

The Potential Impact of the Better Care Reconciliation Act on Home and Community-Based Services Spending

H. Stephen Kaye, Ph.D.

Executive Summary

The second “Discussion Draft” of the Senate’s Better Care Reconciliation Act (BCRA), released on July 13, 2017, retains provisions contained in the prior version that would cap Federal Medicaid reimbursements to the states on a per-enrollee basis. The caps would be based largely on 2016 spending, adjusted for inflation, and would go into effect in 2020. The amount of the cap would increase each subsequent year, at first keeping pace with inflation in healthcare costs and then, beginning in 2025, increasing more slowly than the rise in healthcare costs.

Added to the second version of the bill is a new home and community-based services (HCBS) demonstration program that would allow states to apply for additional funding, with a total budget of \$8 billion over four years. As in the prior version, the bill would end the enhanced Federal reimbursement rate for the Community First Choice Option, a new HCBS program introduced in the Affordable Care Act.

Because HCBS are not a mandated part of each state’s Medicaid program, it is likely that these services would be among the first to be cut if caps were to be imposed. In this report, we estimate the extent to which per-enrollee caps on Medicaid reimbursements would likely have influenced state HCBS spending, had such caps been imposed during the decade of the 2000s.

We find that:

- Caps would have caused HCBS spending on people with physical disabilities, seniors, and others with non-developmental

disabilities to have been reduced by between 23 and 30 percent after 9 years.

- Caps would have caused states to reduce spending on HCBS for people with intellectual and developmental disabilities by an initial 11 percent, rising to as much as 14 percent after 9 years.
- If caps had been imposed in 2005, annual HCBS spending on all populations would have been reduced below actual spending by as much as \$18 billion by 2013. Adjusting for inflation in healthcare costs, which typically double over a 15-year period, these reductions are projected to be as much as \$36 billion per year in 2028 dollars.
- Over the nine years of caps, total HCBS spending would have been reduced below actual by between \$72 and \$98 billion. Adjusting for inflation to 2020-28 dollars, **reductions would total between \$149 and \$202 billion.**
- A new HCBS demonstration program budgeted at \$8 billion total would replace only about 4 percent of the potential \$202 billion in reduced expenditures.
- The 8 states offering a Community First Choice program in 2015 received \$453 million through an enhanced Federal match of their program spending. Eliminating the enhanced match would reduce Federal HCBS spending by a minimum of \$6.5 billion over 10 years, adjusted for inflation. The Congressional Budget Office, assuming substantial growth in the program because of the enhanced match, estimates a \$19 billion reduction in Federal HCBS spending through the elimination of the match.

Background

The decade of the 2000s saw rapid growth in state Medicaid spending on home and community-based services. Part of the growth was due to increased numbers of beneficiaries receiving such services, and part was due to increased spending per enrollee, due to both program changes and inflation in healthcare and social service costs. Nearly all states increased HCBS spending during the period, and many did so rapidly over a few years, as they developed new programs, made infrastructure investments, or offered a more robust package of benefits to serve people with higher levels of need. As a result, there were growth spurts in HCBS spending in many states, with per-enrollee amounts increasing by about 50 percent or more over a one- or two-year period, followed by a longer period of stability or modest growth. When state budgets became tight beginning in 2009, as a result of the Great Recession, the growth in HCBS spending slowed considerably.

The Better Care Reconciliation Act proposes to cap Federal Medicaid reimbursements to the states on a per-enrollee basis, effectively limiting growth to a rate that at first only modestly exceeds the rate of inflation and then falls below inflation. The cap would be set according to each state's 2016 per-enrollee spending, inflation-adjusted for each subsequent year. Caps would take effect in 2020. The inflation adjustment for 2016 to 2019 is the consumer price index for medical care (CPI-MC) for all types of enrollees, including people with disabilities and seniors who receive HCBS. Between 2020 and 2024, adjustments depend on enrollment category: the adjustment for people with disabilities and seniors is set at CPI-MC plus 1 percentage point, and the adjustment for other enrollment categories is CPI-MC. Beginning in 2025, the inflation adjustment is greatly reduced to the Consumer Price Index for all items, which does not take into account the higher growth rate of healthcare costs. Over the past ten years, the growth in the Consumer Price Index for all items averaged 1.8 percent per year, and the CPI-MC increased by an average of 3.3 percent per year.

For most people who receive HCBS, it is by far the largest component of their Medicaid spending. If the BCRA were to be enacted, it is reasonable to assume that most states would limit HCBS spending to the per-enrollee cap amount; otherwise, any excess comes entirely out of the state budget.

Methods

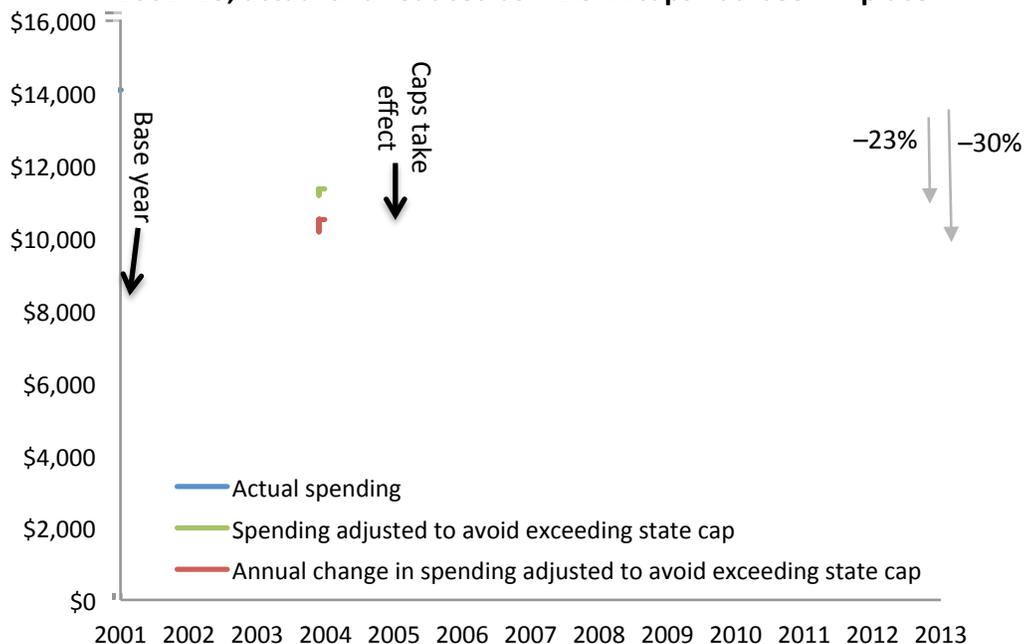
For this analysis, we used all publicly available data for 2001–2013 on state per-enrollee spending on 1915(c) waiver programs and state plan personal care services programs. Expenditure data come from the annual Truven Health Analytics reports,¹ and number of participants in the two programs comes from the Kaiser Family Foundation and the University of California San Francisco.²

Spending was analyzed separately for enrollees with and without intellectual or developmental disabilities (I/DD). The analysis for enrollees without I/DD includes all state spending on personal care services programs and 1915(c) waiver programs other than for people with I/DD. The analysis for enrollees with I/DD is of 1915(c) waiver programs specifically targeted to that population.

Because of data limitations, other HCBS programs are not included; data for a few states include extrapolated numbers in the final years of the time period, due to shifting of participants to a managed care or Community First Choice program. Data from all states and the District of Columbia were used, except for those states with unavailable or inconsistent data due to the use of managed care arrangements (Arizona, Rhode Island, and Vermont; Hawaii, Minnesota, and Wisconsin were also excluded from the non-I/DD analysis).

We developed two scenarios of the impact that hypothetical BCRA-like reimbursement caps might have had on Medicaid spending, under the assumption that states would not exceed their per-enrollee cap. In both scenarios, we treated 2001 as the baseline year (equivalent to 2016 in the BCRA), and 2005 as the year that caps would have been implemented (equivalent to 2020). Following the procedure proposed in the BCRA, caps were inflation-adjusted using the

Figure 1. Average annual HCBS spending per non-I/DD enrollee, 2001–13, actual and reduced as if BCRA caps had been in place



CPI-MC of the data years (i.e., we applied CPI-MC to the base-year spending for 2002–04, CPI-MC plus 1 percentage point for 2005–09, and CPI all items to 2010–13).

In Scenario 1, per-enrollee spending in any year is the lower of actual spending or the cap amount. The impact of the cap is therefore assumed to be limited to the years in which the actual spending exceeded the cap.

In Scenario 2, each state’s actual, year-to-year percent increase (or decrease) in per-enrollee spending is applied to the prior year’s spending, unless that change would have caused the per-enrollee spending to exceed the cap. In that case, per-enrollee spending is set to the cap level, and the following year’s percent increase (or decrease) is applied to that amount. Thus, the impact of the cap extends to future years, because increases that were limited by the cap are not made up by additional increases in subsequent years.

Results

In spending for non-I/DD beneficiaries, 38 out of the 49 states with full or partial data (including DC as a “state”) exceeded the hypothetical cap in at least one year between

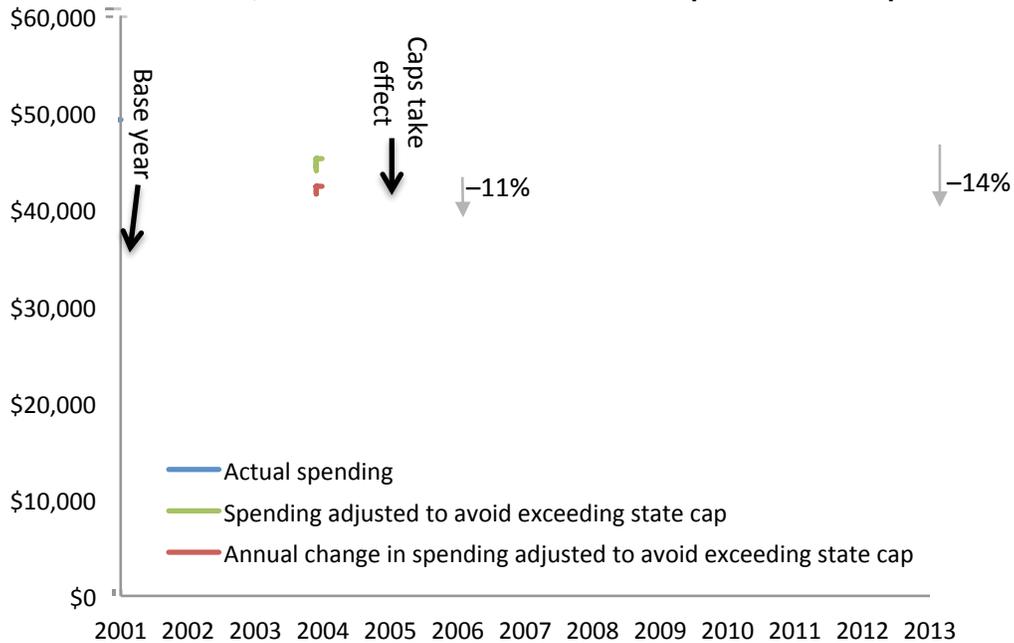
2005 and 2013; 33 exceeded the cap in 6 or more of those years (see Table 1). Initially low-spending states are especially subject to seeing growth impacted by the caps. The five states with the least amount of per-enrollee spending in 2001 (DC, SD, OK, MI, and MO) all exceeded the cap amount over the entire period.

The blue line in Figure 1 shows the average national per-enrollee HCBS spending for programs targeted to people without I/DD. As caps take effect, spending in both scenarios begins to diverge substantially from actual spending. By 2013, spending under Scenario 1 (green line) is 23 percent less than actual spending. Spending under Scenario 2 (red line) is 30 percent less.

Using the 2013 figure for U.S. non-I/DD HCBS expenditures (\$44.4 billion¹), a 23- to 30-percent reduction translates to between \$10.3 and \$13.5 billion less spending over a single year.

With respect to I/DD spending, most states (32 of the 49 with full or partial data) had per-enrollee spending above the hypothetical cap in one or more years, as indicated in Table 1. Once again, the states spending the least per enrollee in the “base year” of 2001 (DC, MS, FL, NV, GA) would have been particularly hard hit by

Figure 2. Average annual HCBS spending per I/DD enrollee, 2001–13, actual and reduced as if BCRA caps had been in place



the caps, exceeding them in all or nearly all years and by quite substantial amounts.

Figure 2 shows national per-enrollee spending data for I/DD beneficiaries. With fewer growth spurts among these more established programs, the impact of caps is somewhat less dramatic but still substantial. Both scenarios diverge from actual spending as soon as the hypothetical caps take effect, with spending at 11 percent less by the second year. Spending under Scenario 1 begins to catch up to actual spending by 2013. Scenario 2, in contrast, remains low, with 2013 spending at 16 percent below actual.

With I/DD spending at \$30.7 billion¹ in 2013, a reduction of between 4 and 14 percent would mean between \$1.3 and \$4.2 billion less spent on I/DD services.

Altogether, annual HCBS spending for all populations would have been reduced by between \$11.6 and \$17.7 billion, in 2015 dollars. Across all nine years of the hypothetical caps, total HCBS expenditures would have been reduced by between \$72.3 (Scenario 1) and \$98.3 billion (Scenario 2).

Conclusions

If per-enrollee caps like those proposed in the Better Care Reconciliation Act had been imposed in the mid-2000s, they would likely have caused many states to restrict HCBS spending to amounts far lower than spending under existing Medicaid reimbursement rules. States spending the lowest amounts initially—those likely most in need of improvement—would have been among the hardest hit, either in terms of reduced Federal reimbursements or having to abandon plans for building a more robust HCBS system.

Indeed, states that invested heavily in HCBS infrastructure, expanded benefits to serve people with higher needs, or created new HCBS programs would probably have become far less ambitious had Federal match been capped. A capped reimbursement would have discouraged states, especially laggard states, from innovating in delivering the types and amounts of services that could meet people’s needs.

The consequences would have been readily apparent: Without their long-term services and supports needs met, more people would have been institutionalized, and those remaining in

their homes would have been more isolated, experienced worse health, and been prevented from participating in their communities. The great success of HCBS program expansion in enabling people to continue living at home and promoting successful community integration would have been seriously jeopardized.

References

1. Eiken S, Sredl K, Burwell B et al. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015. Cambridge, MA: Truven Health Analytics, 2017.
2. Ng T, Harrington C, Musumeci M et al. Medicaid Home and Community-Based Service Programs: 2013 Data update. Issue Paper. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2016.

Funding

The Community Living Policy Center is funded by the National Institute on Disability, Independent Living, and Rehabilitation Research (grant 90RT5026) and the Administration for Community Living, U.S. Department of Health and Human Services. Opinions are those of the author and not the funders.

Table 1. Maximum amount and number of years during which state HCBS expenditures exceeded hypothetical AHCA-like cap, 2005–13

| | Non-I/DD expenditures | | I/DD expenditures | |
|----------------------|-----------------------|-------------|-------------------|-------------|
| | Max. % > cap | Years > cap | Max. % > cap | Years > cap |
| Alabama | 21.6 | 7 | 30.8 | 9 |
| Alaska | 45.9 | 9 | — | — |
| Arkansas | 22.5 | 8 | 25.4 | 9 |
| California | 24.5 | 7 | — | — |
| Colorado | 22.4 | 9 | — | — |
| Connecticut | 38.8 | 9 | 49.0 | 4 |
| Delaware | — | — | 14.1 | 8 |
| District of Columbia | 97.0 | 9 | 96.3 | 9 |
| Florida | 55.6 | 7 | 29.6 | 9 |
| Georgia | 27.7 | 6 | 32.3 | 7 |
| Hawaii* | 7.7 | 1 | 30.8 | 9 |
| Idaho | 28.3 | 3 | — | — |
| Illinois | 36.1 | 9 | 4.2 | 1 |
| Indiana | 7.0 | 1 | — | — |
| Iowa | 34.5 | 9 | 8.8 | 9 |
| Kansas | — | — | — | — |
| Kentucky | 31.9 | 6 | 4.7 | 1 |
| Louisiana | 23.9 | 3 | 26.6 | 5 |
| Maine | 55.0 | 9 | 23.2 | 2 |
| Maryland | 38.4 | 9 | 10.1 | 2 |
| Massachusetts | — | — | 22.4 | 7 |
| Michigan | 16.0 | 9 | — | — |
| Minnesota | 31.2 | 9 | 21.8 | 9 |
| Mississippi | 45.1 | 9 | 55.8 | 9 |
| Missouri | 26.6 | 9 | 26.1 | 9 |
| Montana | — | — | — | — |
| Nebraska | 10.3 | 4 | — | — |
| Nevada | 17.8 | 7 | 46.2 | 9 |
| New Hampshire | 9.2 | 9 | 17.0 | 1 |
| New Jersey | — | — | 40.1 | 9 |
| New Mexico | 1.9 | 1 | — | — |
| New York | 40.6 | 9 | 19.8 | 8 |
| North Carolina | — | — | — | — |
| North Dakota | — | — | 2.7 | 1 |
| Ohio | — | — | — | — |
| Oklahoma | 43.0 | 9 | — | — |
| Oregon | 23.1 | 8 | — | — |
| Pennsylvania | 40.4 | 9 | 0.3 | 1 |
| Rhode Island* | — | — | 25.9 | 4 |
| South Carolina | 21.2 | 6 | 21.8 | 8 |
| South Dakota | 48.8 | 9 | 0.5 | 1 |
| Tennessee | 56.6 | 6 | 42.3 | 9 |
| Texas | 53.7 | 9 | — | — |
| Utah | 57.3 | 6 | 1.4 | 2 |
| Virginia | 30.4 | 9 | 13.2 | 8 |
| Washington | — | — | 26.4 | 9 |
| West Virginia | 25.8 | 6 | 8.8 | 2 |
| Wisconsin | — | — | — | — |
| Wyoming | 33.8 | 9 | — | — |

*Analysis includes 2005–08 only.

Consistent data not available for Arizona or Vermont.