Insight on the Issues

Major Threat: How the Better Care Reconciliation Act Jeopardizes Medicaid Home- and Community-Based Services

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Each year, millions of people with physical, cognitive, or mental impairments receive some type of long-term services and supports (LTSS) through Medicaid. These include assistance with bathing, dressing, and toileting as well as complex care such as wound care and managing medications. People with disabilities may receive LTSS in their home or community, or in an institutional setting such as a nursing home.

Medicare and private health insurance typically do not pay for LTSS. Oftentimes, as their ability to care for themselves declines, individuals and their families deplete their life savings and turn to Medicaid for assistance. While nursing facility services are a mandatory Medicaid benefit, home and community-based services are not, even though an overwhelming majority of people would prefer to receive services in their homes and communities—an option that often is also more cost-effective. Access to home- and community-based services (HCBS) through Medicaid, already limited in most states, could be jeopardized if the Better Care Reconciliation Act (BCRA) becomes law.

Under the BCRA, the federal government would give states a fixed dollar amount for each person enrolled in Medicaid. If the amount proves insufficient, the states are responsible for the additional funding needed per person. To arrive at a per person cap and its growth over time, the BCRA uses calculations that bear little relationship to what health care and LTSS actually cost in Medicaid, and the rate at which they increase. In 2025, the bill would cut the growth rate even further for everyone receiving Medicaid, putting the value of benefits increasingly behind the actual costs of the care people need.

According to the Congressional Budget Office (CBO), the BCRA would cut federal funding to Medicaid by 26 percent, or about $772 billion, in 2026. This cut would increase over time to about 35 percent in 2036.[1] The end result would be a shift in cost over time to both states and Medicaid enrollees. Millions of people who currently receive coverage for health care and LTSS could lose Medicaid coverage.

If the BCRA becomes law, states will need to make significant cuts in services while staying within the limits of their allotted per capita caps. New data from the AARP Public Policy Institute demonstrate that HCBS could be particularly vulnerable to these cuts.

HOME- AND COMMUNITY-BASED SERVICES: COSTS AND CONSUMER PREFERENCES

Older adults face a significant possibility of needing LTSS at some point in their lives. More than half (52 percent) of people turning 65 today, for example, will need assistance with basic life functions or

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have a severe cognitive impairment.[2] In addition, more than 22 million adults ages 18–64 in the United States live with some type of disability, and nearly one-third of this group (6.2 million) receive health and LTSS coverage through Medicaid. In most cases, individuals receive help from family caregivers and pay out of pocket, but Medicaid serves as an important last resort once these resources and support are exhausted. Medicaid, in fact, is the largest public payer of LTSS.

In fiscal year (FY) 2015, Medicaid spent approximately $158.2 billion on these services, almost one-third of all Medicaid costs.[3] There are ways the Medicaid program can help contain its LTSS costs while continuing to serve older adults and people with disabilities; one way is through greater access to HCBS.

Across all populations that receive LTSS, Medicaid dollars can support roughly three people in the home and community for each person in an institution.[4] These services also are in line with consumer preference; AARP research shows that more than 85 percent of adults prefer to stay in their homes and communities for as long as possible.[5]

In FY 2015, more than half (55 percent) of Medicaid LTSS dollars went toward home- and community-based care as an alternative to nursing homes and other institutions.[6] Over the past 30 years, the delivery of LTSS has evolved toward a greater reliance on receiving services in the home and community. States made great progress in increasing the proportion of Medicaid spending going toward HCBS, enabling more people to live in their homes and communities. However, as noted in Picking Up the Pace of Change: Long-Term Services and Supports State Scorecard 2017 Edition, states will need to accelerate this progress in order to meet increasing demand among the growing and aging 65+ population.[7]

Investing in home- and community-based services by increasing the portion of Medicaid LTSS dollars going to HCBS can better meet the needs of older people and people with disabilities and help contain Medicaid costs. However, the proposed Medicaid per capita caps could undermine and reverse states' progress toward providing HCBS.

HOME- AND COMMUNITY-BASED SERVICES COULD BE JEOPARDIZED

Access to home- and community-based care could be jeopardized if the BCRA becomes law. This is a result of the "institutional bias," which is an outdated Medicaid law: nursing home care is a mandatory benefit and states must provide this care to all eligible individuals, but services delivered in the home and community are generally considered optional benefits and at a state's discretion. If the Senate bill is enacted, states will be forced to cut or limit services and may look first at those services considered optional.

According to recent analyses from the CBO[8] and the Centers for Medicare and Medicaid Services (CMS),[9] states would respond to Medicaid cuts and caps in part by limiting access to optional Medicaid services like HCBS. In fact, research from the Community Living Policy Center analyzed historical Medicaid spending data and found that if per capita caps like those proposed in the BCRA had been enacted in the past, most states would need to reduce their HCBS spending to stay within their allotted caps, and that nationally states would have cut HCBS by as much as 30 percent over a 10-year period.[10]

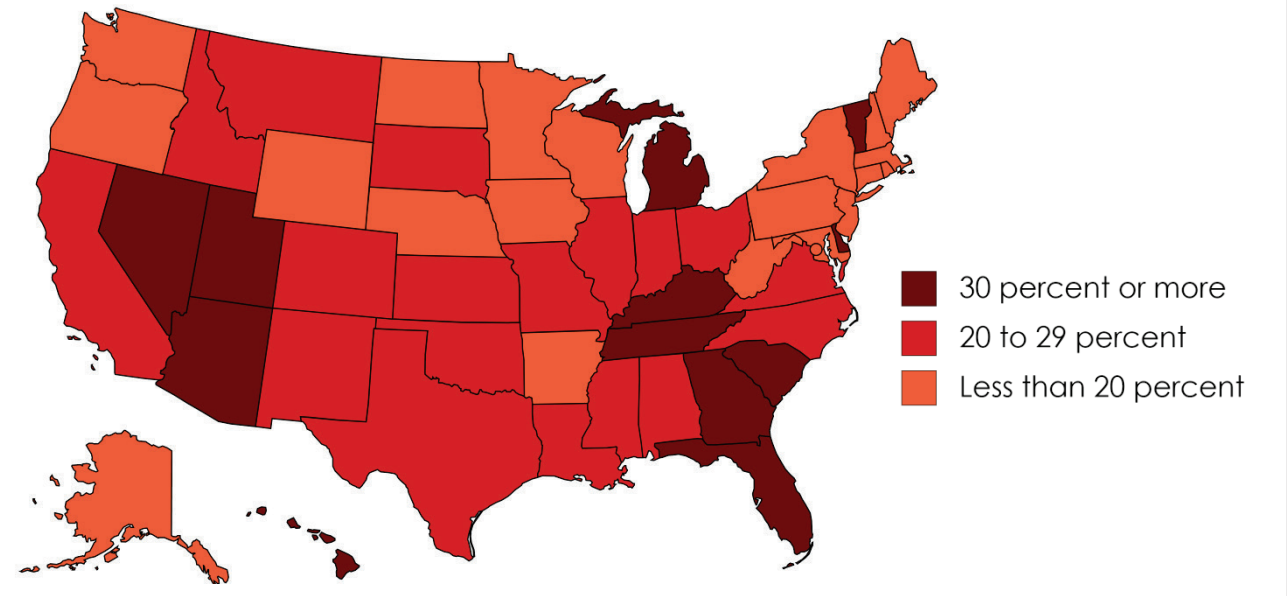
Also of concern is the question of who would be most impacted. According to new research from the Center on Budget and Policy Priorities, 88 percent of Medicaid spending on optional services went toward older adults and people with disabilities, and of this optional spending, more than half went toward home- and community-based services.[11] Thus, cuts to optional services would disproportionately impact older adults and people with disabilities.

NEW AARP PUBLIC POLICY INSTITUTE DATA: THE BCRA POSES RISK TO HOME- AND COMMUNITY-BASED SERVICES IN EVERY STATE

Cost and spending projections show reason for more concern. Using a model developed by Manatt Health, the AARP Public Policy Institute presents new data comparing projected HCBS spending in 2026 with projected BCRA Medicaid cuts that same year.

Projected 2026 Medicaid HCBS spending exceeds projected per capita cap–related Medicaid cuts in all states, increasing the likelihood that states might turn to HCBS as a source of savings to potentially

EXHIBIT 1
Potential HCBS Cut Needed to Stay within the Per Capita Cap under the BCRA, by State, 2026



minimize the need for other cuts. The data show the extent to which caps could jeopardize HCBS as states seek to cut Medicaid spending to avoid going over the caps.

Nationally, states might cut $46 billion of HCBS in 2026, or 22 percent of total projected Medicaid HCBS spending under current law, assuming that states eliminate the Medicaid expansion once the matching rate declines (several states have statutory language that does this automatically).[12]

The level of spending cuts in HCBS a state might need to make in 2026 varies; it is at least 12 percent in all states and as high as 54 percent (in Arizona). Exhibit 1 shows the state-level percentage of HCBS each state would need to cut to stay within its allotted per capita cap in 2026.

Data for every state are available in the appendix, highlighting the impact of the BCRA on HCBS. The states that would potentially see the largest percentage cuts in HCBS are listed in exhibit 2. In reality, these states (and all others) would likely need to roll back HCBS even further, as individuals losing services may have higher acute care costs and/or need more expensive nursing home care.

EXHIBIT 2
States with the Largest Potential Percentage Cuts to HCBS under the BCRA, 2026

State	Potential Cut to Medicaid HCBS under the BCRA, 2026
Arizona	54%; $1.68 billion
Tennessee	39%; $1.23 billion
Utah	38%; $284 million
Hawaii	38%; $203 million
Florida	36%; $2.50 billion

Capping federal Medicaid funding as proposed in the BCRA will also discourage new investments in HCBS, undermining and reversing states' progress toward providing services at home for older adults and people with disabilities.

CONCLUSION

The cuts proposed to the Medicaid program under the BCRA pose significant risks to states and consumers. Foremost among these, perhaps, are the implications for home- and community-based services. While HCBS are more in line with

consumer choice and have the potential to limit cost growth, they are optional in Medicaid and thus in jeopardy if the bill becomes law.

States that have increased their reliance on HCBS will be locked into lower baseline spending for LTSS relative to states that still deliver the majority of care through more costly institutional services. As a result, beneficiaries relying on HCBS could experience greater service disruptions as these states feel pressure to cut optional HCBS spending and reallocate a greater percentage of Medicaid dollars to mandatory nursing home care. And even while nursing home care is a mandatory benefit in Medicaid, states could be forced to cut LTSS more broadly by restricting eligibility for nursing home care and/or cutting nursing home provider rates. This may be especially true for states with significant projected growth in their older adult population (such as Utah, Alaska, Colorado, Texas, and Nevada).[13]

Potential cuts to HCBS are a significant piece in the broader conversation about cuts to Medicaid. Under the BCRA, the AARP Public Policy Institute projects a total (federal and state) Medicaid spending cut of between $2.0 trillion and $3.8 trillion over the 20-year period between 2017 and 2036. Cuts of this magnitude would impact families across this country—including middle-class families who have already spent through their resources paying out of pocket for LTSS and who rely on Medicaid for these critical home- and community-based services.

Going forward, discussion around health reform should focus not on where to cut Medicaid, but rather on how existing funds could be used more efficiently to meet people's needs.

APPENDIX

TABLE 1

Projected State-by-State Spending Cuts under BCRA Per Capita Cap Compared with Projected Medicaid HCBS Spending in 2026, Expansion Eliminated in All States

State	Projected Medicaid HCBS Spending under Current Law	Projected Shortfall under BCRA Per Capita Cap	HCBS Cut Needed to Stay under Cap
Alabama	$1,929,098,189	$421,835,680	22%
Alaska	$856,623,402	$115,642,502	13%
Arizona	$3,101,633,550	$1,675,608,075	54%
Arkansas	$2,462,029,800	$338,469,669	14%
California	$24,417,593,128	$6,425,689,210	26%
Colorado	$3,118,551,996	$678,793,153	22%
Connecticut	$3,910,160,637	$564,589,415	14%
Delaware	$664,291,388	$237,745,559	36%
District of Columbia	$855,315,922	$136,052,900	16%
Florida	$6,912,307,204	$2,496,719,535	36%
Georgia	$3,211,243,657	$1,098,007,141	34%
Hawaii	$539,232,976	$202,988,028	38%
Idaho	$855,878,076	$237,219,175	28%
Illinois	$5,416,220,493	$1,166,463,616	22%
Indiana	$3,427,056,367	$762,997,856	22%
Iowa	$2,490,408,047	$308,529,126	12%
Kansas	$1,433,638,959	$290,856,345	20%
Kentucky	$2,076,101,339	$664,083,785	32%
Louisiana	$2,335,156,822	$562,349,326	24%

State	Projected Medicaid HCBS Spending under Current Law	Projected Shortfall under BCRA Per Capita Cap	HCBS Cut Needed to Stay under Cap
Maine	$1,216,930,128	$200,671,626	16%
Maryland	$4,072,147,826	$737,865,019	18%
Massachusetts	$9,447,318,780	$1,589,073,969	17%
Michigan	$3,421,796,779	$1,150,447,789	34%
Minnesota	$7,250,266,463	$1,127,919,854	16%
Mississippi	$1,526,285,670	$443,641,903	29%
Missouri	$4,324,245,725	$844,080,327	20%
Montana	$625,814,431	$152,641,502	24%
Nebraska	$957,363,145	$168,120,013	18%
Nevada	$928,948,177	$318,045,892	34%
New Hampshire	$1,055,799,857	$135,813,688	13%
New Jersey	$5,434,728,363	$863,976,487	16%
New Mexico	$2,202,708,760	$488,254,038	22%
New York	$28,370,863,983	$5,132,625,696	18%
North Carolina	$6,876,832,521	$1,475,270,064	21%
North Dakota	$616,002,570	$85,276,051	14%
Ohio	$8,379,622,221	$1,774,802,333	21%
Oklahoma	$1,571,682,654	$381,121,154	24%
Oregon	$4,033,968,758	$605,365,274	15%
Pennsylvania	$10,020,253,791	$1,650,923,658	16%
Rhode Island	$1,140,433,728	$216,289,695	19%
South Carolina	$1,864,787,621	$612,001,828	33%
South Dakota	$373,166,512	$72,996,241	20%
Tennessee	$3,170,525,834	$1,229,762,764	39%
Texas	$13,906,637,877	$3,300,223,587	24%
Utah	$748,075,052	$284,227,029	38%
Vermont	$618,056,391	$215,968,650	35%
Virginia	$4,034,563,330	$795,149,502	20%
Washington	$4,604,246,856	$806,558,971	18%
West Virginia	$1,632,301,159	$220,016,990	13%
Wisconsin	$4,862,957,570	$766,005,134	16%
Wyoming	$314,726,178	$50,612,492	16%
United States	$209,616,600,661	$46,280,389,314	22%

Sources: AARP Public Policy Institute; Manatt Medicaid Financing Model.

Model assumptions: Total LTSS spending is based on reported FY 2015 Medicaid LTSS spending, allocated to aged and disabled eligibility groups based on type of service. LTSS spending is projected to grow at the same rate as other Medicaid spending, and each year 3.3 percent of institutional spending is replaced by HCBS. For the BCRA shortfall, the model uses projections of Medicaid per enrollee cost growth and medical consumer price index (M-CPI) and the consumer price index for all urban consumers (CPI-U) from the CMS Office of the Actuary and assumes that states discontinue their expansion adult coverage when the matching rate decreases and limit their total Medicaid spending to the amount that will be matched with federal funds.

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