# The Potential Impact of the Medicaid Caps on Home and Community-Based Services Spending in Arizona

H. Stephen Kaye, Ph.D.

## Executive Summary

Medicaid caps would heavily impact spending on home and community-based services in Arizona, where more than 45,000 people rely on these services to remain in their homes, avoid institutionalization, and participate in their communities.

- If Medicaid caps similar to those in the Republican healthcare bill had been enacted in the decade of the 2000s, Arizona would have seen annual Federal reimbursements reduced by about 13 percent, or over $140 million per year.
- If Arizona had limited HCBS spending to the amount allowed under the cap, annual per-enrollee spending would have dropped by about $2,800.

## Background

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 large growth spurts in HCBS spending in Arizona and many other states.

The Better Care Reconciliation Act (BCRA) 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.[1] 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

[1] This procedure reflects the author's understanding of the provisions of the Senate "Discussion Draft" of the BCRA, released June 22, 2017.

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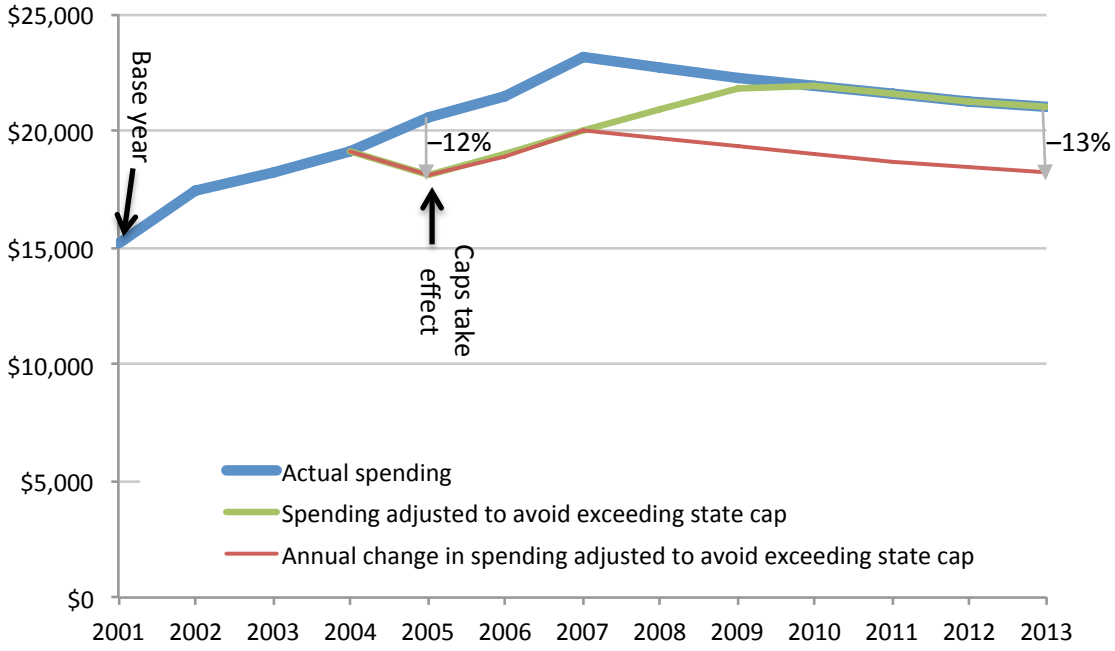
Community Living Policy Center, University of California San Francisco
www.communitylivingpolicy.org

**Figure 1. Average annual HCBS spending per Arizona enrollee, 2001–13, actual and reduced as if BCRA caps had been in place**




amount; otherwise, any excess comes entirely out of the state budget.

## Methods

For this analysis, we used publicly available data for 2001–2013 on state per-enrollee spending on Medicaid HCBS programs. Data on Arizona HCBS expenditures and participants come from reports produced by the Kaiser Family Foundation and the University of California San Francisco.[1] Unlike in most other states, Arizona data are not differentiated by program or population type.

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 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, the 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

Arizona HCBS spending exceeded the hypothetical cap by a substantial amount. An immediate 12 percent reduction in expenditures would have been necessary (or the state would have had to make up the difference) in the first year of the caps, widening to 13 percent by Year 3.

The blue line in Figure 1 shows Arizona per-enrollee HCBS spending. Although spending under both capped scenarios drops as soon as caps take effect, it gradually rises to meet actual spending in Scenario 1 (green line). In Scenario 2 (red line), spending remains below actual spending, ending at 13 percent less than actual.

## 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 Arizona, as well as many other states, to restrict HCBS spending to amounts much lower than spending under existing Medicaid reimbursement rules. States like Arizona that invested 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, 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

1. 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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