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Medicaid Cuts in Cassidy-Graham Plan Would Reduce Access to Home- and Community-Based Services

By Judith Solomon and Jessica Schubel

The legislation to repeal and replace the Affordable Care Act (ACA) sponsored by Senators Bill Cassidy and Lindsey Graham, which the Senate is now considering, would replace the ACA's marketplace subsidies and Medicaid expansion with an inadequate block grant. Like other House and Senate repeal bills, it would also affect the entire Medicaid program by converting Medicaid's current federal-state partnership to a per capita cap, which would cap and cut federal Medicaid per-beneficiary funding for seniors, people with disabilities, and families with children.[1] As a result, it would make home- and community-based services (HCBS) that states fund through Medicaid especially vulnerable to deep cuts. Facing steep cuts in their overall federal Medicaid funding, states would likely curtail these services, which in 2013 allowed almost 3 million seniors and adults and children with disabilities to receive care at home instead of in a nursing home.[2] (See Appendix Table 1.)

Federal HCBS waivers and other state options have given states new ways to address the needs of their residents, including seniors as well as both children and adults with serious disabilities. Progress by the states has been dramatic; the share of Medicaid expenditures for long-term services and supports that states allocate to HCBS has climbed from 18 percent in 1995 to 53 percent in 2014, with the number of people served with HCBS rising dramatically as well. States now spend more for HCBS than for nursing home care.

The Cassidy-Graham bill would place a fixed cap on per-beneficiary federal Medicaid funding, cutting federal funding to the states by growing amounts over time.[3] Capping and cutting federal

[1] Jacob Leibenluft *et al.,* "Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market, Center on Budget and Policy Priorities, September 18, 2017, https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-plan-would-add-millions-to-uninsured

[2] Terence Ng *et al.*, "Medicaid Home and Community-Based Services Programs: 2013 Data Update," The Kaiser Commission on Medicaid and the Uninsured, October 2016, http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/.

[3] Edwin Park and Matt Broaddus, "Cassidy-Graham Plan's Damaging Cuts to Health Care Funding Would Grow Dramatically in 2027," Center on Budget and Policy Priorities, September 16, 2017,

funding would force many states to make excruciating decisions on whom they cover, the benefits they provide, and how much they pay providers, likely jeopardizing coverage and care for vulnerable populations that Medicaid covers. Seniors, as well as children and adults with disabilities, who rely on Medicaid-funded services to avoid having to live in a nursing home or other institution — and those who will need such services in the future — would be among those hit hardest. The cuts in Cassidy-Graham would likely prompt many states to roll back their progress in expanding access to care in the community and prevent them from making more progress in the future.

That's because unlike most services in Medicaid, which states *must* cover, most HCBS are *optional* Medicaid benefits that states can cut when they face funding shortfalls.[4] (The services that states provide in their HCBS programs vary, but they generally provide home health services plus help with chores, meals, transportation, and other services such as adult day care and respite care for family caregivers.) Most states already limit HCBS due to funding constraints, and HCBS are a likely target if states must make substantial cuts due to federal funding shortfalls, because they spend more on optional HCBS than on any other optional benefit. Cassidy-Graham therefore would likely generate large increases in HCBS waiting lists, and some states could eliminate their HCBS programs altogether.

As the population ages, the need for HCBS will grow, as will the need for the direct care workers who deliver HCBS services, including nursing assistants, home health aides, and personal care aides. The direct care workforce is poorly paid, and it will be hard to meet the growing demand without improving their wages and training. The federal funding caps in Cassidy-Graham would leave states hard-pressed to meet the needs of a growing population in need of HCBS and other long-term services and supports.

Per Capita Cap in Cassidy-Graham Cuts Federal Medicaid Funding for All States

Medicaid is a federal-state partnership that provides affordable, high-quality health insurance to children, pregnant women, seniors, and people with disabilities. Medicaid's current financing structure — in which the federal government matches state spending at a state-specific rate (now averaging 64 percent) — allows spending to account for the variation in health care markets, residents' needs, and state policy choices. It also allows states to respond to increases in health care costs that occur due to changing demographics, new ways of delivering care, new medical technology and prescription drugs, epidemics, public health emergencies, and environmental disasters.[5]

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https://www.cbpp.org/research/health/cassidy-graham-plans-damaging-cuts-to-health-care-funding-would-grow-dramatically-in.

[4] Of the 3 million people receiving HCBS services in 2013, about 672,000 received mandatory home health benefits, 774,000 received personal care services (an optional HCBS benefit), and 1.55 million received services through an HCBS waiver. Ng *et al., op cit.*

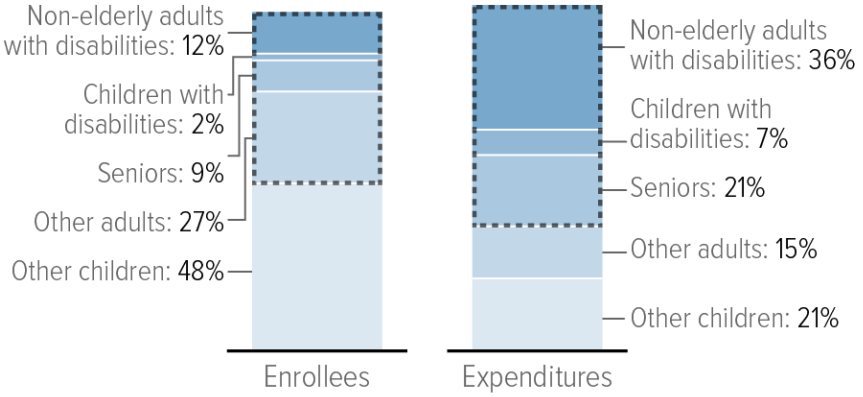
[5] See, for example, Jocelyn Guyer and David Rosales, "Medicaid's Role in Public Emergencies and Health Crises," State Health Reform Assistance Network, April 2017, http://www.statenetwork.org/wp-content/uploads/2017/04/RWJF_Manatt_HealthCrisis_IssueBrief_Final.pdf.

Cassidy-Graham would change Medicaid's financing structure by capping federal funding on a per-beneficiary basis (a "per capita cap").[6] The proposal is intended to reduce federal Medicaid costs by setting the cap for each state below projected federal Medicaid spending under current law and adjusting the cap by a rate below expected cost growth. Shortfalls in federal funds would grow over time, since increases in the cap wouldn't keep up with rising health care costs.[7] Prior estimates from the Congressional Budget Office (CBO) suggest that Cassidy-Graham would cut the rest of Medicaid (outside of the expansion) by $175 billion between 2020 and 2026, with the cuts reaching $39 billion (8 percent) by 2026, relative to current law. Moreover, the cuts would grow deeper in coming decades. According to new estimates from Avalere, the Cassidy-Graham per capita cap would cut federal Medicaid spending by *$1.1 trillion* through 2036 (in addition to the cuts resulting from elimination of the expansion).[8]

FIGURE 1

Seniors, People with Disabilities Account for Disproportionate Share of Medicaid Spending

Medicaid enrollment and spending by coverage group, fiscal year 2011



Note: Includes both full-benefit enrollees and enrollees who receive select benefits such as family planning or help with Medicare cost-sharing. Totals may not sum due to rounding.

Source: Kaiser Family Foundation/Urban Institute estimates based on data from fiscal year 2011 Medicaid Statistical Information Statistics and Centers for Medicare & Medicaid Services-64. MSIS fiscal year 2010 data adjusted to fiscal year 2011 spending were used for states missing fiscal year 2011 data.

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Moreover, Cassidy-Graham would put even more pressure on states to make cuts than prior repeal bills because its block grant to replace marketplace subsidies and Medicaid expansion *ends*

[7] Edwin Park, "Medicaid Per Capita Cap Would Shift Costs and Risks to States and Harm Millions of Beneficiaries," Center on Budget and Policy Priorities, February 27, 2017, http://www.cbpp.org/research/health/medicaid-per-capita-cap-would-shift-costs-and-risks-to-states-and-harm-millions-of.

[8] Elizabeth Carpenter and Chris Sloan, "Graham-Cassidy-Heller-Johnson Bill Would Reduce Federal Funding to States by $215 Billion," Avalere Health, September 20, 2017, http://avalere.com/expertise/life-sciences/insights/graham-cassidy-heller-johnson-bill-would-reduce-federal-funding-to-sta.

after 2026. In 2027 alone, federal funding for health coverage would be cut by $299 billion.[9] Overall, Cassidy-Graham would reduce federal funding to states by over $4 trillion between 2020 and 2036, Avalere estimates.[10]

Medicaid is already highly efficient, covering people at lower costs than private insurance and with slower growth in per-beneficiary costs over time, which means that states wouldn't be able to absorb a loss in federal funding without cutting eligibility, benefits, or provider payments.[11] No group covered by Medicaid would be immune to these cuts in coverage — especially seniors and people with disabilities, who accounted for over 60 percent of Medicaid spending in 2011.[12] (See Figure 1.)

How the Per Capita Cap Works

Under the Cassidy-Graham bill, each state's overall federal funding for Medicaid would be capped beginning in 2020. The cap would be based on the number of beneficiaries in each of four groups — children, seniors, people with disabilities, and adults (such as low-income parents and pregnant women) — and per-beneficiary spending for each of those groups.[13] To determine the overall federal funding cap, the federal government would first calculate federal Medicaid spending per beneficiary in each state for a base period consisting of eight fiscal quarters selected by the state, projected forward based on the medical component of the Consumer Price Index (M-CPI), a slower rate than the Congressional Budget Office's current growth projection for Medicaid.[14] Because the caps would be based on federal spending in the state in prior years, states effectively would be locked into a base of what they spent on care during this prior period *and* growth insufficient to meet beneficiaries' needs over time.

Under Cassidy-Graham, in 2020, the federal government would then determine a per-beneficiary amount for each eligibility group for 2020 based on the above calculations. Next, each per-beneficiary cap would be multiplied by the number of beneficiaries in each eligibility group and

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[9] Park and Broaddus, *op. cit.*

[10] Carpenter and Sloan, *op. cit.*

[11] See Teresa A. Coughlin *et al.*, "What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults," Kaiser Family Foundation, May 2013, http://kff.org/medicaid/issue-brief/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and-financial-protection-under-medicaid-for-low-income-adults/; Edwin Park *et al.*, "Frequently Asked Questions About Medicaid," Center on Budget and Policy Priorities, updated January 21, 2016, http://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid; Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP," June 2016, https://www.macpac.gov/wp-content/uploads/2016/06/Trends-in-Medicaid-Spending.pdf.

[12] MaryBeth Musumeci and Katherine Young, "State Variation in Medicaid Per Enrollee Spending for Seniors and People with Disabilities," Kaiser Family Foundation, May 1, 2017, http://kff.org/medicaid/issue-brief/state-variation-in-medicaid-per-enrollee-spending-for-seniors-and-people-with-disabilities/. With coverage of adults under the expansion, the share of spending on seniors and people with disabilities is now closer to 50 percent.

[13] The following populations are excluded from the per capita cap model: qualified Medicare beneficiaries, beneficiaries receiving emergency Medicaid and family planning services, beneficiaries enrolled under the tuberculosis and breast and cervical cancer eligibility groups, beneficiaries enrolled in employer-sponsored premium assistance, American Indians and Alaska Natives, and children enrolled in the Children's Health Insurance Program.

[14] The period of eight consecutive fiscal quarters can't start before the first quarter of fiscal year 2014 and can't end after the third fiscal quarter of 2017.

together would equal the overall federal funding cap for the state. If a state spent more on one group in a year than that group's allotment, it could stay within its overall federal funding cap by spending less on other groups. But if a state claimed more than its overall cap in any year, it would have to repay the excess the following year.

Beginning with the calculation for 2020 and until 2025, the growth rate for the per-beneficiary caps for seniors and people with disabilities would be M-CPI plus 1 percentage point. Starting in fiscal year 2025, the annual cap adjustment for children and adults would be reduced substantially to general inflation (CPI-U), which is about 2.5 percentage points lower than projected annual increases in per-beneficiary costs for those groups. In addition, the annual adjustment for seniors and people with disabilities would fall to M-CPI. While the per capita cap growth rate would be higher for seniors and people with disabilities than for children and adults starting in 2020, seniors and people with disabilities would still be subject to eligibility and benefit cuts. The overall inadequacy of the cap across all groups would lead to federal funding shortfalls, requiring states to cut across their entire Medicaid programs, regardless of how much each group's per capita cap contributed to the total shortfall.

Per Capita Cap Would Jeopardize Long-Term Services and Supports for Seniors and People with Disabilities

Cassidy-Graham would cap the federal funds available to states to operate their Medicaid programs, but it wouldn't change the mandatory benefits that Medicaid must provide for seniors and people with disabilities or that individual states must cover.[15] Care in a nursing home remains a mandatory benefit, and most HCBS — increasingly popular alternatives to institutional care — are still optional, which means states choose whether and to what extent to cover them. The amount states spend on care for seniors and people with disabilities varies considerably, which is reflected in differences in per-beneficiary spending across states. (See Appendix Table 2.)

Because Cassidy-Graham bases per-beneficiary caps for each group on what the state spent in prior years, it's unlikely states would expand the availability of HCBS in the future, whether by increasing eligibility or the types of HCBS. Without cutting other services, states wouldn't have room under the overall federal funding cap for new spending. The more likely scenario, if federal funding were capped and states had to cut their programs, is that they would roll back HCBS.[16] The risk of cuts to HCBS is especially great because states spend more on HCBS than any other optional benefit, and most states already limit HCBS due to constraints on available funding.

[15] The block grant option for children and adults other than seniors and people with disabilities would allow states to stop providing benefits that are now mandatory, such as Medicaid's comprehensive benefit for children known as EPSDT (Early and Periodic, Screening, Diagnostic and Treatment).

[16] See information on Medicaid.gov at https://www.medicaid.gov/medicaid/hcbs/.

Medicaid Expansion Isn't Squeezing Out Funding for HCBS

Opponents of the Medicaid expansion have repeatedly claimed falsely that it is squeezing out funding for other Medicaid beneficiaries and causing long waiting lists for HCBS, a claim the *Washington Post*'s fact checker gave "4 Pinocchios."[a] Also, Department of Health and Human Services Secretary Tom Price has described the House-passed ACA repeal bill as an attempt "to improve the Medicaid system, make it more responsive to patients so that there are more resources to be able to be utilized for the disabled and the aged."[b] The truth is there isn't a connection between waiting lists for HCBS and Medicaid expansion. Nine of the 11 states *without* HCBS waiting lists are expansion states, and the two states with the biggest waiting lists (Texas and Florida) are *non*-expansion states.

As this paper shows, the real threat to HCBS is capping federal funds for Medicaid.

[a] Judith Solomon, "False Claims That the Medicaid Expansion Is Causing Waiting Lists," Center on Budget and Policy Priorities, March 20, 2017, http://www.cbpp.org/blog/false-claims-that-the-medicaid-expansion-is-causing-waiting-lists. For more, see Michelle Ye He Lee, "Did the Obamacare Medicaid expansion force people onto wait lists?," *Washington Post*, March 24, 2017, https://www.washingtonpost.com/news/fact-checker/wp/2017/03/24/did-the-obamacare-medicaid-expansion-force-people-onto-waitlists/?utm_term=.1014c08a6868.

[b] Mallory Shelbourne, "Price: Medicaid will be more ''responsive'' under GOP plan," *The Hill*, May 7, 2017, http://thehill.com/homenews/sunday-talk-shows/332273-price-medicaid-will-be-more-responsive-under-gop-plan.

States Are Shifting Long-Term Services and Supports from Institutional Care to the Community

HCBS waivers became available in 1981 to provide states with a way to provide long-term services and supports (LTSS) outside of institutions. Skilled nursing care and home health services have always been mandatory services in Medicaid, but because many individuals need services beyond home health care to stay in their homes, Medicaid was biased toward institutional care.[17] HCBS waivers gave states new ways to address the LTSS needs of their residents, including seniors and children and adults with disabilities, leading to a big shift in the program since 1981. Progress has been dramatic: the share of LTSS spending on HCBS climbed from 18 percent in 1995 to 53 percent in 2014.[18] (See Figure 2.)

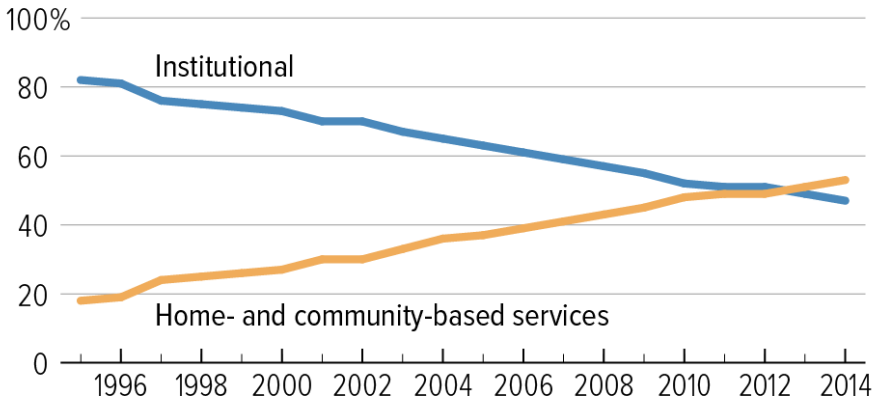
[17] Home health services include nursing services, home health aide services, medical supplies, and equipment. 42 CFR §441.15.

[18] Terence Ng *et al.*, "Medicaid Home and Community-Based Services Programs: 2013 Data Update," The Kaiser Commission on Medicaid and the Uninsured, October 2016, http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/.

FIGURE 2

States Have Shifted Spending to Home- and Community-Based Services, and Away From Institution-Based Services

Share of total Medicaid long-term services and supports spending



Source: Truven Health Analytics, "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014"

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The services states provide in their HCBS programs vary, but they generally include home health services plus help with chores, meals, transportation, and other services such as adult day care and respite care for family caregivers. Many states have multiple HCBS programs targeted to specific groups, and the package of services for each program is designed to ensure that members of the target population get the services they need to remain in their homes instead of having to be placed in a nursing home.

HCBS waivers also allow people who were previously only financially eligible if they were applying all their income to care in a nursing home or other institution to become eligible for Medicaid outside of the institution and receive the services they need to stay in their homes. States also provide HCBS to children with disabilities whose parents' incomes exceed Medicaid limits.

Under traditional Medicaid rules, parental income *isn't* counted if children are placed in an institution, but it *is* counted when they live at home. In 1981, President Reagan addressed the harsh choice often faced by parents of children with special health care needs and created an option for states to allow children to get care at home through a waiver of Medicaid rules on counting parental income. In 1982, an option was added to the Medicaid statute, allowing states to provide HCBS to children without getting a waiver of federal rules. As of 2015, all states but one (Tennessee) used one of these eligibility pathways for children.[19] (See Appendix Table 3.)

[19] Musumeci and Young.

The ACA enhanced state options for HCBS. It significantly improved an option first added to the Medicaid statute in 2005 by allowing states to target services to particular populations and making other changes that help states address the needs of people with behavioral health conditions who aren't eligible for HCBS waivers.[20] It also provided states with higher matching funds as an incentive for them to implement the Community First Choice option, which provides eligible beneficiaries with comprehensive community-based services as an alternative to care in an institution. Cassidy-Graham would eliminate this incentive, putting the program in jeopardy in the eight states that have taken it up and making it less likely that other states will adopt it.[21]

HCBS Services at High Risk Under Cassidy-Graham

Unlike nursing home care, which must be provided to all financially eligible beneficiaries who meet functional and medical criteria, states can control their expenditures for HCBS based on their fiscal and organizational capacity to support the services. States usually do this by limiting the number of slots available for people served by HCBS waivers and creating waiting lists, and they would likely further limit HCBS services under a per capita cap.

The largest share by far of state spending on optional Medicaid services goes for HCBS, data from the Medicaid and CHIP Payment and Access Commission (MACPAC) show.[22] MACPAC sorted 2013 Medicaid spending and enrollment data into four categories — spending on mandatory services for mandatory enrollees, optional services for mandatory enrollees, mandatory services for optional enrollees, and optional services for optional enrollees — and also looked separately at mandatory and optional spending on long-term services and supports, which include both institutional care and HCBS. Overall, MACPAC found that about two-thirds of all Medicaid spending was for services provided to seniors and people with disabilities, and just over one-third of total Medicaid spending was on optional services, with the bulk of those services going to seniors and people with disabilities:

- Optional services represented close to half of spending for care provided to people with disabilities and seniors, while less than 1 percent was for children and 29 percent was for adults without disabilities.
- Of the total $147 billion in spending on optional services, $129 billion (88 percent) was for services provided to seniors and people with disabilities.
- Most spending on optional services for both seniors (64 percent) and people with disabilities (57 percent) was for LTSS, but the share of mandatory spending on LTSS was much lower for people with disabilities (15 percent) than for seniors (72 percent). This disparity reflects the

[20] States can't have waiting lists for HCBS services available under the state option, which has been taken up by 18 states.

[21] Jessica Schubel, "Little-Noticed Medicaid Changes in House Plan Would Worsen Coverage for Children, Seniors and People with Disabilities and Increase Uncompensated Care," Center on Budget and Policy Priorities, March 15, 2017, http://www.cbpp.org/research/health/little-noticed-medicaid-changes-in-house-plan-would-worsen-coverage-for-children.

[22] Martha Heberlein, "Analysis of Mandatory and Optional Populations and Benefits," Medicaid and CHIP Payment and Access Commission, April 21, 2017, https://www.macpac.gov/wp-content/uploads/2017/04/Review-of-June-Report-Chapter-Analysis-of-Mandatory-and-Optional-Populations-and-Benefits.pdf.

greater reliance on home- and community-based services for people with disabilities and higher concentration of spending on nursing home care for seniors.

Because HCBS represent such a large share of state spending on optional services, which states can cut, Cassidy-Graham would likely lead to big increases in HCBS waiting lists or the elimination of HCBS waivers altogether in many states as federal funding shortfalls grew.

The aging of the population adds to those risks. Per-beneficiary costs for seniors will increase as the baby boomers age and more seniors move from "young-old age" to "old-old age." A look at 32 states with available estimates shows that all these states will experience a rise in the share of seniors who are 85 or older between 2025 and 2035, in most cases by at least 25 percent. (See Figure 3.) People in their 80s or 90s have more serious and chronic health problems and are likelier to require long-term services and supports. For example, seniors aged 85 or older incurred average Medicaid costs in 2011 that were more than 2.5 times higher than those aged 65 to 74. But under Cassidy-Graham, each state's funding per senior beneficiary would be based on its spending per senior beneficiary in 2016, so federal funding wouldn't adjust to reflect the rise in seniors' per-beneficiary costs.[23] The resulting funding shortfall would further squeeze states' capacity to keep up with the growing need for HCBS and other services.

States with lower per-beneficiary costs in 2016 would be even harder pressed to maintain their HCBS and meet future demands. An analysis of how states would have fared in 2011 if a cap like Cassidy-Graham's had been implemented in 2004, based on 2000 spending levels, showed that states with lower per-beneficiary spending in the base year experienced faster cost growth in subsequent years and were more likely to experience federal funding shortfalls.[24]

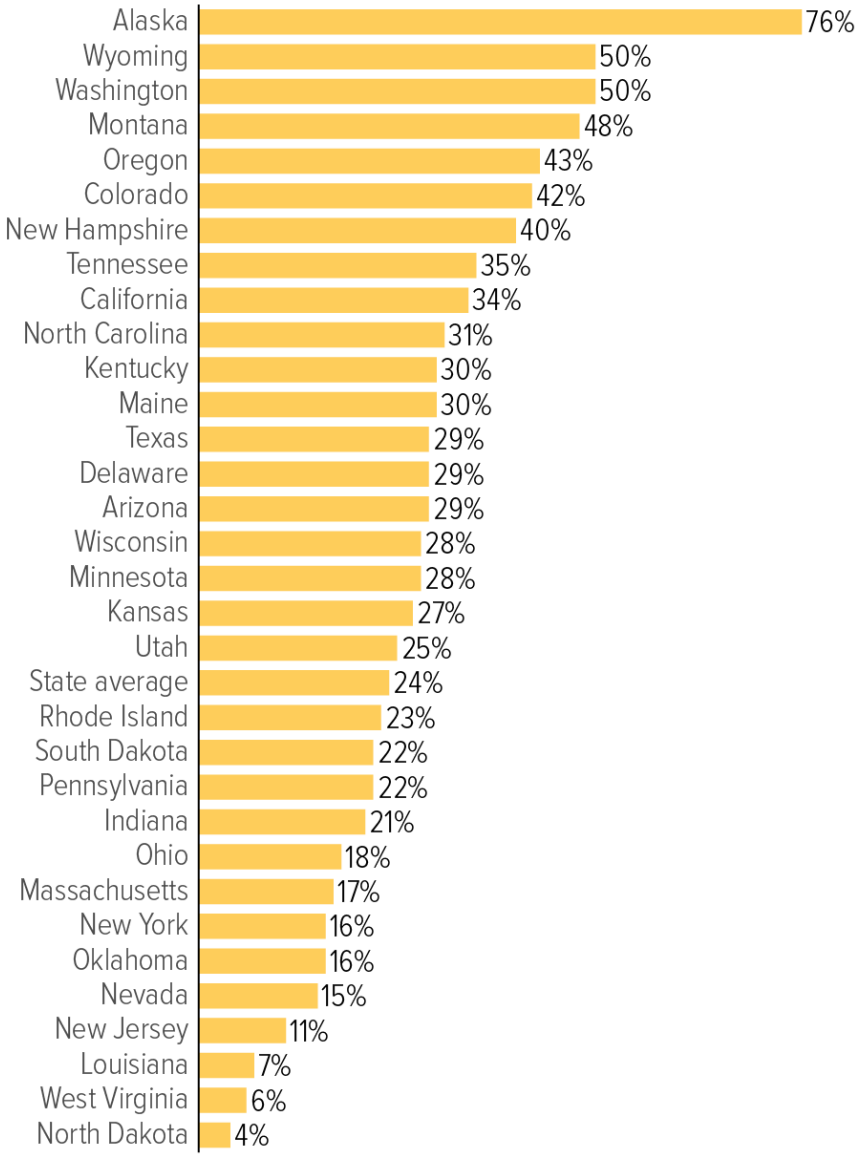
[23] Matt Broaddus, "Population's Aging Would Deepen House Health Bill's Medicaid Cuts for States," Center on Budget and Policy Priorities, March 24, 2017, http://www.cbpp.org/blog/populations-aging-would-deepen-house-health-bills-medicaid-cuts-for-states.

[24] Loren Adler, Matthew Fiedler, and Tim Gronniger, "Effects of the Medicaid Per Capita Cap Included in the House-Passed American Health Care Act," Brookings Institution, May 2017, https://www.brookings.edu/wp-content/uploads/2017/05/es_chp_medicaidpercapitacap_adlerfiedlergronniger_51017.pdf.

FIGURE 3

Growing Share of Seniors Will Be 85 or Older

Percentage increase between 2025 and 2035 in states with available projections



Source: CBPP analysis of rates of population change projected by state sources (available at https://www.census.gov/population/projections/data/state/st-prod-proj-list.html) applied to July 2015 Census Bureau state population estimates.

Per Capita Cap Would Affect Direct Care Workforce Providing HCBS

The per capita cap also would likely make it harder to meet the growing need for direct care workers who deliver HCBS, including nursing assistants, home health aides, and personal care aides, making it hard for many families to find the care they need.[25] The home care workforce has doubled in size over the last ten years, as states have increased HCBS, but the need will continue to grow.[26] In 2014, there were 3.3 million direct care workers, comprising 21 percent of the nation's health workforce. The Bureau of Labor Statistics estimates an additional 1.1 million direct care workers will be needed by 2024 — a 26 percent increase over 2014.[27]

Direct care workers generally receive low wages, averaging about $10 to $13 an hour in 2015, leaving 1 in 4 of them with income below the poverty line.[28] A recent National Academy of Medicine report cited the need for adequate compensation and better training to address high turnover resulting from low pay and inadequate training.[29]

A per capita cap would exacerbate the shortage of direct care workers, which is already described as a crisis in some areas.[30] Medicaid pays for a large share of the care delivered by direct care workers, so there is a direct link between states' capacity to increase provider reimbursements and the direct care workforce's salaries and working conditions. Improvements in wages for direct care workers would increase per-beneficiary costs, making it harder or even impossible for states to stay under their federal funding caps. Thus, capped federal funding would leave little room for home health providers to increase wages and other enhancements to attract and maintain a sufficient skilled workforce.

Cassidy-Graham's elimination of the Medicaid expansion by 2020 would also affect direct care workers' access to health care. In addition to low pay, direct care workers often don't have an offer of employer coverage. In 2010, 28 percent of direct care workers were uninsured, compared with 17 percent of all workers. By 2014 the shares fell to 21 percent and 16 percent, respectively,

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[25] Judith Graham, "A Shortage of Caregivers," *New York Times*, February 26, 2014, https://newoldage.blogs.nytimes.com/2014/02/26/a-shortage-of-caregivers/.

[26] "U.S. Home Care Workers: Key Facts," PHI, 2017, http://phinational.org/sites/phinational.org/files/phi-home-care-workers-key-facts.pdf.

[27] Judith Graham, "Severe Shortage of Direct Care Workers Triggering Crisis," Kaiser Health News, May 9, 2017, https://www.disabilityscoop.com/2017/05/09/severe-shortage-care-crisis/23679/; "U.S. Home Care Workers: Key Facts."

[28] Government Accountability Office, "Long-Term Care Workforce: Better Information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers," GAO-16-718, August 2016, http://www.gao.gov/assets/680/679100.pdf.

[29] John W. Rowe *et al.*, "Preparing for Better Health and Health Care for an Aging Population," National Academy of Medicine, September 19, 2016, https://nam.edu/wp-content/uploads/2016/09/Preparing-for-Better-Health-and-Health-Care-for-an-Aging-Population.pdf.

[30] Graham, Kaiser Health News.

representing an increase of about 500,000 direct care workers with insurance. The coverage gains were due mostly to the Medicaid expansion.[31] Repealing the expansion would reverse this progress.

Conclusion

Faced with deep and growing cuts from a per capita cap, states would likely cut back HCBS to reduce Medicaid costs in the short run, even though doing so could ultimately force more seniors and people with disabilities into nursing homes, worsening their quality of life and raising long-term state costs. Ohio Governor John Kasich pointed to HCBS as one way he has managed the growth in Medicaid costs in his state, which has a highly successful Medicaid expansion.[32] The growing use of HCBS and other state Medicaid innovations would be at serious risk under Cassidy-Graham.[33]

Incentive Payments Demonstration Project Wouldn't Help States Maintain HCBS

Cassidy-Graham, like the Senate's Better Care Reconciliation Act, establishes a demonstration project allowing states to increase payments for HCBS. But the project would not fill the gap in federal funds left by the per capita cap and elimination of Medicaid expansion.

The new project would provide up to $8 billion from 2020 through 2023. States could use it to increase the rates they pay HCBS providers, but not to provide more HCBS. Moreover, not all states would receive the increased funds. States have to apply, and only some states would be selected, with priority given in competition for the funds to the 15 states with the lowest population density.

Also, states would be left on their own to maintain the increased payment rates after four years, which would become increasingly difficult as the cuts from the per capita cap continued to grow.

[31] Stephen Campbell, "The Impact of the Affordable Care Act on Health Coverage for Direct Care Workers," PHI, March 2017, https://phinational.org/research-reports/impact-affordable-care-act-health-coverage-direct-care-workers.

[32] CNN State of the Union interview, May 7, 2017.

[33] Judith Solomon, "Caps on Federal Medicaid Funding Would Give States Flexibility to Cut, Stymie Innovation," Center on Budget and Policy Priorities, January 18, 2017, http://www.cbpp.org/research/health/caps-on-federal-medicaid-funding-would-give-states-flexibility-to-cut-stymie

APPENDIX TABLE 1

Total Medicaid Home- and Community-Based Services Participants, by State

State	2013
Total	2,994,685
Alaska	9,291
Alabama	20,019
Arkansas	36,564
Arizona	40,364
California	440,841
Colorado	49,755
Connecticut	55,932
District of Columbia	12,432
Delaware	2,077
Florida	105,041
Georgia	56,694
Hawaii	4,691
Iowa	42,089
Idaho	18,435
Illinois	125,386
Indiana	44,313
Kansas	32,349
Kentucky	39,289
Louisiana	47,772
Massachusetts	76,751
Maryland	33,554
Maine	11,547
Michigan	102,810
Minnesota	103,268
Missouri	96,714
Mississippi	25,240
Montana	9,285
North Carolina	107,911
North Dakota	6,925
Nebraska	15,702
New Hampshire	11,692
New Jersey	65,022
New Mexico	26,642
Nevada	11,792

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Total Medicaid Home- and Community-Based Services Participants, by State

State	2013
New York	281,283
Ohio	139,520
Oklahoma	35,306
Oregon	46,196
Pennsylvania	92,225
Rhode Island	1,350
South Carolina	25,360
South Dakota	7,394
Tennessee	19,009
Texas	196,974
Utah	11,947
Virginia	44,557
Vermont	5,564
Washington	82,712
Wisconsin	91,054
West Virginia	21,195
Wyoming	4,850

NOTES: Data may not sum to total due to rounding. Total Medicaid HCBS comprises Medicaid home health state plan services, Medicaid personal care state plan services, and Medicaid § 1915(c) HCBS waivers. Arizona did not operate any § 1915(c) waivers over the study period because all HCBS were provided through a § 1115 managed care waiver. Hawaii transitioned all non-Intellectual/Developmental Disabilities (I/DD) § 1915(c) waiver participants to a § 1115 waiver in 2009. Rhode Island terminated its § 1915(c) waivers in mid-2009 and provided services under a § 1115 waiver. Vermont terminated its § 1915(c) waivers in 2006 and provided services under a § 1115 waiver.

SOURCES: Kaiser Commission on Medicaid and the Uninsured (KCMU) and compilation of University of California, San Francisco (UCSF) analyses of Medicaid Home Health and Personal Care Services Policy Surveys and Centers for Medicare and Medicaid Services (CMS) Form 372.

APPENDIX TABLE 2

State Variation in Medicaid Per Enrollee Spending for Seniors and People with Disabilities

	Spending per enrollee, fiscal year 2011		
State	Children with Disabilities	Non-Elderly Adults with Disabilities	Seniors
Alabama	$11,020	$9,903	$18,473
Alaska	$32,734	$28,151	$24,288
Arizona	$32,303	$19,300	$16,145
Arkansas	$14,317	$13,894	$20,484
California	$24,909	$19,268	$12,019
Colorado	$17,834	$20,045	$18,478
Connecticut	$17,273	$31,039	$30,560
Delaware	$20,091	$24,136	$27,666
DC	$21,952	$29,948	$27,336
Florida	$13,373	$15,584	$14,253
Georgia	$7,829	$11,475	$14,142
Hawaii	$21,472	$16,574	$18,439
Idaho	$23,073	$21,426	$15,558
Illinois	$12,534	$16,941	$11,431
Indiana	$14,827	$20,151	$21,269
Iowa	$21,263	$20,036	$21,163
Kansas	$14,282	$17,875	$18,328
Kentucky	$12,442	$12,954	$15,757
Louisiana	$11,264	$16,235	$15,491
Maine	$22,424	$16,270	$19,881
Maryland	$20,678	$24,415	$23,491
Massachusetts	$10,351	$19,146	$27,205
Michigan	$16,994	$14,784	$17,599
Minnesota	$25,425	$27,159	$25,030
Mississippi	$11,963	$13,260	$18,592
Missouri	$20,759	$17,370	$17,020
Montana	$21,203	$15,549	$26,704
Nebraska	$17,451	$17,449	$14,997
Nevada	$12,391	$16,762	$13,226
New Hampshire	$53,557	$21,313	$26,794
New Jersey	$18,759	$20,217	$19,160
New Mexico	$21,966	$17,661	N/A
New York	$20,082	$37,132	$28,336
North Carolina	$17,971	$14,403	$10,518

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State Variation in Medicaid Per Enrollee Spending for Seniors and People with Disabilities

State	Spending per enrollee, fiscal year 2011		
	Children with Disabilities	Non-Elderly Adults with Disabilities	Seniors
North Dakota	$18,360	$29,813	$31,155
Ohio	$15,499	$22,768	$27,494
Oklahoma	$14,460	$15,117	$12,315
Oregon	$18,737	$18,180	$24,253
Pennsylvania	$16,634	$16,372	$21,372
Rhode Island	$30,043	$19,588	$16,998
South Carolina	$13,366	$12,707	$12,256
South Dakota	$16,689	$19,816	$16,374
Tennessee	$6,945	$16,044	$15,745
Texas	$18,261	$17,503	$14,739
Utah	$21,683	$19,391	$11,763
Vermont	$42,030	$13,967	$14,258
Virginia	$15,418	$19,681	$16,367
Washington	$17,152	$16,072	$16,183
West Virginia	$14,045	$12,867	$23,243
Wisconsin	$9,950	$18,130	$16,344
Wyoming	$18,684	$26,830	$32,199
United States	$16,758	$18,912	$17,522

Notes: Spending per enrollee includes full benefit enrollees. All spending per-enrollee categories exclude those in Maine enrolled only in Q4 and seniors excludes New Mexico due to data quality issues.

Sources: Kaiser Family Foundation & Urban Institute estimates based on data from FY 2011 MSIS & CMS-64 reports. Because FY 2011 data were unavailable, FY 2010 data were used for Florida, Kansas, Maine, Maryland, Montana, New Mexico, New Jersey, Oklahoma, Texas, and Utah. KFF, Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015 (March, 2016). KFF, Medicaid Home and Community-Based Services Programs: 2013 Data Update (Oct. 2016). KFF, Medicaid Section 1115 Managed Long-Term Services and Supports Waivers: A Survey of Enrollment, Spending, and Program Policies (Jan. 2017). KFF, State Health Facts, Section 1915(k) Community First Choice State Plan Option (March 2016).

APPENDIX TABLE 3

State Variation in Medicaid Eligibility and Services for Seniors and People with Disabilities

	Optional Eligibility Pathways, 2015				Optional HCBS		
States	100% FPL	Katie Beckett or equiv. waiver	Work Dis. Buy In	LTC Special Income Rule	Pers. Care Serv., 2013	Sec. 1915 (i), 2015	CFC, 2016
Alabama		X		X			
Alaska		X	X	X	X		
Arizona	X	X	X	X			
Arkansas	X	X	X	X	X		
California	X	X	X		X	X	X
Colorado		X	X	X		X	
Connecticut		X	X	X		X	X
Delaware		X	X	X	X	X	
DC	X	X	X	X	X	X	
Florida	X	X		X	X	X	
Georgia		X	X	X			
Hawaii	X	X					
Idaho	X	X	X	X	X	X	
Illinois	X	X	X				
Indiana	X	X	X	X		X	
Iowa		X	X	X		X	
Kansas		X	X	X	X		
Kentucky		X	X	X			
Louisiana		X	X	X	X	X	
Maine	X	X	X	X	X		
Maryland		X	X	X	X	X	X
Massachusetts	X	X	X	X	X		
Michigan	X	X	X	X	X	X	

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	Optional Eligibility Pathways, 2015				Optional HCBS		
States	100% FPL	Katie Beckett or equiv. waiver	Work Dis. Buy In	LTC Special Income Rule	Pers. Care Serv., 2013	Sec. 1915 (i), 2015	CFC, 2016
Minnesota	X	X	X	X	X		
Mississippi		X	X	X		X	
Missouri		X		X	X		
Montana		X	X	X	X	X	X
Nebraska		X	X		X		
Nevada		X	X	X	X	X	
New Hampshire	X	X	X	X	X		
New Jersey	X	X	X	X	X		
New Mexico		X	X	X	X		
New York	X	X	X		X		X
North Carolina	X	X	X		X		
North Dakota		X	X		X		
Ohio		X	X	X		X	
Oklahoma	X	X		X	X		
Oregon		X	X	X	X	X	X
Pennsylvania	X	X	X	X			
Rhode Island	X	X	X	X	X		
South Carolina	X	X		X			
South Dakota		X	X	X	X		
Tennessee				X	X		
Texas		X	X	X			X
Utah	X	X	X	X	X		
Vermont		X	X	X	X		

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State Variation in Medicaid Eligibility and Services for Seniors and People with Disabilities

	Optional Eligibility Pathways, 2015				Optional HCBS		
States	100% FPL	Katie Beckett or equiv. waiver	Work Dis. Buy In	LTC Special Income Rule	Pers. Care Serv., 2013	Sec. 1915 (i), 2015	CFC, 2016
Virginia	X	X	X	X			
Washington		X	X	X	X		X
West Virginia		X	X	X	X		
Wisconsin	X	X	X	X	X		
Wyoming		X	X	X			
United States	21 States	50 States	44 States	44 States	32 States	17 States	8 States

Notes: **100% FPL:** States that have elected to increase Medicaid eligibility for seniors and people with disabilities with incomes above the SSI level (about 73 percent of the poverty line) up to 100 percent of the poverty line; **Katie Beckett:** States that disregard parental income in determining Medicaid eligibility for children with significant disabilities who live at home and would be Medicaid-eligible if institutionalized; **Buy-in:** States that allow people with disabilities who work and have incomes above Medicaid limits to buy into Medicaid; **LTC Special Income:** States that allow people in need of nursing facility level of care to qualify for Medicaid with incomes up to 300 percent of the SSI level (about 219 percent of the poverty line); **Personal Care Services:** States that have elected to provide personal care services, such as help getting dressed or bathing, in their Medicaid state plans; **1915(i):** States that have elected to provide home- and community-based services to a targeted population in their Medicaid state plans; **CFC:** States that have elected to provide comprehensive, alternative community-based rather than facility-based long-term services and supports.

Source: Kaiser Family Foundation & Urban Institute estimates based on data from FY 2011 MSIS & CMS-64 reports. Because FY 2011 data were unavailable, FY 2010 data were used for Florida, Kansas, Maine, Maryland, Montana, New Mexico, New Jersey, Oklahoma, Texas, and Utah. KFF, Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015 (March, 2016). KFF, Medicaid Home and Community-Based Services Programs: 2013 Data Update (Oct. 2016). KFF, Medicaid Section 1115 Managed Long-Term Services and Supports Waivers: A Survey of Enrollment, Spending, and Program Policies (Jan. 2017). KFF, State Health Facts, Section 1915(k) Community First Choice State Plan Option (March 2016).