CAPPING MEDICAID:

How Per Capita Caps Would Affect Long-Term Services & Supports and Home Care Jobs

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INTRODUCTION

The American Health Care Act (AHCA) – passed by House Republicans in May, and currently under consideration in the Senate – would dramatically change Medicaid's financing structure. Currently, Medicaid operates as a federal-state partnership where each pays a percentage of Medicaid's costs and federal financial support increases with need. Under the per capita cap system proposed in the AHCA, the federal government would provide states with an aggregate amount of funding based on the number and category of eligible beneficiaries in the state, with nominal differences in the amount per beneficiary category. The proposed per capita cap system would adjust for overall population growth, but would not account for other relevant factors affecting Medicaid expenditures, such as changes in health care needs or costs. The Congressional Budget Office estimates that this change in the financing structure along with other changes proposed in the AHCA would cut $834 billion from the Medicaid program.[1] States would likely have to account for the decreased funding by cutting benefits, cutting payments to providers, changing eligibility requirements, and/or adding to program waiting lists.

A per capita cap system would have serious implications for people receiving long-term services and supports (LTSS) – including millions of older adults with functional and cognitive impairments. LTSS include a range of typically non-medical services designed to help individuals perform activities of daily living such as bathing, dressing and eating. Medicaid is the primary payer for LTSS so reductions in Medicaid funds would have serious consequences for people receiving LTSS.

States provide LTSS both in the community and in institutional settings. Per capita caps would cause a shift away from home and community based services (HCBS) toward institutional care such as nursing homes. This is because providing LTSS services through HCBS is optional under Medicaid rules while institutional care is mandatory. HCBS varies by state but generally includes home health services and other services such as adult day care.[2]

This brief provides information on some of the factors that would affect states' abilities to provide LTSS in a per capita cap system. Additionally, we look at a portion of the labor force that provides LTSS – home health aides and personal care aides specifically – and predict that across the United States, between 305,000 and 713,000 home health aides and personal care aides would lose their jobs if the proposed per capita cap system in the AHCA were to be implemented.

FACTORS THAT WOULD AFFECT STATES' ABILITY TO PROVIDE LTSS IN A PER CAPITA CAP SYSTEM

There are multiple state-based factors that are likely to influence the magnitude of the challenges a state would face in the proposed per capita cap system. Table 1 below describes five factors that would negatively influence a state's ability to respond to a per capita cap system.

[1] Congressional Budget Office (2017). Cost Estimate on H.R. 1628 American Health Care Act of 2017. Retrieved from https://www.cbo.gov/publication/52752

[2] Erica L. Reaves and MaryBeth Musmeic (2015). Medicaid and Long-Term Services and Supports: A Primer. *The Kaiser commission on Medicaid and the Uninsured*. Retrieved from http://files.kff.org/attachment/report-medicaid-and-long-term-services-and-supports-a-primer

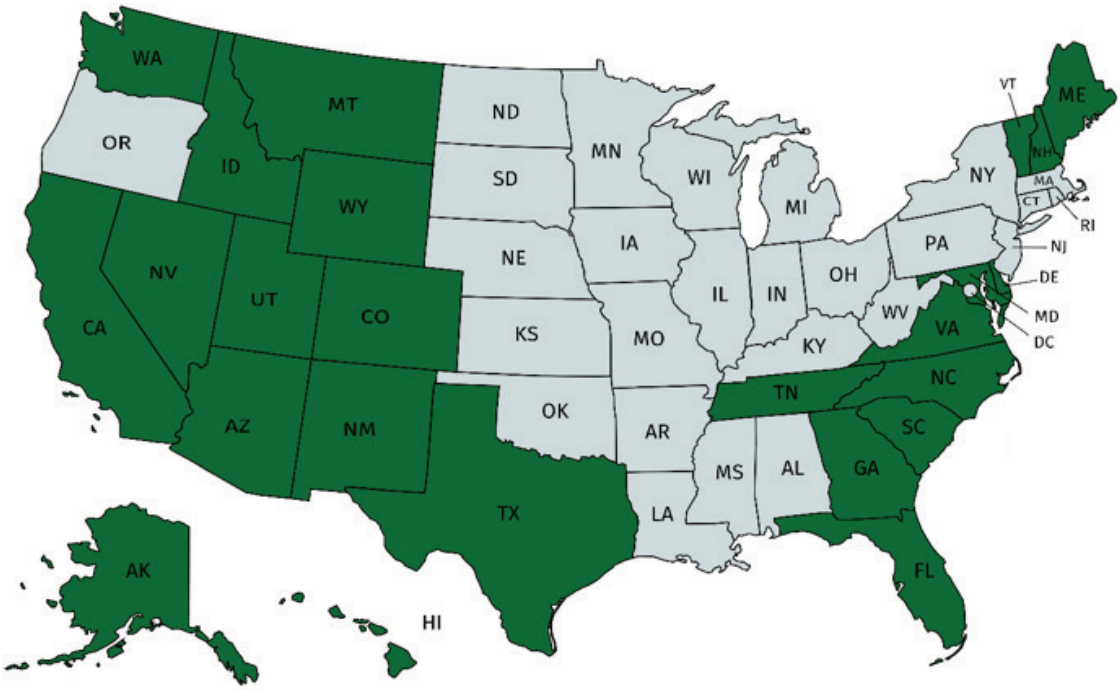
Table 1:
Factors that would affect states' ability to provide LTSS in a per capita cap system

State-based Factor	Rationale
1. Rate of growth in the population age 85 and over between 2015 and 2025	Per capita caps are based on population growth with an adjustment for inflation. They ignore changes in the age distribution of the over-age 65 population. Because LTSS need grows significantly as the population ages, and a rapidly growing "older" population will require more LTSS resources, states will experience gaps between the cap and the costs of addressing growing need.
2. The percentage of the population over age 65 with four or more chronic conditions	Changes in the health status of individuals will affect the adequacy of the cap, and are unaccounted for in the current per capita cap definition. As the percentage of the population with chronic conditions grows, LTSS need will also grow and the cap will not account for this.
3. Having an above-average federal medical assistance percentage	Those states that have a greater dependency on the federal government for Medicaid funding will experience more pressure to cut services or to increase state spending to make up differences between LTSS need and diminished federal funding.
4.Having above-average expenditures on home and community based services	States that provide greater levels of home and community based care (HCBS) compared to institutional care would experience greater service disruptions, as they would be forced to reallocate more scarce federal dollars to mandatory services like nursing home care.
5. Having above-average expenditure growth on people age 65 and older	States that have been spending at a faster rate than others to meet the needs of an aging population would be forced to cut back more drastically on their Medicaid spending, thus putting more pressure on LTSS provider networks.

The five maps below illustrate the states that are particularly vulnerable to each of the five factors listed above.[3] Comparisons on each of these factors are made to the national average for that factor. Of note, all states would be severely impacted by a shift to per capita caps and all states face at least one of these factors.

[3] Please see Appendix A for a tabular representation of the information presented in the maps below.

States with an above average rate of growth for the population age 85 and over between 2015 and 2025 (shown in green)



Note: Average rate of growth for the age 85 and over population across the United States is 17%.

Source: Analysis of U.S. Census Bureau, Population Division, Interim State Population Projections, 2005, Table B1, https://www.census.gov/population/projections/data/state/projectionsagesex.html

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The map above shows states with an above average rate of growth for the population age 85 and older between 2015 and 2025. People age 85 and over are four times more likely to need LTSS compared to people age 65 to 84.[4] While enrollment in Medicaid is dominated by adults and children, most spending is on older adults due to their complex health needs.[5] According to a recent report by AARP, adults age 65-74 have on average less than half the Medicaid per-enrollee costs compared to adults age 85 and above.[6] The above-85 population is projected to triple from 6.2 million in 2014 to 14.6 million in 2040.[7] The AHCA per capita cap system would not keep pace with the needs of this population, resulting in significant unmet need and increasing strain on family caregivers.

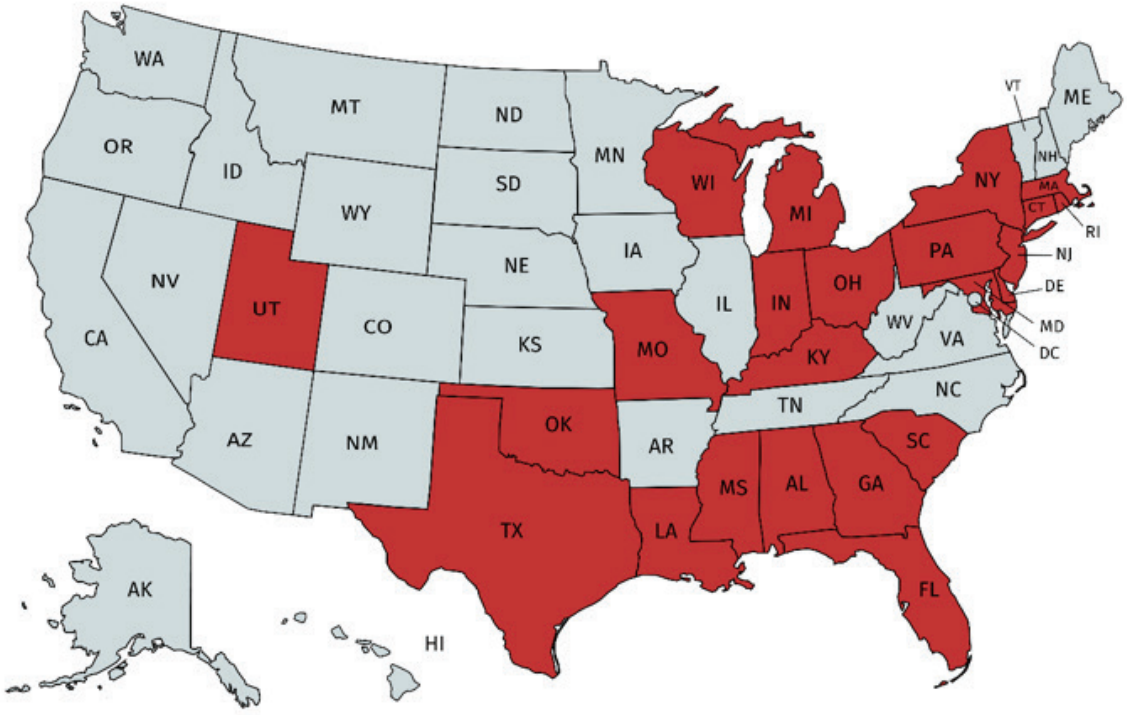
[4] Erica L. Reaves and MaryBeth Musmeic (2015). Medicaid and Long-Term Services and Supports: A Primer. *The Kaiser Commission on Medicaid and the Uninsured*. Retrieved from http://files.kff.org/attachment/report-medicaid-and-long-term-services-and-supports-a-primer

[5] Medicaid's Role: What's at Stake Under a Block Grant or Per Capita Cap? (February 2017). *The Kaiser Family Foundation*. Retrieved from http://www.kff.org/medicaid/video/medicaids-role-whats-at-stake-under-a-block-grant-or-per-capita-cap/

[6] Brendan Flinn and Ari Houser (June 2017). Capped Financing for Medicaid Does Not Account for the Growing Aging Population. *AARP Public Policy Institute*. Retrieved from http://www.aarp.org/content/dam/aarp/ppi/2017/01/Capped-financing-for-Medicaid-Does-Not-Account-For-The-Growing-Aging-Population.pdf

[7] A Profile of Older Americans: 2015. *Administration on Aging, Administration for Community Living*. https://www.acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2015-Profile.pdf

States with an above average percent of the age 65 and over population with four or more chronic conditions (shown in red)



Note: The average percentage of people age 65 and over with four or more chronic conditions across the U.S. is 38%.

Source: Analysis of CMS data found in https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/MCC_Main.html

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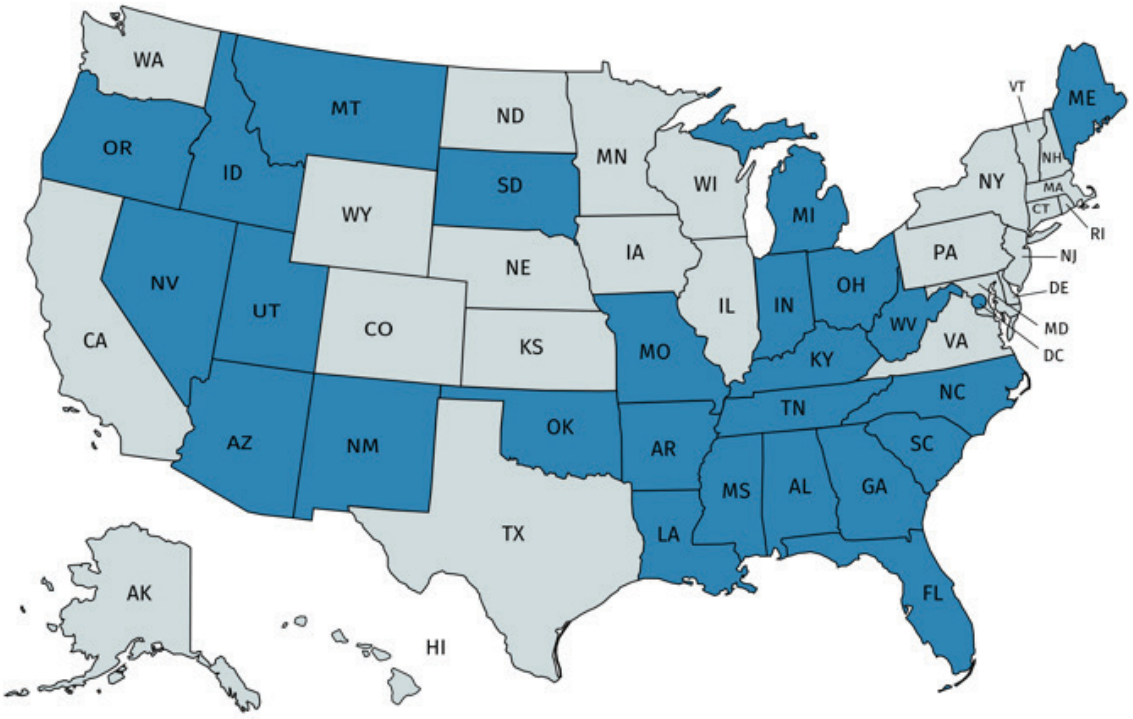
The map above shows states where there is an above average number of adults age 65 and older with four or more chronic conditions. The prevalence of functional and cognitive impairments in the over-age-65 population would affect the adequacy of a per capita cap system. Studies on LTSS costs show a sharp rise in the need for LTSS and medical services as people age due to the higher prevalence of chronic conditions necessitating LTSS.[8, 9, 10]

[8] AARP (2012). Across the States: Profiles of Long-Term Services and Supports. Ninth Edition, Washington, D.C.

[9] Functional Impairments a Key Factor in High Medical Spending. *Anne Tumlinson Innovations*. Retrieved from http://media.mcknights.com/documents/270/ati_fact_sheet_fi_and_medical__67496.pdf

[10] Erica L. Reaves and MaryBeth Musmeic (2015). Medicaid and Long-Term Services and Supports: A Primer. *The Kaiser Commission on Medicaid and the Uninsured*. Retrieved from http://files.kff.org/attachment/report-medicaid-and-long-term-services-and-supports-a-primer

States with an above average Federal Medical Assistance Percentage (shown in blue)



Note: The average Federal Medical Assistance Percentage across the 50 states and the District of Columbia is 59%.

Source: U.S. Department of Health and Human Services. Federal Register /Vol. 80, No. 227/Wednesday, November 25, 2015/Notices. Federal Medical Assistance Percentages and Enhanced Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages, Effective October 1, 2016 – September 30, 2017. (Fiscal Year 2017) https://aspe.hhs.gov/system/files/pdf/167966/FMAP17.pdf

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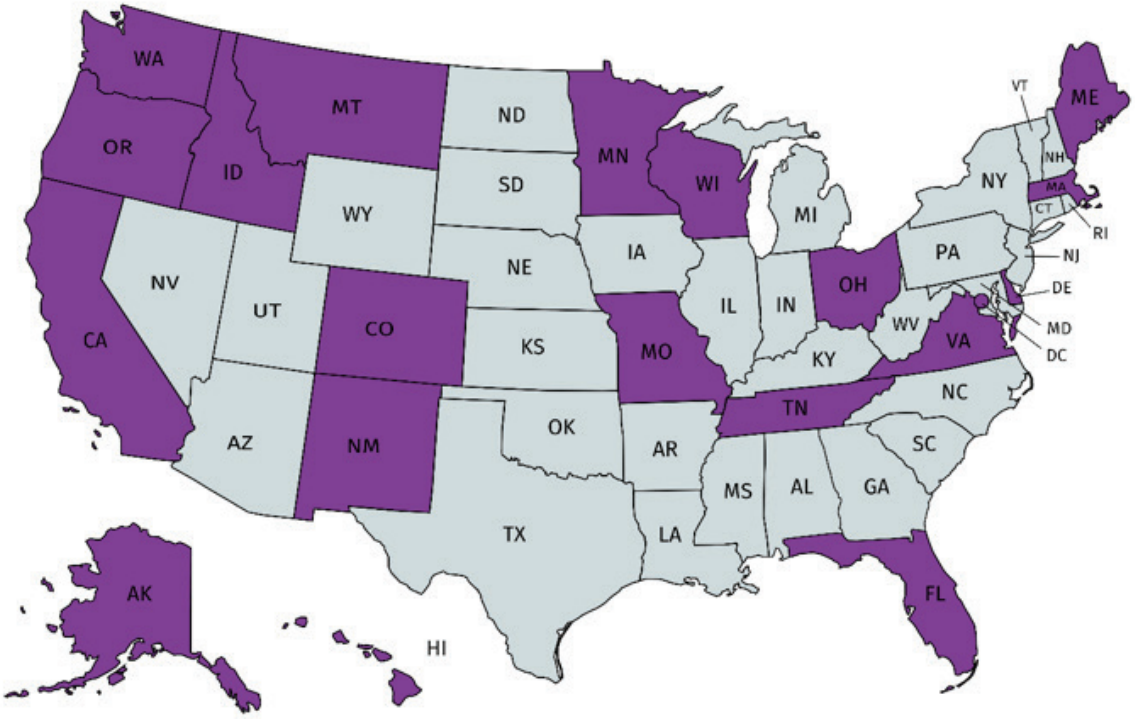
The above map shows states with an above average federal medical assistance percentage (FMAP, or federal match). The FMAP is the federal government's share of the cost of covered services in state Medicaid programs. The rate is set, in part, based on the level of economic resources available in a state. Thus, for example, states with lower personal income growth receive a higher match than do states with higher income growth. States with above-average FMAPs would have more limited state resources in a per capita cap system with which to make up the difference between reduced federal funds and the LTSS costs.

States with above average expenditures on home and community based services (shown in purple)



Note: The average HCBS expenditure percentage across the 50 dates and District of Columbia is 49%.

Source: Manatt analysis of Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book*, December 2016, Exhibit 17, https://www.macpac.gov/macstats/

States provide LTSS both in the community and in institutional settings. Per capita caps would cause a shift away from home and community based services (HCBS) toward institutional care such as nursing homes. This is because providing LTSS services through HCBS is optional under Medicaid rules while institutional care is mandatory. HCBS varies by state but generally includes home health services and other services such as adult day care.[11] Historically, Medicaid has spent more on institutional care than care in the community. However, that trend has shifted significantly over the last 20 years. The percent of LTSS spending on HCBS has climbed from 18 percent in 1995 to 55 percent in 2015 and now Medicaid provides HCBS to over 5 million individuals.[12] Many of the recipients of HCBS services are under age 65 living with intellectual and/or developmental disabilities.

Supporting people in the community, as opposed to in institutions, improves health, lowers Medicaid costs and reflects people's desire to remain in their own homes.[13] Of all optional Medicaid services,

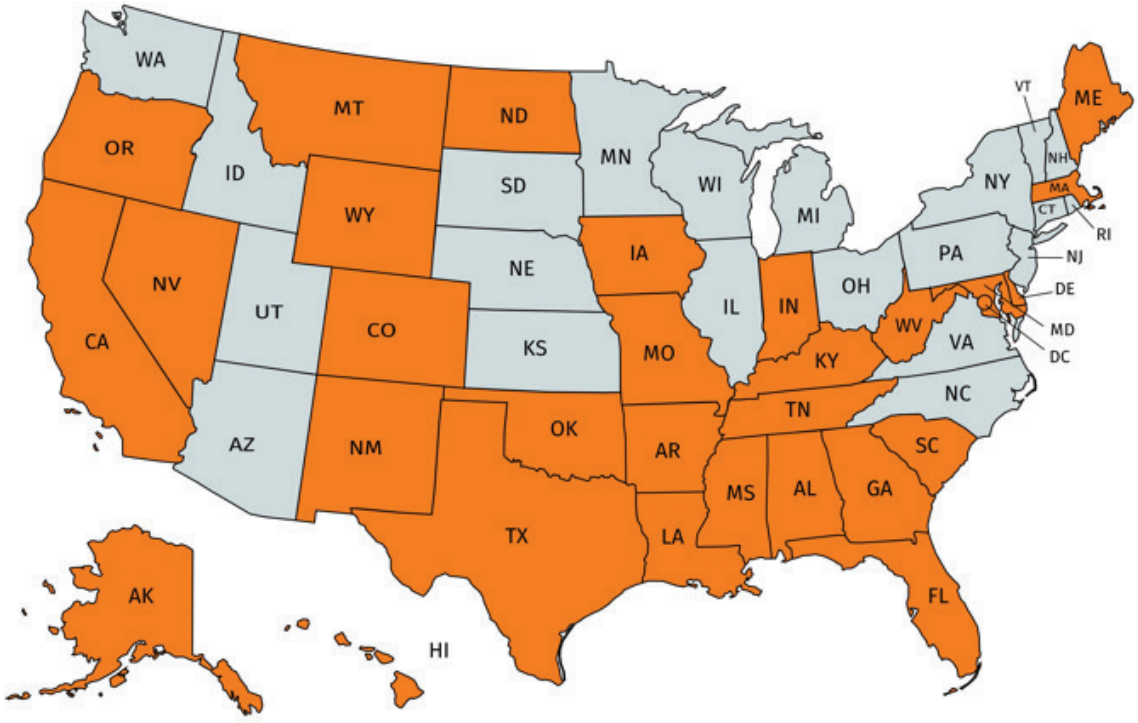
[11] Erica L. Reaves and MaryBeth Musmeic (2015). Medicaid and Long-Term Services and Supports: A Primer. *The Kaiser Commission on Medicaid and the Uninsured*. Retrieved from http://files.kff.org/attachment/report-medicaid-and-long-term-services-and-supports-a-primer

[12] Steve Eiken, Kate Sredl, Brian Burwell and Paul Saucier (2015). Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013. *Truven Health Analytics*. Retrieved from https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-fy2013.pdf

[13] Carol V. Irvin, Noelle Denny-Brown, Alex Bohl, John Schurrer, Andrea Wysocki, Rebecca Coughlin, and Susan R. Williams (2015). Money Follows the Person 2014 Annual Evaluation Report. *Mathematica Policy Research*. Retrieved from https://www.mathematica-mpr.com/our-publications-and-findings/publications/money-follows-the-person-2014-annual-evaluation-report

the largest share is spent on HCBS.[14] Shifting to a per capita cap system would likely cause even larger HCBS waiting lists or the elimination of HCBS altogether. The result would be that some individuals would be forced into institutional settings, other would join waiting lists, family caregiving efforts would come under increased strain, and others would go without needed care. States that provide greater levels of HCBS compared to institutional care would experience greater service disruptions, as they would be forced to reallocate more scarce federal dollars to mandatory services like nursing home care.

States with above average Medicaid expenditure growth for the age 65 and over population (shown in orange)



Note: The average percentage increase in Medicaid expenditures on the age 65 and over population across the country from FY 2000 to 2011 was 3.7%

Source: Analysis of Kaiser Family Foundation, *Average Growth in Annual Medicaid Spending from FY 2000 to FY 2011 for Full-Benefit Enrollees*, http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/?currentTimeframe=0

States that have been spending at a faster rate than others to meet the needs of an aging population will be forced to cut back more drastically on their spending or cut services, thus putting more pressure on the state to come up with cost-saving measures such as cuts to provider payment rates, benefit cuts, and changes to eligibility rules.

[14] Judith Solomon and Jessica Shubel (2017). Medicaid Cuts in House ACA Repeal Bill Would Limit Availability of Home- and Community-Based Services. *Center on Budget and Policy Priorities*. Retrieved from http://www.cbpp.org/research/health/medicaid-cuts-in-house-aca-repeal-bill-would-limit-availability-of-home-and

PER CAPITA CAPS MAY CAUSE SIGNIFICANT JOB LOSS FOR HCBS PROVIDERS

An additional impact of the proposed per capita cap system is that that there would likely be reductions in the demand for the para-professionals providing HCBS under the Medicaid program. Low-income individuals with LTSS needs would likely get fewer Medicaid services and would not be able to pay for care privately. Home health aides and personal care aides provide the bulk of HCBS and comprise one of the fastest growing sectors in the U.S. economy, growing by roughly 7 percent per year.[15] In 2014, there were slightly more than 3 million direct care workers comprising roughly one in five health workers. 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.[16] The resources to pay for these services and attract workers into this sector would decline under a per capita cap system. Moreover, these workers are currently among the lowest paid in the healthcare workforce, earning an average of $11.00 per hour.[17] As states would face pressures to reduce HCBS expenditures, this would also have a negative impact on provider reimbursement, hence the already-low salaries and working conditions for these workers. This would have a significant health equity impact, as well, as nine in ten home care workers are women, and more than half are women of color.[18]

To predict how a per capita cap system would affect jobs in the HCBS sector, we tabulated the number of personal care aides and home health aides in each state between the years of 2010 and 2015, using Bureau of Labor Statistics data.[19] We also tabulated the number of Medicaid HCBS recipients in each state between 2010 and 2012 using data from the Medicaid Analytic eXtract file tabulated by Truven Analytics.[20] For each of these three years, we constructed a ratio of the number of employees to the number of Medicaid HCBS recipients in each state, and averaged this ratio over the three-year period. We used this average state-based ratio to calculate the expected job losses associated with a varying percentage declines in HCBS recipients in each state. We modeled reductions in HCBS recipients of 15 percent, 25 percent and 35 percent, which given the level of projected reductions in overall Medicaid expenditures, represent a reasonable range for the likely aggregate reductions in the number of HCBS beneficiaries. We then calculated the expected job losses as a percent of total jobs in each state, with the total jobs in each state tabulated from Bureau of Labor Statistics data.[21]

Table 2 provides more detail on the potential employment-related impacts of the policy. This table shows the likely number of jobs lost due to cutbacks in HCBS compared to current levels of employment. They are single-year estimates. In total, we estimate between 305,000 and 713,000 jobs would be lost as a result of a change in the Medicaid financing structure to per capita caps.

[15] Analysis of Bureau of Labor Statistics data May 2017. https://www.bls.gov/oes/tables.htm

[16] Judith Graham (2017). Severe Shortage of Direct Care Workers Triggering Crisis. *Kaiser Health News*. Retrieved from https://www.disabilityscoop.com/2017/05/09/severe-shortage-care-crisis/23679/

[17] Analysis of Bureau of Labor Statistics data May 2017. https://www.bls.gov/oes/tables.htm

[18] U.S. Home Care Workers: Key Facts. *The Paraprofessional Healthcare Institute*. Retrieved from https://phinational.org/sites/phinational.org/files/phi-home-care-workers-key-facts.pdf

[19] Analysis of Bureau of Labor Statistics data on home health aides and personal care aides 2010-2012, 2015. https://www.bls.gov/oes/tables.htm

[20] Analysis of Truven Analytics Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013. https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-fy2013.pdf and associated tables sent by personal correspondence for 2010-2012

[21] Bureau of Labor Statistics (2017). State and Metro Area Employment, Hours, & Earnings. https://www.bls.gov/sae/#tables

Table 2:
Projected Job Losses for Home Health Aides and Personal Care Aides Resulting from Cutbacks in HCBS Recipients

	Projected Reduction in Medicaid HCBS Recipients		
	15%	25%	35%
	Decline in Employees		
Alabama	2,636	4,393	6,150
Alaska	970	1,616	2,262
Arizona	6,338	10,564	14,789
Arkansas	3,275	5,459	7,642
California	19,432	32,387	45,342
Colorado	4,529	7,548	10,567
Connecticut	3,928	6,546	9,164
Delaware	524	873	1,222
District of Columbia	1,046	1,743	2,441
Florida	7,620	12,700	17,780
Georgia	3,055	5,092	7,128
Hawaii	1,131	1,885	2,639
Idaho	1,540	2,567	3,593
Illinois	10,725	17,875	25,025
Indiana	5,604	9,341	13,077
Iowa	2,722	4,537	6,351
Kansas	3,630	6,050	8,470
Kentucky	1,578	2,631	3,683
Louisiana	5,322	8,870	12,418
Maine	2,368	3,946	5,525
Maryland	3,447	5,745	8,043
Massachusetts	7,380	12,301	17,221
Michigan	8,613	14,356	20,098
Minnesota	13,988	23,314	32,640
Mississippi	1,683	2,805	3,927
Missouri	5,831	9,718	13,605
Montana	1,103	1,838	2,573
Nebraska	829	1,381	1,934
Nevada	1,735	2,892	4,049
New Hampshire	1,114	1,856	2,598
New Jersey	5,594	9,323	13,053
New Mexico	4,158	6,930	9,703
New York	42,462	70,771	99,079

Table 2 continued

	Projected Reduction in Medicaid HCBS Recipients		
	15%	25%	35%
	Decline in Employees		
North Carolina	10,366	17,277	24,187
North Dakota	1,146	1,909	2,673
Ohio	12,949	21,581	30,213
Oklahoma	3,057	5,095	7,133
Oregon	4,067	6,779	9,490
Pennsylvania	16,858	28,096	39,335
Rhode Island	1,441	2,402	3,362
South Carolina	3,092	5,153	7,215
South Dakota	788	1,314	1,839
Tennessee	5,877	9,795	13,713
Texas	29,339	48,899	68,459
Utah	1,290	2,151	3,011
Vermont	1,822	3,037	4,251
Virginia	5,778	9,630	13,482
Washington	4,151	6,919	9,687
West Virginia	3,131	5,219	7,306
Wisconsin	6,975	11,625	16,275
Wyoming	443	738	1,033
U.S.	305,397	508,995	712,592

Source: Analysis of Bureau of Labor Statistics data on home health aides and personal care aides 2010-2012, 2015. https://www.bls.gov/oes/tables.htm and analysis of Truven Analytics Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013. https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-fy2013.pdf and associated tables sent by personal correspondence for 2010-2012

SUMMARY

This report presents a preliminary view of how a Medicaid per capita cap system would affect states' ability to meet LTSS needs and impact the LTSS labor force. The proposed financing structure in the AHCA does not adequately take into account a variety of important factors associated with whether or not states can meet growing LTSS needs. In addition, a shift to per capita caps has the potential to result in significant decreases in home health aide and personal care aide jobs as there would be fewer resources available to pay these workers, even as the need for their services continues to grow in the years ahead. Finally, a per capita cap system would add strain to the tens of millions of unpaid family caregivers who provide significant assistance to their family members and who already experience heavy financial, emotional and physical tolls.[22]

[22] Evertte James and Meredith Hughes (2016). Embracing the Role of Family Caregivers in The U.S. Health System. *Health Affairs Blog*. Retrieved from http://healthaffairs.org/blog/2016/09/08/embracing-the-role-of-family-caregivers-in-the-u-s-health-system/

APPENDIX A

Table 3:
States with above average characteristics that would affect a shift to Medicaid per capita caps

	Above average rate of growth in the 85+ population between 2015 and 2025 compared to the growth of the over 65 population	Above average percentage of the 65+ population with four or more chronic conditions	Above average federal medical assistance percentage	Above average expenditures on HCBS	Above average expenditures growth on 65+ population
Alabama		X	X		X
Alaska	X			X	X
Arizona	X		X		
Arkansas			X		X
California	X			X	X
Colorado	X			X	X
Connecticut		X			
Delaware	X	X		X	X
District of Columbia			X	X	X
Florida	X	X	X	X	X
Georgia	X	X	X		X
Hawaii	X			X	X
Idaho	X		X	X	
Illinois					
Indiana		X	X		X
Iowa					X
Kansas					
Kentucky		X	X		X
Louisiana		X	X		X
Maine	X		X	X	X
Maryland	X	X			X
Massachusetts		X		X	X
Michigan		X	X		
Minnesota				X	
Mississippi		X	X		X
Missouri		X	X	X	X
Montana	X		X	X	X

Table 3 continued

	Above average rate of growth in the 85+ population between 2015 and 2025 compared to the growth of the over 65 population	Above average percentage of the 65+ population with four or more chronic conditions	Above average federal medical assistance percentage	Above average expenditures on HCBS	Above average expenditures growth on 65+ population
Nebraska					
Nevada	X		X		X
New Hampshire	X				
New Jersey		X			
New Mexico	X		X	X	X
New York		X			
North Carolina	X		X		
North Dakota					X
Ohio		X	X	X	
Oklahoma		X	X		X
Oregon			X	X	X
Pennsylvania		X			
Rhode Island		X			
South Carolina	X	X	X		X
South Dakota					
Tennessee	X		X	X	X
Texas	X	X			X
Utah	X	X	X		
Vermont	X				
Virginia	X			X	
Washington	X			X	
West Virginia			X		X
Wisconsin		X		X	
Wyoming	X				X

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