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ISSUE BRIEF

Health Care on the Chopping Block: How Older Americans Will Suffer Under Senate Republicans' Proposal to Cap Medicaid Funding

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Eric Carlson
Directing Attorney, Justice in Aging

Natalie Kean
Staff Attorney, Justice in Aging

Executive Summary

Medicaid is a Vital and Efficient Program

The Medicaid program provides for medically necessary health care that low-income older Americans otherwise cannot afford. Over six million older Americans rely on Medicaid every year.[1] Medicaid coverage is particularly important for older persons who need services not covered—or not adequately covered—by Medicare. Specifically, Medicaid is vital for older persons who no longer can live independently. The long-term assistance that they need, whether provided at home or in a nursing home, can be covered by Medicaid but not by Medicare.

Medicaid programs combine federal and state funding. Federal Medicaid law sets certain basic standards, with state discretion to add additional services or eligibility categories. Also, Medicaid is a relatively efficient program. Data show that Medicaid provides coverage with a lesser per-person cost than Medicare or private insurance.

1 Molly O'Malley Watts et al., Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015, Figure 2 (Kaiser Family Foundation 2016), *available at* kff.org/medicaid/report/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015/.

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The Republican Senate Bill Will Harm State Medicaid Programs and Beneficiaries

Significant decreases in federal funding

Through the Better Care Reconciliation Act of 2017, Senate Republicans propose to impose a per capita cap on federal Medicaid payments. Starting in 2020, federal Medicaid payments to a state would be limited by a cap based on two previous years of federal Medicaid payments to the state, as adjusted upward by specified inflation rates. Data show that, if such a capped system had been in place in recent years, it

would have caused significant decreases in Medicaid funding for states. Even under inflationary rates more favorable to states, by the eighth year of the program, 28 states would have exceeded the state's cap, causing a reduction of the federal contribution in an amount equivalent to 11% of total state Medicaid spending. If each state had replaced the lost federal funding with state monies, four states would have had to increase their spending by over 40%, with one state facing a 77% increase.

Unfairness of capped funding system

For at least four reasons, such a cap system would lead to unfair reductions in a state's Medicaid funding, which in turn would deprive low-income older Americans of needed health care.

1. **Funding based on a pre-set cap rather than on medical necessity.** Like Medicare and other health insurance programs, Medicaid covers health care needs based on medical necessity. Under the Senate Republican bill, however, medical necessity often would be superseded by financial considerations, as the capped federal reimbursement would require states to impose significant cuts on eligibility, coverage, or both. Due to the capped funding, federal Medicaid funding often will be insufficient to meet beneficiaries' needs, which will result in states denying coverage for medically necessary services.

2. **One-sidedness to the detriment of state Medicaid programs.** The bill's proposed cap structure is more unfair than even a fixed allocation of money would be. Assume that a state overspends its cap by $5 billion in one year, but underspends by $5 billion the following year. Under the Senate bill, the state will be required to pay back the $5 billion for overspending, but will not receive any credit for underspending.

   Due to this same feature—use of a cap rather than an allocation—states will be penalized even if the cap's inflation rate is identical to the actual national rate of health care inflation. Because health care inflation rates vary from state to state, some states' health care expenses will increase faster than the national rate of inflation, while other states' expenses will increase at a slower rate. Under the bill's cap mechanism, the higher-inflation states will suffer a financial penalty, while the lower-inflation states will receive no benefit for spending under the cap.

3. **Preventing state Medicaid programs from making necessary improvements.** By using previous years' Medicaid expenses as a base for the cap, the Senate bill implicitly assumes that the state's expenses during those two years were in the proper proportion. This assumption, however, may well be incorrect. Payments in excess of the cap may *not* indicate extravagance or inefficiency, and instead may indicate a state's process to bring its Medicaid program up to current standards. Data support this observation: if a cap like that proposed in the bill had been in place from 2000 to 2011, much of its financial penalty would have been imposed on states that started that period with relatively low per-beneficiary spending.

4. **Failure to account for rising health care needs of aging population.** The cap system fails to account for the aging of a state's beneficiary population. Consider a state's "aged" eligibility category, comprised of persons age 65 or older. This eligibility group may have an average age of 75 (for example) during the base year, but an average age of 85 in a subsequent year, due to a different proportion of beneficiaries. The group with the average older age will almost certainly have greater health care needs, given the clear correlation between advanced age and health care needs, but the cap on funding will not take this change into account. Such a state would suffer unfair financial penalty due to the natural and expected aging of its population.

Likely cuts to state Medicaid programs

Of course, the greatest harm ultimately will fall on low-income persons who rely on Medicaid for health care. The bill's cap structure guarantees that states will have insufficient funding, and states almost certainly will react to insufficient funding by cutting their Medicaid programs. Older Americans in particular could expect to see the following three reductions in state Medicaid coverage.

1. **Cuts in Optional Eligibility and Services.** Federal Medicaid law distinguishes between mandatory and optional eligibility groups, and mandatory and optional services. Over two-thirds of Medicaid spending is for a service that is "optional" under the law—either because it is provided to a person in an optional coverage group, or is an optional service, or both. Notably, the vast majority of nursing home residents are covered through an optional eligibility group. Also, all home and community-based services are considered optional services.

2. **Limiting Home and Community-Based Services.** As mentioned immediately above, home and community-based services (HCBS) are optional services. Also, Medicaid law authorizes states to limit HCBS to certain areas of the state, or to cap enrollment at a set level. A state looking to shed Medicaid expenses likely will impose some or all of these limitations on its HCBS programs, resulting in elimination of programs, geographic limitations, and/or waiting lists.

3. **Decreased Access to Health Care Providers.** In order to cut expenses, state Medicaid programs also are likely to reduce reimbursement rates paid to health care providers. Because Medicaid rates already are low in comparison to other reimbursement sources, these reductions will drive some providers from the Medicaid program, and cause others to accept fewer Medicaid beneficiaries.

Health Insurance Should Cover Services Based on Medical Necessity

Like Medicare and other health insurance programs, Medicaid covers services based on medical necessity. In evaluating whether a service can be covered, the first question is whether the program offers the service. The second question is whether the beneficiary needs the service, based on physician recommendations and other medical considerations. If the answer to both questions is "yes," the program covers the service, and the federal and state governments are obligated to provide the necessary funding.

Everything changes, however, in a rationing system, such as the capped reimbursement system being proposed currently by Senate Republicans. In these systems, the financing drives service authorization, rather than the reverse. More specifically, if the system is designed with a set limit on overall expenditures, the limit has a significant negative effect on individual coverage determinations. A service might be medically necessary and yet nonetheless be denied, or technically "covered" but at an insufficient duration or reimbursement level.

Senate Republicans are proposing that federal Medicaid funding be subject to a per capita cap—a funding limit based on a per-person allocation of funds. Under such a cap, the federal government provides its typical contribution towards the total cost only if total Medicaid expenses have not exceeded an overall cap calculated from the per-person allocation. Once total expenses reach the cap, however, the federal government no longer contributes. The state government bears complete financial responsibility for all expenses exceeding the cap.

This issue brief focuses on the negative impact of a capped reimbursement system. As explained below, such a system would have a particularly harsh impact on older Americans, many of whom rely on Medicaid for at-home assistance or nursing home care.

Medicaid Protects Low-Income Older Americans

Medicaid covers vital health care that persons otherwise cannot afford

The Medicaid program provides health care coverage to low-income persons who otherwise cannot afford needed health care services. One path to eligibility is age—specifically, being age 65 or older. Currently over six million older Americans are Medicaid-eligible nationwide.[2]

These older persons can be eligible for Medicaid coverage if their savings are extremely low—no more than

2 Watts et al., *supra* note 1, at Figure 2.

$2,000 in many states, for example. Income also is relevant, because Medicaid rules allow beneficiaries to have income only up to a specified amount. This amount varies from state to state, but often is tied to the federal poverty level.

Medicaid—not Medicare—provides services when older adults no longer can live independently

In addition to Medicaid, the Medicare program also provides health care coverage for older Americans. Medicare coverage does not require limited savings or income; instead, Medicare eligibility requires sufficient years of work (with payroll contributions to the Medicare program) from the person or the person's spouse.

Although the Medicare program provides strong coverage in many ways, it also has significant holes. One major gap is Medicare's extremely limited coverage for services needed when someone no longer can live independently. The Medicare program focuses nearly exclusively on acute care services, and provides very limited assistance for long-term services and supports such as assistance with activities of daily living.

Mrs. Rodriguez has Alzheimer's disease, and needs several daily hours of assistance in order to dress, bathe, and eat. Federal Medicaid law gives states the option of developing programs to provide the assistance Mrs. Rodriquez needs at home. Through established channels such as home and community-based waiver programs, states can provide personal care services and assistance for family caregivers. By contrast, the Medicare program has no mechanism to provide the needed assistance.

The same discrepancy is present when necessary services are provided in a nursing home. The Medicare program pays for nursing home services under extremely limited conditions: only when those services are a follow-up to acute-care hospitalization, only when the person is receiving heightened nursing or rehabilitative services and, in any case, only for a maximum of 100 days. Medicaid, on the other hand, can cover nursing home services indefinitely, with the recognition that the person no longer is able to live independently at home and cannot afford to pay privately for the necessary care. Nursing home care on average costs over $82,000 annually,[3] and few persons can afford this level of expense on an ongoing basis. As a result, 63% percent of nursing home residents are Medicaid-eligible.[4]

Medicaid is an Efficient Joint Federal/State Program

Medicaid programs combine federal and state funding

Medicaid programs operate with a combination of federal and state funds. Under current law, federal funding is based on the number of Medicaid beneficiaries and their needs. Each state Medicaid program offers the services required by federal Medicaid law, along with whatever optional services that state wishes to offer. Beneficiaries then are covered for the specified services as long as the services are prescribed by a physician (as necessary), determined to be medically necessary by the Medicaid program, and provided by a certified person or entity. The federal government covers a specified percentage of the total cost, and the state is responsible for the remainder.

All told, the federal government pays for 63% of total Medicaid expenses.[5] For most Medicaid services, the

3 Genworth Cost of Care Survey, *available at* genworth.com/about-us/industry-expertise/cost-of-care.html.

4 Charlene Harrington & Helen Carrillo, Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2014, at 1, 8 (Kaiser Family Foundation 2015), *available at* kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2014/.

5 Office of the Actuary, Centers for Medicare & Medicaid Services. 2016 Actuarial Report on The Financial Outlook for Medicaid, at page iii, *available at* cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf.

federal contribution rages from 50% to 74.63% of the total, depending on the state's average personal income.[6] Those states with the highest average personal incomes receive the 50% federal contribution; those states with lower average incomes receive a greater percentage contribution. A separate federal matching rate applies in the case of the Medicaid "expansion" population, i.e., those low-income persons under age 65 who obtained eligibility through 2010's Affordable Care Act. For "expansion" Medicaid, the federal government currently covers 95% of the cost; this amount is scheduled to decrease to 94% in 2018, 93% in 2019, and then 90% in 2020 and subsequent years.[7]

Federal Medicaid law sets certain basic standards, with states having discretion to add additional services or eligibility categories

State Medicaid programs must follow certain mandatory standards set by federal statute and regulation. Beyond those mandatory standards, however, state Medicaid programs have significant discretion to individualize their programs to address a state's needs and preferences. Each state develops a detailed state Medicaid plan, and then revises that plan as necessary to respond to changed conditions. The state plan must be approved by the federal government, to ensure compliance with the federal minimum requirements.

For example, certain Medicaid services are mandatory—these include inpatient and outpatient hospital services, physician services, rural health clinic services, and nursing home services. Certain other services are optional—these include private duty nursing services, physical therapy, and dental services. A state adopts an optional service by making the choice in the state plan.

Likewise, certain eligibility categories are mandatory, while others are optional. For example, a state Medicaid program must provide coverage to older Americans who are eligible for Supplemental Security Income (SSI), but has the option of providing coverage for older Americans with incomes up to the federal poverty level.[8] A state makes these choices in its Medicaid state plan. Importantly, the current design of the Medicaid program encourages states to expand eligibility and provide optional services because federal matching funds are available for both mandatory and optional services.

Medicaid is an efficient program

The Centers for Medicare & Medicaid Services (CMS) states the matter simply: "Medicaid is the most efficient health coverage program we have, covering people at lower cost than commercial insurance coverage or even Medicare."[9] For example, CMS and state Medicaid programs have worked together in recent years to increase automation and streamline eligibility determinations and enrollment.[10]

Data support the claim that Medicaid dollars are spent productively. One national study found that Medicaid per-beneficiary spending was 22% less expensive than comparable coverage in an employer-sponsored plan.[11] Similarly, Medicaid expenses have shown lesser growth rates: from 1999 to 2014, Medicaid per-beneficiary spending increased relatively slowly, as compared to spending in Medicare or private insurance.[12] Furthermore, in a report to Congress, MACPAC forecast that Medicaid's growth rate would continue to be relatively lower through at least 2023.[13]

6 80 Fed. Reg. 73,779 (2015).

7 42 U.S.C. § 1396d(y)(1).

8 For a single individual, the current SSI rate is $735 monthly, and the current federal poverty level is $1,005 monthly.

9 CMS, Medicaid & CHIP: Strengthening Coverage, Improving Health (Jan. 2017), at 3, *available at* medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf.

10 Strengthening Coverage, *supra* note 9, at 8.

11 Teresa A. Coughlin et al., What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults, at 7 (Kaiser Family Foundation May 2013) ($6,052 per beneficiary for Medicaid; $7,752 for employer-sponsored insurance), *available at* kff.org/medicaid/issue-brief/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and-financial-protection-under-medicaid-for-low-income-adults/.

12 MACPAC, Report to Congress on Medicaid and CHIP, Ch. 1 (Trends in Medicaid Spending), at 8 (June 2016), *available at* macpac.gov/wp-content/uploads/2016/06/June-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

13 MACPAC, *supra* note 12, at 9.

Capped Funding Will Unfairly Reduce Funding for State Medicaid Programs

Senate Republicans propose to ration Medicaid-funded health care by imposing a cap based on a per-person allocation

On June 22, 2017, Senate Republicans released the "Better Care Reconciliation Act of 2017." The bill copy was described as a "discussion draft" to replace the American Health Care Act, H.R. 1628.

The Senate bill contains a multiplicity of provisions relating to health care, including dramatic changes to the insurance markets established by 2010's Affordable Care Act,[14] and the elimination of the enhanced federal contribution rate for the Medicaid "expansion" population, i.e., low-income adults under age 65 who previously did not have a route to Medicaid eligibility. [15] This issue brief focuses on one particularly harmful proposal in the Senate Republican bill—the imposition of a per capita cap on federal Medicaid funding.[16] The proposed funding cap will starve state Medicaid programs financially, forcing states to eliminate or limit vital health care coverage.[17]

Under the Senate bill, federal Medicaid funding would be subject to a per capita cap beginning in 2020. The cap would be calculated based on five beneficiary categories:

- Persons over 65 years old;
- Adults with disabilities;
- Children (excluding children with disability-based eligibility);
- Adults who obtained Medicaid eligibility through Medicaid expansion; and
- Other adults.

For each of these categories, the "cap" allocation would be based on per-person annual health care expenditures for a state-selected two-year period (eight consecutive quarters) within the period from the first quarter of 2014 through the third quarter of 2017.[18] This initial baseline spending amount would be increased pursuant to the consumer price index for medical care to create a baseline spending amount for 2019.[19] Then, for the actual Medicaid payments made in years from 2020 through 2024, this inflationary rate would be increased by one percentage point for two of the categories: persons over 65 years old, and adults with disabilities.[20] From 2025 and thereafter, however, the inflationary rate for each category would be reduced to the overall consumer price index, instead of the medical care consumer price index or (in the case of older persons, or adults with disabilities) the medical care consumer price index plus one percentage point.[21]

The cap allocation for each year would be the per-person allocation for each category, multiplied by the number of persons in the category. The total allocation for the system would be the sum of the allocations for each of the five categories.[22] The table below demonstrates how a cap would be calculated, using representative data from a fictional state.

14 Better Care Reconciliation Act, tit. I, §§ 101- 106; *see* Affordable Care Act, Pub. Law 111-148, tit. I, §§ 1001- 1563 (2010).
15 Better Care Reconciliation Act, tit. I, § 126; *see* Affordable Care Act, Pub. Law 111-148, tit. I, §§ 2001- 2002.
16 Better Care Reconciliation Act, tit. I, § 133.
17 Better Care Reconciliation Act, tit. I, § 133.
18 Better Care Reconciliation Act, tit. I, § 133 (to be codified as Section 1903A(a)(5)(A) of the Social Security Act).
19 The bill describes this index as "the percentage increase in the medical care component of the consumer price index for all urban consumers." Better Care Reconciliation Act, tit. I, § 133 (to be codified as Section 1903A(d)(2)(B) of the Social Security Act).
20 Better Care Reconciliation Act, tit. I, § 133 (to be codified as Section 1903A(c)(3)(A) of the Social Security Act).
21 Better Care Reconciliation Act, tit. I, § 133 (to be codified as Section 1903A(c)(3)(B) of the Social Security Act).
22 Better Care Reconciliation Act, tit. I, § 133 (to be codified as Section 1903A(c)(1) of the Social Security Act).

Table 1

Calculation of Cap Amount for Fictional State[23]

Beneficiary Category	# of Persons in Category	Annual Per-Person Cap for Category	Total Cap Amount for Category
Over 65 Years Old	125,000	$20,000	$2.5 billion
Persons with Disabilities	200,000	$30,000	$6.0 billion
Children	600,000	$4,000	$2.4 billion
Adults with Eligibility Through Affordable Care Act	250,000	$6,000	$1.5 billion
Other Adults	300,000	$6,000	$1.8 billion
Total Spending Cap for State			**$14.2 billion**

Assume that the state's Medicaid program spent $15.2 billion dollars, exceeding the cap by $1 billion. Assume also a 60% match rate, i.e., that the federal government contributes 60¢ of every Medicaid dollar spent in this state. In this case, the federal share of the "excess" spending would be $600 million, and the federal government would recover this $600 million from the state in the following year. Since the Senate bill calls for federal recoupment on a quarterly basis, federal reimbursement would be reduced by $150 million each quarter.[24]

The Senate bill will dramatically shrink federal support for Medicaid

The Senate bill is a modification of the American Health Care Act (AHCA), which was approved by the House of Representatives on May 4, 2017.[25] AHCA's Medicaid provisions were very similar to the Medicaid provisions of the Senate bill, with two notable exceptions: 1) AHCA had a baseline year of 2016 (rather than eight consecutive quarters from 2014 through three quarters of 2017), and 2) the Senate bill, but not AHCA, lowers the inflationary rate to the overall consumer price index for 2025 and subsequent years.[26] This last difference in particular makes the Senate bill more punishing financially to state Medicaid programs.

The Congressional Budget Office (CBO) estimated AHCA's impact on Medicaid, including ramifications of the per capita cap, the proposed elimination of the enhanced contribution rate for the "expansion" eligibility category, and the several other Medicaid-related provisions in the legislation. Overall, the CBO estimated that AHCA would cause federal Medicaid spending to decrease by $150 billion in 2026, representing a decrease of 24%.[27] Total federal Medicaid spending for the ten-year period from 2017 to 2026 would decrease by $834 billion.[28] Cuts of that magnitude cannot be absorbed by providing services with greater efficiency, and instead would require dramatic reductions in the availability of health care for older Americans and other Medicaid beneficiaries.

In a recent study, the Brookings Institution and the USC Schaeffer Center for Health Policy & Economics examined the effect of AHCA's proposed Medicaid per capita cap. Using data on past Medicaid spending, the study considered how actual Medicaid funding would have been affected if AHCA had been in effect during the relevant

23 This table is adapted from a substantially similar table used in a report from The Brookings Institution and the USC Schaeffer Ctr. for Health Policy & Economics. *See* Loren Adler et al., Effects of the Medicaid Per Capital Cap Included in the House-Passed American Health Care Act, at 3-4 (Brookings Institution & USC Schaeffer Ctr. May 2017), *available at* brookings.edu/wp-content/uploads/2017/05/es_chp_medicaidpercapitacap_adlerfiedlergronniger_51017.pdf.

24 Better Care Reconciliation Act, tit. I, § 133 (to be codified as Section 1903A(a)(1) of the Social Security Act).

25 H.R. 1628, 115th Cong. (2017).

26 H.R. 1628, tit. I, subtit. C, § 121 (to be codified as Section 1903A(c)(3)(inflation rate), (d)(1) (baseline spending amount) of the Social Security Act).

27 CBO, Cost Estimate for H.R. 1628 (second report), at 13 and Table 3 (May 24, 2017). The CBO's first cost estimate for H.R. 1628 stated that a decrease of $155 billion represented a percentage decrease of 25%. Thus, a decrease of $150 billion translates to a percentage decrease of 24% (155 X 4 = 620; 150 ÷ 620 = 24.19%, which is rounded down to 24%). CBO, Cost Estimate for H.R. 1628 (first report), at 9 and Table 3 (March 13, 2017).

28 CBO, Cost Estimate for H.R. 1628 (second report), at 13 and Table 3 (May 24, 2017).

years. The study used a baseline year of 2000 (rather than AHCA's baseline year of 2016) and start date in 2004 (rather than AHCA's start date in 2020). The data showed that 28 states would have exceeded the state's cap in 2011, causing a reduction of the federal contribution in an amount equivalent to 11% of total state Medicaid spending. Of the states subject to a reduction in federal funding, the median state would have been required to increase its Medicaid spending by 19% to compensate for the reduced federal funding. Four states would have had to increase their spending by over 40%, with one state facing an increase of 77%.[29]

In addition, as discussed above, the Senate Bill is more punitive towards state Medicaid programs and Medicaid beneficiaries, given the lower inflationary rate that would be in effect from 2025 onwards. The Urban Institute has published an initial examination of how the lower inflationary rate would affect state Medicaid programs. The study looked at the period from 2019 through 2028, comparing federal Medicaid spending under AHCA to federal Medicaid spending with a spending cap tied to the overall consumer price index. In 2020, use of the overall consumer price index would reduce federal Medicaid spending by $18.6 billion *from its level under AHCA*. By 2028, this annual reduction would increase to $63.7 billion and would increase even further in subsequent years.[30]

The Senate bill's per capita cap would inflict perverse penalties on states and their citizens

In at least four ways, the Senate bill's per capita cap would inflict perverse and inappropriate penalties on states and their citizens. First, a cap ties health care coverage decisions to a fixed allocation of funds, rather than to medical necessity. Second, a cap will penalize approximately half the states even if the cap's inflationary rate would accurately reflect the nation's health care costs. Third, a cap is more likely to penalize states with growing rates of health care costs, and those states may well be in the process of building up previously deficient Medicaid programs. Fourth, a cap does not account for differences within an eligibility category—most prominently, differences in health care needs in the older-than-65 category between (for example) 70-year-old persons and 90-year-old persons.

Not based on medical necessity

The first problem has been discussed above in more detail. Historically, Medicaid, like Medicare and private health insurance programs, has authorized services based on medical necessity. A per capita cap is an unwelcome move towards a rationing system where medical need is overridden by external spending limits.

One-sidedness

The second problem stems from the one-sidedness of the per capita cap system—specifically, from the fact that the per capita amount is assessed as a cap rather than an allotment. If the designated amount were implemented as an allotment, rather than a cap, a state would enjoy savings when it spent less than the allotment, but suffer financial consequences when it spent over the allotment. Under a cap, however, the state receives no benefit from spending under the cap, but nonetheless is penalized when spending over the cap.[31]

Due to the cap system's one-sidedness, many states will suffer financial consequences even if the system were to use an inflationary rate that accurately reflects the nationwide increase in Medicaid costs. The national rate incorporates state inflationary rates, some of which may be lower, and some of which may be higher. Under the Senate bill's cap system, in such a situation, the low-inflation states receive no benefit from their relatively low spending rates, while the higher-inflation states are penalized for their "excessive" spending.[32]

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29 Adler et al., *supra* note 23, at 8.

30 Matthew Buettgens, Senate Health Bill Would Lower the Medicaid Per Capita Cap Rate, Causing Greater State Budget Shortfalls (Urban Institute June 21, 2017), *available at* urban.org/urban-wire/senate-health-bill-could-lower-medicaid-capita-cap-rate-causing-greater-state-budget-shortfalls.

31 Adler et al., *supra* note 23, at 4-5.

32 *See, e.g.*, Rachel Garfield et al., Data Note: What if Per Enrollee Medicaid Spending Growth Had Been Limited to CPI-M from 2001-2011?, at 6 (Kaiser Family Foundation March 2017).), *available at* kff.org/medicaid/issue-brief/data-note-what-if-per-enrollee-medicaid-spending-growth-had-been-limited-to-cpi-m-from-2001-2011/.

Historical data show how these state variances lead to unfair financial penalties. If an accurate national inflationary rate was used from 2000 to 2011 to develop per capita caps for 2011, Medicaid funding regardless would have been cut by $15.3 billion in 2011. Furthermore, 25 states would have been subject to financial penalty for incurring "excessive" Medicaid expenditures.[33]

Tying spending to baseline that may not be appropriate

The third problem results from the Senate bill's implicit assumption that rising Medicaid expenditures indicate overspending. In fact, in a good number of instances, a state's growing Medicaid expenditures may be something to celebrate rather than punish. In the previously-discussed study that looked retrospectively at Medicaid expenditures, increased spending rates were more often seen in states that had started with relatively low expenditure rates. Data showed that, in 2011, Medicaid programs nationwide would have exceeded spending caps by $30.8 billion. Of this, $26.6 billion (86%) was spent in states that originally had been below the median in state Medicaid spending, with the remaining $4.2 billion (14%) spent in states above the median. As the report points out, it "is hard to justify" a system that concentrates spending reductions on states that started with lower per-beneficiary expenses.[34] That is one drawback of implementing a system that implicitly concludes that the "right" rate of spending is the rate from 2000 (in the case of the study), 2016 (in the case of AHCA), or a recent two-year period (Senate bill).

Failure to account for greater health care needs of older persons

Finally, the fourth problem is that the Senate bill's per capita cap fails to recognize how increasing age corresponds to a greater need for health care. In 2011, for example, persons aged 85 and over incurred average Medicaid costs that were 2.5 times higher than the average costs incurred by beneficiaries aged 65 to 74.[35]

Assume that a state currently has a large percentage of Medicaid beneficiaries in their early 70s. The base rate for that state will be weighted heavily towards the average health care needs of persons in their 70s, and that weighing will affect the cap amounts imposed in 2027, when the large group of beneficiaries will be in their early 80s — with different and more extensive needs for health care. Notably, such a shift in population from the young-old to the old-old is more likely than not, given the overall aging of America's population. From 2025 and 2035, approximately two-thirds of the states will experience a rise in the share of seniors who are 85 and older. In most cases, the increase will be at least 25%.[36]

The Senate Bill, if Enacted, Will Harm Low-Income Older Americans

Cuts in federal reimbursement will lead states to cut back their Medicaid programs

As discussed above, the Senate bill's per capita caps will lead to significant reductions in federal Medicaid spending. What will states do in response? The principal options are either to replace the federal monies with state funds or to shrink state Medicaid programs. The second option is by far the most likely. State budgets are generally tight, and Medicaid already accounts for a significant percentage of state expenditures.[37] Note also that a state's "extra" dollar would be relatively less effective in the absence of a federal match. In a state with a 60% match rate, for example, the federal government contributes $1.50 for every state dollar, resulting in a combined contribution of

33 Adler et al., *supra* note 23, at 15-17.

34 Adler et al., *supra* note 23, at 11-12.

35 Judith Solomon & Jessica Schubel, Medicaid Cuts in House ACA Repeal Bill Would Limit Availability of Home- and Community-Based Services, at 8 (Ctr. on Budget & Policy Priorities May 18, 2017), *available at* cbpp.org/research/health/medicaid-cuts-in-house-aca-repeal-bill-would-limit-availability-of-home-and.

36 Solomon & Schubel, *supra* note 35, at 8-9.

37 *See, e.g.*, Adler et al., *supra* note 23, at 6; Allison Valentine et al., Implications of Reduced Federal Medicaid Funds: How Could States Fill the Funding Gap? (Kaiser Family Foundation May 2017), *available at* kff.org/medicaid/issue-brief/implications-of-reduced-federal-medicaid-funds-how-could-states-fill-the-funding-gap; CBO, Cost Estimate for H.R. 1628 (first report), at 10-11 (March 13, 2017).

$2.50.[38] Once the cap is reached, however, the state's "extra" dollar is not matched, and thus will not go nearly as far as the state's earlier matched dollars.[39]

All of these factors are exacerbated by a basic political reality: low-income persons like Medicaid beneficiaries often have relatively limited political power. As a result, the Senate bill inevitably would result in real-world harm to low-income older Americans. As discussed below, they likely would lose coverage and have access to fewer services.

Loss of eligibility and services

Medicaid beneficiaries will lose coverage

Current federal Medicaid law requires coverage of certain low-income populations. For older Americans, one mandatory coverage group includes those persons who have monthly incomes of no more than $735 and available assets of no more than $2,000, and who thus are eligible for Supplemental Security Income (SSI). Another mandatory eligible group includes persons with slightly higher incomes who are eligible for a State Supplementary Payment (only certain states offer SSP).

In general, persons with higher incomes are eligible only through optional Medicaid programs. Significantly, this includes the vast majority of the over 850,000 persons who receive Medicaid-funded nursing home care.[40] A nursing home resident is eligible for SSI (and automatic Medicaid) only if he or she has countable monthly income of $30 or less.[41] As a result, nursing home residents almost never receive Medicaid eligibility through the SSI eligibility route. Instead, they obtain coverage under the optional Medicaid categories of "would be eligible for SSI if living outside of a nursing home"[42] and "living in a nursing home and having income below a 'special income limit.'"[43] In some states, eligibility instead is obtained through the optional "medically needy" program, which is based on the older person having health care expenses that outstrip his or her ability to pay, based on monthly income.[44]

Similarly at risk are those older Americans receiving Medicaid home and community-based services (HCBS). These are services that provide an alternative to nursing home care; HCBS programs commonly pay for assistance with dressing and bathing, for meal services, for home modifications, and for similar services that give some older persons the support they need to remain in their homes. As discussed below, HCBS programs themselves are optional. In addition, HCBS beneficiaries generally obtain eligibility through the optional eligibility category of "would be eligible if residing instead in a nursing home."[45]

All of these persons in these optional categories would be at risk under the Senate bill. Nursing home care and HCBS are indisputably vital to vulnerable older Americans, but these services also represent a considerable expense. Nationally, over 850,000 persons receive Medicaid-funded nursing home care,[46] and almost 3 million persons receive HCBS.[47] State Medicaid programs incur annual expenses exceeding $43 billion and $61 billion, respectively, to fund these vital services.[48] Under the Senate bill, unfortunately, the financial pressure on states might well lead those

38 100/250 = .40.

39 *See, e.g.*, Adler et al., *supra* note 23, at 6.

40 Medicaid's Role in Nursing Home Care, at 1 (Kaiser Family Foundation June 2017) (1.4 million nursing home residents, 62% of residents covered by Medicaid; 1.4 million X 62% = 868,000), *available at* files.kff.org/attachment/Infographic-Medicaids-Role-in-Nursing-Home-Care.

41 42 U.S.C. § 1382(e)(1)(B)(i); 20 C.F.R. § 416.414(b)(1).

42 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(IV), 1396b(f)(4)(C).

43 42 U.S.C. § 1396a(a)(10)(A)(ii)(V).

44 42 U.S.C. § 1396a(a)(10)(C).

45 42 U.S.C. § 1396a(a)(10)(A)(ii)(VI).

46 Medicaid's Role in Nursing Home Care, *supra* note 39, at 1.

47 These services include home health services, personal care services, and home and community-based waiver services. Terence Ng & Charlene Harrington, Medicaid Home and Community-Based Services Program: 2013 Data Update, at 1 (Kaiser Family Foundation 2016), *available at* kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/.

48 Distribution of Fee-for-Service Medicaid Spending on Long-Term Care (Kaiser Family Foundation FY 2016 data), *available at* kff.org/medicaid/state-indicator/spending-on-long-tercare/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. This data understates total spending, because it includes only fee-for-service Medicaid spending and thus does

states to deny eligibility to these vulnerable Medicaid beneficiaries, regardless of their indisputably meager financial resources and lack of options.

Enrollment data illustrate the danger to older Americans. In 2013, 6.8 million persons received Medicaid based on age. For 2.2 million of these persons (32%), eligibility was derived from an optional eligibility category.[49] Furthermore, 69.9 percent of incurred expenses were optional under federal Medicaid law, as shown in Table 2. Thus, more than two-thirds of spending for older Americans is vulnerable to whatever cuts states would be compelled to make under the Senate bill's proposed cap system.

Table 2

Medicaid Spending, Mandatory v. Optional, for Persons of Age 65 or More (Fiscal Year 2013)[50]

Mandatory v. Optional	Spending (billions of $)	% of Total Spending
Mandatory Eligibility & Mandatory Service	29.8	32.2%
Mandatory Eligibility & Optional Service	17.7	19.1%
Optional Eligibility and Mandatory Service	18.1	19.6%
Optional Eligibility and Optional Service	27	29.2%
Total	**92.6**	**32.2% Mandatory 67.9% Optional***

*Due to a rounding discrepancy, the percentages total to 100.1%.

States will eliminate or limit the home and community-based services that allow older Americans to stay at home

As discussed above, home and community-based services are an optional Medicaid benefit that enables older adults and people with disabilities to remain in their homes rather than moving into a nursing home or other institution. CMS has been encouraging states to provide more home-based care for their most vulnerable older citizens, and providing the matching funds to make that possible. From 1995 to 2014, the ratio of HCBS expenditures to total long-term services and supports expenditures (including home expenses) leaped from 18% to 53%.[51] In 2013, almost three million Medicaid beneficiaries received HCBS, with a total expenditure of over $56 billion.[52]

However, under the Senate bill's dramatic funding cuts, states will be under tremendous pressure to reduce such services or tighten eligibility criteria to serve fewer people. As described above, states might eliminate the optional eligibility categories that give older persons access both to HCBS and to other Medicaid-funded services. A state might also choose to eliminate other optional benefits, such as home health care, dental services, or physical therapy.[53]

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not include Medicaid spending made through managed care organizations.

49 Martha Heberlein, Analysis of Mandatory and Optional Populations and Benefits, at 9 (MACPAC April 21, 2017), *available at* macpac.gov/wp-content/uploads/2017/04/Review-of-June-Report-Chapter-Analysis-of-Mandatory-and-Optional-Populations-and-Benefits.pdf.

50 Heberlein, *supra* note 49, at 12.

51 Steve Eiken et al., Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014 (Truven Health Analytics April 15, 2016), *available at* medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf.

52 These services include home health services, personal care services, and home and community-based waiver services. Ng & Harrington, *supra* note 47, at 1.

53 42 U.S.C. § 1396d(a)(7) (home health care for persons not needing nursing home care), (10) (dental services), (11) (physical

Alternatively, states might well impose enrollment caps on their HCBS programs. A general Medicaid rule requires that a Medicaid service be available to all Medicaid beneficiaries who meet eligibility standards.[54] HCBS programs, however, generally operate under a waiver of this rule, allowing enrollment for a program to be capped at a particular level, or limited to a certain area of the state.[55]

This category encompasses a significant percentage of the total expenses spent for older Medicaid beneficiaries. As set forth above in Table 2, Medicaid programs in 2013 spent a total of $92.6 billion for older beneficiaries. Of that amount, $28.4 billion (30.1%) was spent on optional long-term services and supports, a category including home and community-based services as well as nursing home services provided to persons in optional eligibility categories.[56]

Access to services will be diminished by inadequate provider rates

When faced with inadequate federal support, one option for a state Medicaid program is reducing the rates paid to doctors, nursing homes, and other health care providers.[57] Federal Medicaid law obligates state Medicaid programs to pay a rate sufficient to attract an adequate number of health care providers,[58] but providers frequently complain that rates fall short.[59]

As discussed above, the Senate bill will shave billions of dollars from state Medicaid budgets. State budgetary pressures, which already push down Medicaid reimbursement rates, will be even more likely to result in inadequate rates, which in turn will result in providers leaving the Medicaid program or limiting their acceptance of Medicaid beneficiaries. Consequently, many beneficiaries will not have access to services, or will confront an extremely limited choice of providers.

Conclusion

The Medicaid program is over fifty years old. Its current structure reflects decades of modifications, and a relatively nuanced balancing of consumer and provider needs, along with federal and state budgetary realities.

Up to this point, Medicaid service authorization has been based primarily on medical necessity. Under the Republican Senate bill, however, medical necessity often will be overridden by the bill's funding cap, which will force states to cut back on eligibility or services, or both. Many older Americans will be forced to move out of their homes, as states cut the home and community-based services programs that, while "optional" under Medicaid law, are vital to beneficiaries' health and dignity.

As discussed above, the Senate bill's per capita cap is a flawed concept. Congress should discard the idea of per capita caps, and instead focus on ways of strengthening state Medicaid programs, rather than financially starving them.

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therapy).

54 42 U.S.C. § 1396a(a)(1), (10)(B).

55 42 U.S.C. § 1396n(c)(3).

56 Heberlein, *supra* note 49, at 14.

57 CBO, Cost Estimate for H.R. 1628 (first report), at 11 (March 13, 2017).

58 Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67,575 (2015).

59 *See, e.g.*, Settlement Agreement, Florida Pediatric Society v. Dudek, Case No. 05-23037-CIV (S.D. Fla. April 2016) (settling claims alleging inadequate reimbursement rates for Medicaid-funded services for children); Armstrong v. Exceptional Child Ctr., Inc., 135 S. Ct. 1378 (2015) (no right by provider to file suit against state Medicaid program for allegedly inadequate compensation).