COMMUNITY CATALYST

Impact of Medicaid Per Capita Caps on Long Term Services and Supports

Republicans in the House of Representatives (House) are proposing to fundamentally alter the financing of the Medicaid program from a federal-state partnership to a per capita cap program. Changing Medicaid to a per capita cap program will in all likelihood take dollars away from states. Per capita caps provide states with a set amount of funding per beneficiary and if costs exceed the per capita cap, the state would have to pay for them or individuals would have to forego needed care. While this type of financing adjusts for population growth, it does not account for other factors driving Medicaid expenditures like changes in health care needs or increases in the cost of health care services. Sometimes those changes are unpredictable, like the current opioid epidemic or the past H1N1 flu epidemic, and at other times we know changes are coming. Unless Congress accounts for these changes, per capita caps will shift all of these risks to the states, placing tremendous fiscal pressure on state budgets and placing our frailest citizens at significant risk. More specifically, those individuals – primarily older adults– who need long term services and supports (LTSS) because of functional and cognitive impairments, will suffer the most under a program based on a per capita cap method of allocating funds; such a program neither adjusts for their level of need nor for the fact that the population of aging Americans is growing.

Long term services and supports (LTSS) includes a range of typically non-medical services designed to help impaired individuals perform activities of daily living like bathing, dressing, and eating. This type of care is not covered by traditional health insurance, or by Medicare, and only a very small segment of the population has private long-term care insurance policies. Thus, Medicaid is the primary public payer for LTSS and any changes to this program have important implications for people residing in nursing homes or receiving home and community-based care (HCBS). Reductions in financial commitments to the program mean less care to those with LTSS needs.

The growing aging population means an increased need for LTSS

The need for LTSS increases with age and the country is clearly growing older:

- As of 2014, there were 46.2 million older Americans over the age of 65 and by 2060 that number is expected to reach 98 million. Even more striking is the expected increase in the numbers of the "super-elderly" (those who are over 85 years old). The age 85 and over population is projected to triple from 6.2 million in 2014 to 14.6 million in 2040.
- Among people age 65 and over, it is estimated that 70 percent will use LTSS, and people age 85 and over are four times more likely to need LTSS compared to people age 65 to 84.
- The projected growth in the over age 65 Medicaid population is almost 4 times higher compared to the growth in all Medicaid enrollees and those 85 and over are projected to grow at a rate that is twice as fast as the rest of the population.

Studies on LTSS costs (including in the private sector) show a sharp rise in the need for LTSS for those who are 65 and older. If a per capita cap is based only on the numbers of people over a specific age, say 65, and not on the underlying age distribution within that population, there will be a significant shortfall in service dollars. This is because a state that has 20 percent of its over-age 65 population in the 85-95 age range has a much greater need for LTSS services than a state that has only 10 percent of its population in this age range. In other words, population demographics matter.

To be concrete, Arizona has the fastest growth rate for the 65 and older population, while Alaska has the highest for the 85 and older population. Both would be hurt by an approach that ignored population age-composition. In addition to accounting for the age mix, a per capita cap approach whose goal is to provide sufficient funds to meet a state's LTSS needs must account for other factors like health status, disability prevalence, and functional/cognitive needs, to name a few. Rates of disability and need for LTSS vary across the states and thus a payment based solely on the number of people will significantly short-change those states that have higher need due to these other factors.

Long term care costs for caring for an older population will increase

LTSS costs for older adults, including the economic value of family or unpaid care, exceeded $400 billion in 2011. Moreover, those who have functional impairments cost the Medicare program 3 times more than do those without such impairments. Almost a third of people ages 75 to 84 and more than half of those age 85 or older report functional limitations. Medicaid federal and state spending for LTSS in 2014 was about $152 billion and while enrollment in Medicaid is dominated by adults and children, expenditures are dominated by seniors due to their complex health needs.

In the recent proposal under consideration to repeal and replace the Affordable Care Act (ACA), the per capita cap model does not take into account the expected growth in health care spending for the elderly or changes in health status and population longevity – all contributors to a growing, not shrinking need, for LTSS. The risk of imposing per capita caps is that states would need to cut back on optional services such as HCBS – precisely the ones that people value the most since they support aging in place. The pressure on states to cut back on services will shift costs and caregiving burdens back onto the most vulnerable populations.

The annual growth in current Medicaid spending, coupled with the aging of the population, will present states with very difficult choices, made even more challenging by an approach that ignores major determinants of need. A state like Alaska, for example, has had Medicaid spending grow at an annual rate of 9.4 percent (between 2000 and 2011) and its population age 85 and older is projected to grow at an annual rate of 5.2 percent between 2015 and 2025 compared to the national rate of 1.6 percent. If the baseline for per capita caps is tied to average state spending or spending per beneficiary, the needs of the population simply will not be met.

Per capita caps would need to account for an expected decline in family caregivers

There are over 17.7 million family caregivers in the U.S. that are providing assistance and support to individuals age 65 and older who have significant impairments. The CBO estimates the value of this care is $234 billion. Yet, smaller family size, the increasing employment mobility of adult children, and strains associated with "sandwich generation" caregivers, are all trends that portend less and less available family-provided care in the future, even as the overall amount of caregiving needed balloons. Thus, at the same time that per capita caps will diminish Medicaid's ability to support those with LTSS needs, the family caregiving system is under increasing strain. The implication is that either greater numbers of caregivers will need to make workforce accommodations to care for aging parents – thus leading to declines in productivity and diminished contributions to economic growth – or more people with LTSS needs will go without needed care. Because many of these caregivers will be forced to reduce their own labor force participation, this will likely create future strains on the social safety net as they will have had less opportunity to accumulate savings for their own retirement.

Finally, when faced with sharp Medicaid cuts, states will likely need to cut payments to providers, which will diminish providers' capacity to provide high quality care resulting in a situation of greater under-met and unmet need. It may also result in fewer providers willing to participate in Medicaid and could induce providers to raise private pay rates.

Per capita caps reinforce institutional bias

Medicaid is the primary payer for low-income seniors needing nursing facility care. Nearly 63 percent of residents in nursing facilities have Medicaid. Institutional LTSS accounts for nearly 11.2 percent ($59.5 billion) of the total Medicaid benefit spending. As mentioned, the per capita caps approach would force states to cut back on their commitments to HCBS since these are optional services and coverage for nursing home care is mandated. So for example, in a state like Ohio where 15 percent of the state's total Medicaid spending is on HCBS, adequate levels of these services would be difficult to maintain in the presence of per capita caps. A total of 19 other states also spend more on HCBS than institutional care and would face a similar situation. Per capita caps would immediately restore the institutional bias of the Medicaid program, and force older adults into institutional care that they typically do not want. Over the last 25 years institutional bias has been greatly diminished and the Medicaid program has become far more responsive to elders needs and desires to receive care at home. With per capita caps, we could return to a scenario where institutional settings would again serve as the primary site for LTSS service delivery.

Conclusion

The bottom line is that the current financing structure of Medicaid facilitates and supports states' ability to cope with the shifting health and LTSS needs of the most vulnerable populations. Per capita caps fail to do that and would undermine access to care, jeopardize the fiscal stability of states, add strains to already over-burdened caregivers, and lead to significant quality declines in LTSS services.