HHS and RWJF initiate the Medicaid cash and counseling demonstration, allowing beneficiaries to self-direct their HCBS in lieu of traditional agency-provided services.

1999

Supreme Court's *Olmstead* decision promotes broader HCBS coverage for people with disabilities, per ADA's community integration mandate.

2000

Americans Act Caregiver Program established, authorizing grants to states to fund a range of supports that assist family and informal caregivers to care for their loved ones at home.

2001

New Freedom Initiative established to remove barriers to community living for people with disabilities.

Centers for Medicare & Medicaid Services and Administration on Aging Real Choice Systems change grants available to states and non-profit agencies to develop integrated LTSS systems.

2005

Deficit Reduction Act provides federal funding to states to expand community-based care; authorizes the Medicaid Money Follows the Person (MFP) Rebalancing demonstration program; allows states to add an optional Medicaid state plan benefit for HCBS ; and allows states to offer self-direction of personal care services. It also lengthens the look-back period for transfers of assets for nursing home Medicaid applications from 36 to 60 months. In addition, it allows for Qualified State Long-Term Care Partnerships, which encourage individuals to purchase LTC insurance while still allowing them to qualify for Medicaid if their LTC needs extend beyond the period covered by their insurance policy.

2006

OAA Amendments of 2006 signed into law, including the principles of consumer information for long-term care planning, evidence-based prevention programs, and self-directed community based services to older individuals at risk of institutionalization.

THE ERA OF HEALTH REFORM

2010

The Affordable Care Act (ACA) provides new options to states under the Medicaid program to incentivize the improvement of their LTC infrastructures and expand HCBS. Provisions include the Balancing Incentive Program, the Community First Choice state plan option and an MFP extension, among others. In addition, for the 5-year period beginning January 1, 2014, states are required to apply spousal impoverishment standards in determining eligibility for married Medicaid applicants receiving HCBS. Prior to this, these standards were applied to the spouses of nursing home residents only.

Under the ACA, The Community Living Assistance Services and Supports (CLASS) Act is enacted, with the intention of offering a national, voluntary long term services and supports (LTSS) insurance program financed by individual premium contributions.

2011

First of the nation's baby boomers turn 65.

2013

The American Taxpayer Relief Act of 2012 repeals the CLASS Act and establishes the time-limited, bipartisan Commission on Long-Term Care.

The Commission on Long-Term Care issues a report to the Congress, reviewing LTSS policy and program issues. The report makes recommendations regarding service delivery and workforce. No agreement on financing recommendations are reached; instead the report puts forward financing approaches suggested by members.

2014

CMS finalizes new rules outlining the qualities that settings must meet to be considered “home and community-based” for the provision of Medicaid services.

2015

CMS revises the Five-Star Quality rating system for nursing homes, reflecting an improvement of performance standards.