

The Potential Impact of the American Health Care Act on Home and Community-Based Services Spending

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The decade of the 2000s saw rapid growth in state Medicaid spending on home and community-based services (HCBS). 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 American Health Care Act (AHCA) proposes to cap Federal Medicaid reimbursements to the states on a per-enrollee basis, effectively limiting growth to a rate only modestly exceeding the rate of 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. Subsequent inflation 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.¹

For most people who receive HCBS, it is by far the largest component of their Medicaid spending. If the AHCA 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

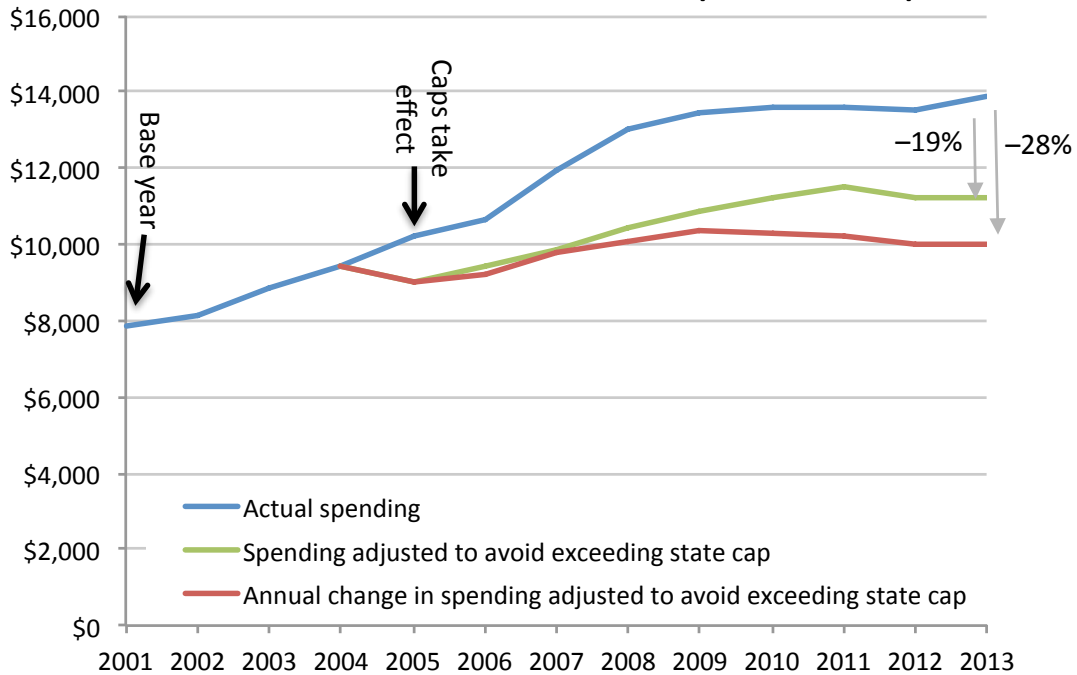
Spending was analyzed separately for enrollees with and without intellectual or developmental disabilities (I/DD). The analysis for enrollees without I/DD includes all state spending on personal care services programs and 1915(c) waiver programs other than for people with I/DD. The analysis for enrollees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

¹ This procedure reflects the author's understanding of the provisions of H.R. 1628, as passed on May 4, 2017.

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



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 AHCA-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 AHCA), and 2005 as the year that caps would have been implemented (equivalent to 2020). Following the procedure proposed in the AHCA, caps were inflation-adjusted using the CPI-MC of the data years (i.e., we applied CPI-MC to the base-year spending for 2002-2004 and CPI-MC plus 1 percentage point for subsequent years).

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

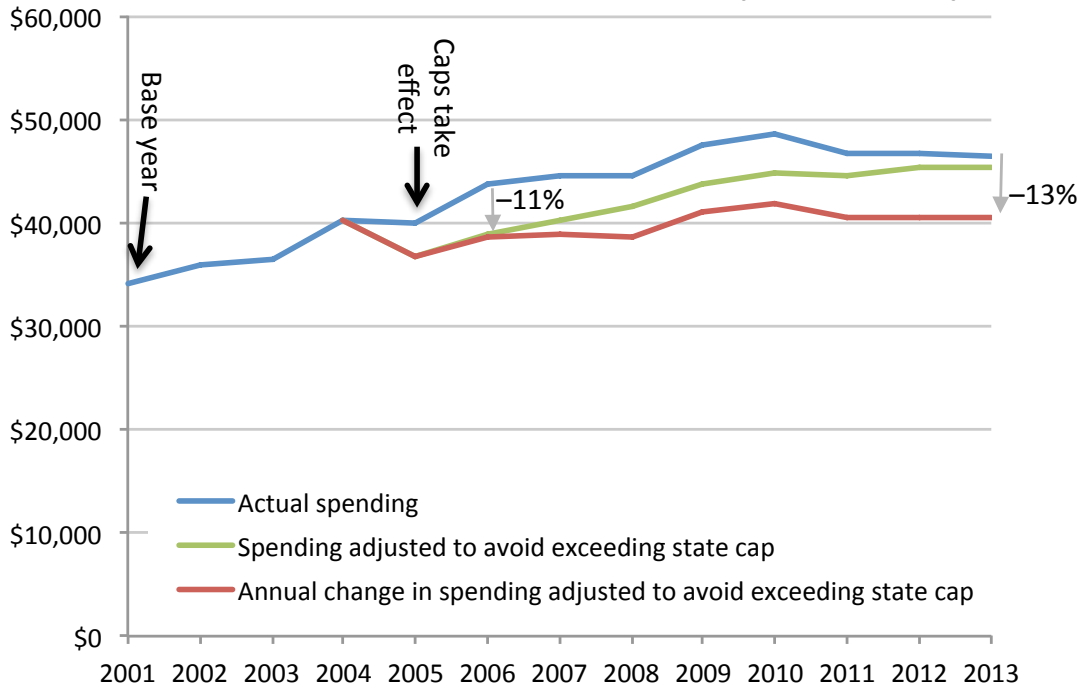
assumed to be limited to the years in which the actual spending exceeded the cap.

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; 31 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

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



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 19 percent less than actual spending. Spending under Scenario 2 (red line) is 28 percent less.

With respect to I/DD spending, more than half of the states (28 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 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 nearly catches up to actual spending by 2013. Scenario 2, in contrast, remains low, with 2013 spending at 13 percent below actual.

Conclusions

If per-enrollee caps like those proposed in the American Health Care 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 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

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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.

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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	17.8	6	27.6	9
Alaska	42.3	9	—	—
Arkansas	19.2	8	18.6	9
California	24.5	6	—	—
Colorado	21.9	9	—	—
Connecticut	32.2	9	48.9	4
Delaware	—	—	13.1	7
District of Columbia	96.6	9	96.1	9
Florida	55.1	7	26.6	8
Georgia	26.8	6	32.4	7
Hawaii*	7.1	1	30.1	9
Idaho	24.8	2	—	—
Illinois	35.3	9	3.6	1
Indiana	3.0	1	—	—
Iowa	34.1	9	7.8	5
Kansas	—	—	—	—
Kentucky	27.3	6	4.7	1
Louisiana	23.0	3	26.1	5
Maine	54.9	8	23.0	2
Maryland	34.9	9	6.2	3
Massachusetts	—	—	18.8	7
Michigan	11.3	9	—	—
Minnesota	30.3	9	21.6	8
Mississippi	42.4	9	55.7	9
Missouri	21.5	9	22.9	9
Montana	—	—	—	—
Nebraska	9.8	4	—	—
Nevada	17.8	7	46.1	9
New Hampshire	5.2	7	16.5	1
New Jersey	—	—	40.0	9
New Mexico	0.9	1	—	—
New York	34.2	9	19.6	8
North Carolina	—	—	—	—
North Dakota	—	—	—	—
Ohio	—	—	—	—
Oklahoma	42.4	9	—	—
Oregon	15.3	8	—	—
Pennsylvania	34.5	9	0.0	1
Rhode Island*	—	—	25.5	3
South Carolina	17.7	5	18.4	7
South Dakota	46.6	9	—	—
Tennessee	54.8	6	42.4	9
Texas	51.7	9	—	—
Utah	56.0	6	—	—
Virginia	28.1	9	9.0	6
Washington	—	—	25.5	9
West Virginia	20.8	6	—	—
Wisconsin	—	—	—	—
Wyoming	29.4	9	—	—

*Analysis includes 2005–08 only.

Consistent data not available for Arizona or Vermont.