What is Medicaid and How Does It Work in Texas

A Look Ahead Quarterly Conference

Arlington, Texas

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1

Public Policy in Simple Terms

1. Laws or Statutes by Legislative Bodies, citations as USC (United States Code) or P.L.#, like P.L. 94-142; open with Findings & Purpose(s)
2. Regulations or Rules by Administrative Agencies, citations as CFR (Code of Federal Regulations)
3. Decisions by Courts and Judges, citations such as Olmstead v. L.C., 527 U.S. 581 (1999)

All policies are based on *values, and values change over time*, based upon advocacy or the lack thereof. Most policies can be amended or repealed at any time, which requires our eternal vigilance! Advocacy is a participatory sport.

2

Title XIX-Grants To States For Medical Assistance Programs

[42 U.S.C. Sec. 1396], enacted **1965**

Administered by CMS (Center for Medicare and Medicaid Services), within DHHS

IL. Dept. of Healthcare & Family Services

"Sec. 1901. For the purpose of enabling each state as far as practicable under the conditions in such State, to furnish (1) **medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services,** and

3

(2) **rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care,**

there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to Sates which have submitted, and had approved by the Secretary, State plans for medical assistance."

4

Medicaid Structure for States

- Eligibility: Mandatory and **Optional**
- Services: Mandatory and **Optional**
- Services: **Amount, Duration and Scope sufficient to meet the purpose (states can and do set limits; a lot of flexibility)**
- Statewideness, Comparability and Freedom of Choice (unless waivers obtained)
- **Reimbursement methodology**: **Rates**
- Provider standards: Compliance with federal regulations and whatever state wants to add
- Quality Assurance:
- **Entitlement to federal matching funds: no cap on federal dollars. $$$$$$$$$$$$$$$$$$$$$$$$$$$$**

5

Eligibility for Medicaid

- **Mandatory:**
  - Low income families and children under 18 in families up to 138% poverty
  - Pregnant women up to 138% FPL
  - **SSI recipients, children, adults and seniors; also low income and assets**
- **Optional:**
  - "Medically Needy" due to high med. cost
  - Katie Beckett families: TEFRA 134
  - Variety of work incentives for PWD
  - ACA Expansion to 138% FPL for parents and childless adults

6

Mandatory State Plan Services:

- Inpatient Hospital Services (not IMD)
- Outpatient Hospital Services and Rural Health Clinic Services
- Other Laboratory and X-Ray Services
- ***Nursing Facility Services for Individuals 21 or Older*** (not IMD)
- Federally Qualified Health Center Services
- Freestanding Licensed Birth Center Services
- Family Planning Services
- Transportation to Medical Care
- Tobacco Cessation Counseling for Pregnant Women

42CFRss440…

Mandatory State Plan Services-2

- EPSDT for individuals under 21
- Rural Health Clinic Services
- Physicians' Services and Medical and Surgical services of a Dentist
- Home Health Services
- Medication Assisted Treatment (MAT)
- Nurse-Midwife Services (where licensed)
- Nurse Practitioner Services (where licensed)
- Pregnancy-Related Services
- Routine patient costs for items and services in qualifying clinical trials

Early Periodic Screening, Diagnosis & Treatment-EPSDT

This act requires that any service which you are permitted to cover under Medicaid that is **necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided** to E.P.S.D.T. participants regardless of whether the service or item is otherwise included in your Medicaid plan.

Optional State Plan Services

- Medical or Other Remedial Care Provided by Licensed Practitioners
- Private Duty Nursing Services
- Dental Services
- Primary Care Case Management Svcs.
- Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing and Language Disorders (and prescriptive equipment)

Assistive Technology Defined:

"…any item, piece of equipment, or product system, whether acquired commercially, modified, or customized that is **used to increase, maintain, or improve functional capabilities** of individuals with disabilities."

- Includes accessibility adaptations to the workplace and special equipment to help people work;
- Definition in 4 federal laws: IDEA; Rehab. Act; Assistive Technology Act; DD Act;

Optional State Plan Services-2

- **Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses**
- Clinic Services
- Diagnostic, Screening, Preventive, and rehabilitative Services
- Inpatient Hospital, etc. Services for Individuals age 65 or over in IMD's
- ICF/DD Services

Optional State Plan Services 3

- Nursing Facility Services Other than in an IMD
- Inpatient Psychiatric Services for Individuals under age 21
- Certified Community Behavioral Health Clinic (CCBHC)
- Personal Care Services
- Any Other Medical Care or Remedial Care Recognized Under State Law

Optional State Plan Services 4

- Emergency Hospital Services
- Respiratory Care for Ventilator-Dependent Individuals
- Home & Community-Based Services (HCBS); waivers or state plans
- Community First Choice
- Medical Health Homes for enrollees with chronic conditions

Medicaid does more than you think:

- Nursing Home Care
- Mental Health
- Children's Mental Health
- Chemical dependency treatment
- Maternity Care
- Aging at Home
- Disabilities Services in School
- Primary Care
- Assisted Living Services
- Medical Equipment
- Home and Community Based Services
- Communication devices
- Doctoral Residency Programs
- Medicaid Waivers

THIS IS MEDICAID

Federal Medical Assistance Percentage (FMAP): Federal Matching Funds to States for Medicaid Services

- Each year the federal government calculates the FMAP for each state based upon population, per-capita income and other factors; **it is an entitlement with no cap on dollars**
- No state gets less than 50%; Mississippi receives 76.9% in 2025 **(Texas receives 60.0% in FY 2025)**
- This opportunity will end if Congress block grants/caps Medicaid to the states.

Evolution of Medicaid "Long Term Care"

- To Today's Legal Language:

LONG TERM SERVICES AND SUPPORTS

Evolution of Medicaid LTSS - 1

- **1965:** Title XIX Enacted with Skilled Nursing Facility as an **ENTITLEMENT (institutional bias)**
- **1967: Intermediate Care (Option)**
- **1971: I.C.F.M.R. and Related Conditions Option-today, ICF/DD (Institutional Bias as "Entitlement if in State Plan)**
- **1981: Managed Care Payment Option (1915-b)**

Evolution of LTSS – 2

- **1981: Home & Community-Based Services (HCBS) *"WAIVER"* (OPTION) (1915-c)**
- **1982: Katie Beckett Waiver of parental income & Resources (Option)(TEFRA134)**
- **1986: HCBS Amendments: Added Supported Employment & Respite Care**
- **1987:** Nursing Home Reform-Fed. Standards **Pre-Admission Screening and Annual Review (PASARR)**

Evolution of Medicaid LTSS - 3

1990: Americans with Disabilities Act-ADA

1990: Community Supported Living Arrangements (CSLA) (Pilot)

1992: Personal Care Attendant (Option)

1995: CSLA made permanent for states to add "Supported Living" (Option)

1999: Olmstead SCOTUS Decision

2005: HCBS State Plan Amendments as an **Entitlement for all within it! (1915 i) &**

(1915 j) Self Directed Services (alternative payment methodology

Evolution of Medicaid LTSS – 4

- 2005: Money Follows the Person (demo) & Enhanced Match for Deinstitutionalization
- 2010: Affordable Care Act:
  - Community First Choice, Section 1915 (k) and its broad definitions encompassing both ADL's and IADL's and cueing, etc.
  - Money Follows the Person extended and expanded
- 2016: Electronic Visit Verification for PCS by 1/1/2021 and for HHCS by 1/1/2023

CHANGES TO MEDICAID HCBS STATE PLAN OPTION UNDER SECTION 1915 (i), in S.2402 (b)

- This is not the traditional state HCBS waiver, which is 1915 (c)
- This state plan option was authorized in the Deficit Reduction Act of 2005 but only four states had chosen to implement it
- State Medicaid Directors' letter 8/6/2010

CHANGES TO MEDICAID HCBS STATE OPTION UNDER SEC. 1915 (i), cont.

- Income eligibility criteria at 150% FPL if not eligible for institutional services; if eligible for institution, can go to 300% FPL
- States may waive "comparability" requirements, target certain populations with different services and amount, duration and scope; States cannot waive statewideness or cap enrollment
- States may get approval for up to 5 years and phase in over 5 years.

CHANGES TO MEDICAID HCBS STATE OPTION UNDER SEC. 1915(i), cont.

- Expands the list of services that can be funded to the identical list in HCBS waiver
- Did not and does not require institutional level of care and cost neutrality as is the case in the HCBS Waiver
- Requires person centered plan and encourages self directed services, budgets
- A major opportunity for individuals with T.B.I., Mental Health Conditions, Autism, Mild I.D., etc.; can use functional groups.

SERVICES AUTHORIZED UNDER HCBS:

- Service Coordination
- Homemaker
- Home Health Aide
- Personal Care
- Adult Day Health
- Habilitation, including supported employment
- NO funds for room and board
- Environment Accessibility & Adaptability Equipment
- Respite Care
- Day Treatment or Other Partial Hospitalization
- Psychosocial Rehabilitation Services
- Clinic Services
- Enhanced Therapies…
- Transportation-Non-Med.
- Personal Emergency Response Systems
- Assisted Living
- CSLA

Texas Has 6 Traditional Medicaid HCBS Waivers – Section 1915 (c)

1. Community Living Assistance and Support Services (CLASS)
2. Deaf Blind with Multiple Disabilities (DBMD)
3. Home and Community-based Services (HCS)
4. Medically Dependent Children Prog. (MDCP)
5. STAR + Plus Home & Community Based Services
6. Texas Home Living (TxHmL)

COMMUNITY FIRST CHOICE MEDICAID STATE PLAN OPTION (2010)

- Section 1915 (k)
- **An attempt to reduce the "institutional bias" in Medicaid long term services**
- Has been attempted since ADAPT's (American Disabled for Attendant Programs Today) early attempts at MiCASA in the early 1990's

COMMUNITY FIRST CHOICE, cont.

- Provides comprehensive home and community based services (HCBS) for **individuals with disabilities who are eligible for a Medicaid "institutional level of care"**
- States who choose this ***must*** make community-based attendant services and supports available to ***all eligible individuals*** and is an **entitlement to HCBS**
- **No waiting lists allowed**……

COMMUNITY FIRST CHOICE

- Services and supports to **assist individuals with disabilities with activities of daily living, instrumental activities of daily living, and health related tasks through hands-on-assistance, supervision, or cueing**
- States who choose this new Medicaid state plan option will receive an **additional 6% federal match rate for this program**

COMMUNITY FIRST CHOICE, cont.

- Eligibility based on **functional need**
- Allows states to have eligibility up to 300% of SSI
- **Services to be provided at home or in a community setting**
- **Excludes** room & board, assistive technology devices and services (except emergency back up systems), medical supplies and equipment, & home modifications

Community First Choice Option States:

- Alaska
- California
- Connecticut
- Maryland
- Minnesota – Community First Services & Supports (CFSS-combined (i) and (k) for Personal Care Services
- Montana
- New York
- Oregon
- **Texas**
- Washington

Money Follows the Person (2005)

- Provides 50% enhanced match for each person for 365 days after leaving institution, including transition and admin. costs
- "To increase the use of HCBS and to decrease the use of institutional services
- To eliminate barriers and mechanisms in State law, State Medicaid plans or State budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid eligible individuals to receive long term care in the settings of their choice

"Qualified Residence" under MFP

- "A home owned or leased by the individual or individual's family member;
- An apartment with an individual lease with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or the individual's family has domain or control; or, a residence, in a community-based setting in **which no more than 4 unrelated individuals reside"**

Supported Living: Key Principles

based on work of John O'Brien, Ph.D.

1. **People with disabilities should be supported in living arrangements that are typical of those in which persons without disabilities reside.**
2. The services that a person receives should change as his or her needs change **without the person having to move elsewhere.**
3. **A person with disabilities should exercise choice over where and with whom he or she lives.**

Supported Living: Key Principles -2

4. People with disabilities should have **control over their own living arrangements.**
5. The aim of furnishing services and supports to a program participant is to assist that individuals to take command of his or her life while building critical and durable relationships with other people. in
6. The **services or supports furnished to an individual should be tailored to his or her needs and preferences.**

Supported Living: Key Principles - 3

7. Services and supports are more effective when furnished where a person lives and within the context of his or her day-to-day activities.
8. Supports must be extremely flexible, not restricted to particular types or categories of services.
9. **People with DD should not be excluded from supported living arrangements based on the nature & severity of their** disabilities.

Gary A. Smith, NASDDDS,1990 (for Medicaid CSLA)

Supported Living is NOT…….

- Simply offering services in "small residences"
- **Synonymous with apartment programs**
- A model that rejects training as a valid component of service provision
- An "unsupervised" living arrangement
- **Another residential alternative.**

SUPPORTED LIVING WAS ADDED TO THE LIST OF MEDICAID HCBS OPTIONS BY CONGRESS FOR STATES IN 1995 TO SEPARATE HOUSING FROM SUPORTS AND TO MOVE AWAY FROM GROUP HOMES!

Housing is Fundamental to Community Living – ACL June 16, 2022 at the NASDDDS Annual Conference

- **Housing creates access to the community and all that it has to offer**
  - Shopping
  - Recreation
  - Entertainment
  - Employment
- **Housing also creates a sense of "belonging"**
  - **A sense of connection to and personal identification with the whole, "community"**
  - It embraces an individual's participation and belief in something larger than themselves.

Housing is a Right

- **Adults with ID/DD have the same rights as others to live independently in the community in a dwelling of their choosing** – whether that is a home, an apartment, or some other kind of community living arrangement.
- **Adults with ID/DD should control where and with whom they live and should have opportunities to rent or buy their own homes.**
- People with ID/DD are also **protected from discrimination in housing** under the Fair Housing Act and the ADA

39

Why is Employment Becoming Part of Medicaid's Focus?

CMS's commitment:

"Work is a fundamental part of adult life for people with and without disabilities. It provides a sense of purpose, shaping who we are and how we fit into our community. **Meaningful work has also been associated with positive physical and mental health benefits and is a part of building a healthy lifestyle as a contributing member of society.** Because it is so essential to people's economic self sufficiency, as well as self esteem and well being, people with disabilities…who want to work should be provided the opportunity and support to work competitively within the general workforce in their pursuit of health, wealth and happiness. **All individuals, regardless of disability and age, can work – and work optimally with opportunity, training, and support that build on each person's strengths and interests.** Individually tailored and preference-based job development, training, and support should recognize each person's employability and potential contributions to the labor market."

➢Highlights CMS's goal to promote integrated employment options

40

Employment First

"Employment is nature's best physician and is essential to human happiness."
— Galen, Greek physician

CMS Issues Final Rules on HCBS and the Definition of Community: Jan. 16, 2014

- Applies to 1915 (c) HCBS waivers; 1915 (I) SPA for HCBS; and, 1915 (k) Community First Choice SPA
- Extensive criteria for the development of a "person centered plan"
- "Informed choice"
- "**Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the PCP……**

CMS Final Rules, 1-16-2014, cont.

…except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS."

- **Home & Community-Based Settings –** "must have all of the following qualities, and such other qualities that the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:…..

CMS Final Rule, 1-16-2014, cont.

" (i) The **setting is integrated** in and supports **full access** of individuals receiving Medicaid HCBS **to the greater community**, including opportunities **to seek employment and work in competitive integrated settings, engage in community life,** control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

CMS Final Rules on HCBS
continued

#3. "Optimizes, but does not regiment individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, & with whom to interact."

45

Person-Centered Service Plans

Final rule includes changes to the requirements regarding person-centered service plans for HCBS waivers under 1915(c) and HCBS state plan benefits under 1915(i) -

- Identical for 1915(c) and 1915(i)
- The person-centered service plan must be developed through a person-centered planning process

46

1915(c) and 1915(i) Home and Community-Based Services

- The person-centered planning process is **driven by the individual**
- **Includes people chosen by the individual**
- Provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible
- Is timely and occurs at times/locations of convenience to the individual
- Reflects cultural considerations/uses plain language
- Includes strategies for solving disagreement

27

47

1915(c) and 1915(i) HCBS Person-Centered Service Plans

- **Offers choices to the individual regarding services and supports the individual receives and from whom**
- Provides method to request updates
- Conducted to reflect **what is important to the individual to ensure delivery of services in a manner reflecting personal preferences** and ensuring health and welfare
- **Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual**
- May include whether and what services are self-directed
- Includes **individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others**

28

48

The Administration for Community Living

ACL is based on a commitment to one fundamental principle—that **people with disabilities and older adults should be able to live where they choose, with the people they choose, and fully participate in their communities.** Inherent in this principle is the core belief that **everyone can contribute throughout their lives.**

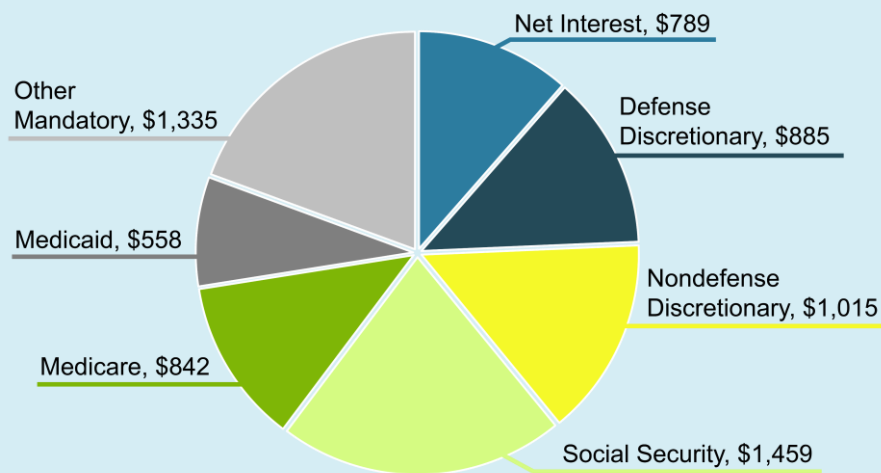
Where is the Future?

Federal Budget

- $6.272 Trillion budget for FY ’22 with a $1.375 Trillion deficit……..
- **National Debt at $31.45 Trillion, the national debt ceiling, which is over $91,000/person in U.S.**
- **On May 30, 2024, the U.S. National Debt was $34.61 Trillion, double what it was 15 years ago in 2009. It amounts to $102,862.00 per person!**

51

Composition of the Proposed FY 2024 Budget
Total Outlays = $6.9 trillion
outlays in billions of dollars



52

The Current Agenda in Washington, DC

- Disregard the size of the federal deficit created by the Tax Reform & Jobs Act; estimated to be at least $1.1 Trillion……
- Attack "Welfare" & "Entitlements"
- Reduce the next ten years of the cost of Medicaid, Medicare, SSI, SNAP, Housing Subsidies, etc. to the federal government
- Congressional Budget Office estimates that the Medicaid proposals will reduce the federal expenditures for Medicaid over the next ten years by $880 Billion……

House Budget Committee Proposals: Total to save $5.3 - $5.7 Trillion over Ten Years with $2.2 Trillion from Medicaid, which is 38.6% of the total

- **Per Capita Caps – up to $918 Billion**
- Equalize Medicaid Payments for Able Bodied Adults–up to$690 Billion from ACA
- Medicaid **Work** Requirements-$120 Billion
- **Lower FMAP Floor Rate** - $387 Billion
- Limit Medicaid Provider Taxes - $175 B.
- Repeal American Rescue Plan FMAP Incentive - $ 18 Billion

House Budget Resolution

- Passed House on February 25, 2025 with a vote of 217 – 215, with 1 R. voting “no”.
- Instructions to 11 Committees with guidelines for reduction.
- **House Energy & Commerce Committee allowed up to $880 Billion in cuts to Medicaid over 10 years!**
- Committees must report to the House Budget Committee by March 27, 2025!
- Goal is to use these numbers for a budget reconciliation bill.
- Budget Continuing Resolution (CR) expired 3/14/2025 –extended to 9/30/2025

55

Senate Budget Resolution
Passed, April 5, 2025, 51-48

- $5 Trillion in Tax Cuts and $1.5 Trillion in New Taxes.
- $4.0 Billion in Budget Cuts with Nothing Specific about Medicaid, Compared with $1.5 Trillion in House Budget Cuts and $880 Billion in Medicaid Cuts.
- Raises the Debt Limit by $5 Trillion, and no Increase in House Bill.(May reach current debt limit in summer, 2025 (GAO).

56

Medicaid Overview: FY' 2022 data CMS Data, July 2023

- Over 94.5 million beneficiaries:
  - 38 % children 16% of expenditures
  - 40% adults(16-64) 30% of expenditures
  - **10% seniors; 22% of expenditures**
  - **12% PWD; 33% of expenditures**

(22 % of population & 55% of $$ in 2022

Total expenditures for federal government, FY'22: $513 Billion (64%)… from a total of $804 Billion

All Medicaid LTSS Expenditures as a Percentage of Total Medicaid Expenditures FY 2020 (Mathematica for CMS)

- **U.S. Average: 33.0%**
- Range: from a low of **20% in New Mexico and LA.**, to a high 55% in North Dakota
- **Texas and Virginia did not send data!**
- Nearby States:
  - KS., 51%; MO., 34%; CO., 34%;
  - OK., 31%; AL., 30%;
  - IL., 21% (4th lowest)

HCBS $ Percentage of All LTSS $ -2020 CMS Data

- **U.S. Median 62.0%**
- Range from a low of 32% in MS. to a high of 84% in Oregon
- **Texas and Virginia did not provide data (TX. Claims 62%!!! On HHS!!)**
- Other Nearby States:
  - KS., 73.0%; CO., 72%;
  - N.M., 71%; MO., 60%;
  - OK., 43%; LA., 35%

Medicaid Total LTSS Expenditures Per State Resident, FY 2020

- **U.S. Average; $678.99**
- Range from **low of $281.89 in Utah** and $295.33 in NV., to a **high of $1.520.59 in New York and $1,183.41 in Minnesota.**
- **Texas and VA. Did not provide data.**
- Other Nearby States:
  - AL., $370.09; Oklahoma, $378.62;
  - LA., $540.76; Colorado, $569.27
  - N.M., $584.28; MO., $600.82
  - KS., $665.62; IL.,$373.57 (43rd)

TEXAS MEDICAID PROGRAM
Feb. 2024 – State Population 31.29 Million

The Texas Medicaid program covered **nearly 4.2 million beneficiaries (13.5% of population or about 1/7) as of February 2024, with approximately 96 percent enrolled in a Medicaid managed care plan**. Texas is not a Medicaid expansion state. The state has six Medicaid managed care programs and is in the process of reprocuring all programs: **STAR** (serving pregnant women, families, and children, as well as aged, blind, and disabled adults in Medicaid Rural Service Areas and not on Medicare), **STAR+PLUS** (serving individuals with disabilities and the aged), **STAR Health** (serving foster children), **STAR Kids** (serving children and adults 20 and younger who have disabilities), the **Children's Health Insurance Program (CHIP),** and the **federal Medicare-Medicaid dual eligible demonstration, which is scheduled to end December 31, 2024**. STAR Health contracts have already been awarded and began September 2023. STAR+PLUS contracts were awarded and are scheduled to begin September 2024. STAR and CHIP contracts have already been awarded, and implementation is expected between September and November 2025.

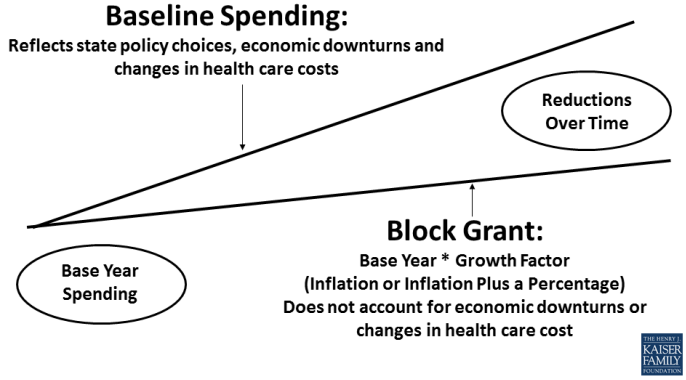
PWD & Medicaid Block Grants

- A **fixed amount of money** given to a state with "more flexibility" and less "entitlements"
- **No additional federal funding regardless of need, economic shifts, demographic changes, etc.**
- Alleges to give states more "flexibility" and it does not do that
- Burden would rest on the state and/or counties on how to address budget shortfalls.
  - Increase their funding
  - Cut services or hours of services
  - Reduce payment rates
  - Tighten eligibility rules
  - Any combination of the above
  - **PWD and seniors most likely to be impacted harder because of current use and expenses**

Block Grants

Figure 2

Under a block grant, reductions in federal spending are obtained by setting caps below expected spending.



Medicaid & Per Capita Caps

- Establishes limits on per capita spending, but how will that be done? **Sets a dollar cap per beneficiary**
  - One statewide average
  - **By population groups-children, women, disabled, elderly**
  - Acute care separate from LTSS and Institutional care
  - Exemption of some groups
  - Exemption of some services such as prescription drugs
  - What is the **formula for annual growth??? Can be changed**
  - How will the caps grow with changing demographics of aging and poverty??
- Federal rules, as in Block Grants, would be altered to allow the states "flexibility" to **reduce costs by changing**:
  - Eligibility; **work requirements**; premiums; co-pays
  - Services available and limits or caps on benefits
  - Payment rates to providers that already are very low
  - **CMS already doing today with 1115 waivers; IN., KY.**

Medicaid Per capita caps

"Medicaid Per Capita Cap Has Same Damaging Effects as Block Grant" – Center for Budget & Policy Priorities

- **Provides fixed funding per person, regardless of needs**
- Essentially caps federal funding, using 2016 as a base year. **Over the next 10 years** federal support is projected to be cut by $880 Billion; **states and/or counties will have to come up with the replacement revenue or make major cuts.**
- Cuts federal/state investments in innovative plans such as coordinating care for people with chronic conditions, or programs for home and community-based long-term services & supports while nursing homes and ICFs are "entitled"

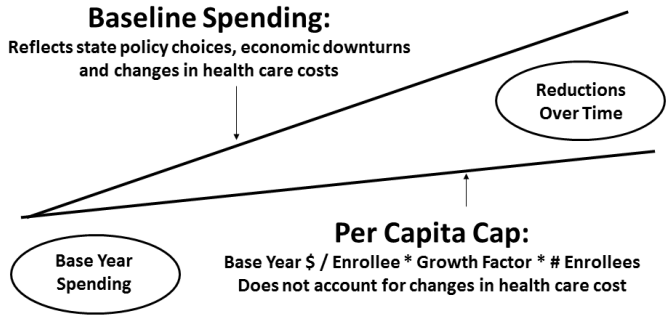
Medicaid Per capita caps

- Cuts would grow each year. As health care costs rise, **or if there is a public health crisis**, states must absorb costs.
- **States will likely impose Medicaid cuts in eligibility, benefits, and provider payments**.
- Medicaid is states' biggest source of federal funding, so cuts under per capita caps will squeeze state budgets overall.
- Will not control health care costs.
- Hits seniors and people with disabilities the hardest, because the majority of Medicaid spending covers their health care & LTSS.

Per Capita Caps

Figure 3

Under a per capita cap, reductions in federal spending are obtained by setting caps below expected spending.



"Equal Justice Under the Law"

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69