FAQs: Medicaid Cuts & Community-Based Services

How do community-based services help people with I/DD?

- Community-based services help people with intellectual and developmental disabilities (I/DD) live full and independent lives in their communities. These person-centered supports may assist with activities of daily living, meal preparation, medication management and employment support, among many other crucial and life-saving services.

How does Medicaid fund community-based I/DD services?

- Community-based services are almost exclusively funded through Medicaid. Medicaid operates as a partnership between states and the federal government to fund certain health care services. States determine the scope and payment for services to be provided for beneficiaries and the federal government provides matching funds at a predetermined rate. This combined funding is then used to reimburse community providers for the services they deliver.

- Unlike other types of health care services, states are not required to provide community-based services. This means that community-based services may only be offered when there is Medicaid funding available after all mandatory services have been funded. When funding is cut, community-based services for people with I/DD can be reduced or terminated. Unfortunately, these programs are already unable to serve everyone in need, creating long waiting lists for services.

How does reducing federal Medicaid funding harm services for people with I/DD?

New Federal Funding Penalties

- Even when Medicaid funding reductions don't specifically target community-based I/DD services, the resulting pressure on state budgets creates an elevated risk of cuts to services for people with I/DD. Reducing the Federal Medical Assistance Percentage (FMAP)—the share of Medicaid costs the federal government covers, including for disability services— would significantly impact funding for all Medicaid services in affected states. The proposal to penalize states that use state dollars to provide health care coverage for undocumented immigrants by reducing the FMAP from 90% to 80% for

Medicaid expansion could have devastating consequences for all Medicaid beneficiaries in that state.

- When the federal government reduces its share of Medicaid funding, states are left to fill the gap. If new funding cannot be found, states are forced to cut funding from other areas including reducing services, restricting eligibility, and lowering provider reimbursement rates. Optional services like community-based services for people with I/DD are often first to be cut. For example, following the Great Recession when federal Medicaid funding dropped significantly between 2010-2012, every state and the District of Columbia cut one or more of their home and community-based programs in response. The federal funding reductions proposed in the budget reconciliation bill are even larger, which places more people with disabilities at risk of losing access to community-based services.

New Upfront Costs for People with Disabilities

Many adults with I/DD have fixed or limited incomes and often struggle to cover their basic cost of living expenses. Cost sharing requirements for people who receive their healthcare coverage through the Medicaid expansion pathway will be harmful, especially for people with disabilities and chronic conditions. These individuals will experience higher out-of-pocket costs for their health care, particularly since people with disabilities often need to visit their healthcare providers more frequently than the non-disabled population. If providers can deny care for individuals who cannot pay, some people with disabilities may also experience decreased access to necessary services and supports that enable them to remain in the community and out of expensive nursing homes or state-operated institutions.

How will new caps and limits to state financing mechanisms harm community-based services for people with I/DD?

New Caps on State Directed Payments

- State Directed Payments (SDPs) allow states to provide additional funding to Managed Care Organizations (MCOs) above and beyond their capitation rates that allow for uniform rate increases for specific services, including home and community-based services for people with I/DD. These SDPs allow MCOs to pay their network providers for services rendered to Medicaid beneficiaries at the same level as their commercial clients. In doing so, SDPs improve access to care by eliminating the financial disincentives that providers encounter when serving Medicaid beneficiaries.

- The current proposal being considered by Congress would lower the payment limit for SDPs, requiring states to cap the total payment rate at 100 percent of the Medicare payment rates for expansion states and 110 percent of the Medicare payment rates for non-expansion states. Capping the SDP as proposed will likely decrease access to care for Medicaid beneficiaries since some providers will be unable to serve those individuals under the lower reimbursement rates.

Freezing Provider Taxes

- Provider taxes are an important regulated tool states use to finance their Medicaid programs. Provider taxes are vetted through statute and regulation, available only in limited circumstances, and serve as a crucial source of Medicaid funding for states. Every state, with the exception of Alaska, utilizes at least one provider tax. In 2018, provider taxes accounted for an average of 17% of the state share of the cost of Medicaid.

- Freezing provider taxes at current rates and prohibiting new provider taxes would have a significant impact on states' ability to fund Medicaid services into the future. Even when provider taxes are not levied against community-based services for people with I/DD, the resulting Medicaid funding is often used to support optional services including home and community-based services. With more than a half million people with I/DD on waiting lists for home and community-based services, the reduction in federal funding runs the risk that states will face budget shortfalls that could impact the availability of community-based services.

How will new red tape requirements harm people with I/DD?

New Administrative Burdens from Work Requirements

- Work reporting requirements are extremely burdensome for beneficiaries to navigate and for states to administer. Requiring people with disabilities who are working to document and verify that they are working will harm those who do not successfully navigate these bureaucratic processes by causing them to lose coverage for the very supports that enable them to continue working. Although some people with disabilities may be exempt from Medicaid work requirements, screening processes may not identify them correctly, and many will not be able to successfully navigate an exemption process.

- Work requirements are also likely to have negative consequences for low-income workers, including direct support professionals who are the backbone of long-term services and supports for people with I/DD. Approximately one-third of direct support professionals (DSPs) work part time or with inconsistent schedules—two job features that are generally incompatible with work requirements.

- The implementation date for proposed work reporting requirements is "…not later than December 31, 2026, or, at the option of the State, such earlier date as the State may specify." This accelerated timeline will pose significant operational challenges for states and will necessitate an expedited design, development, and implementation of new systems for reporting work and verifying compliance as well as enrollee education and awareness activities. Failure to properly test and refine these initiatives prior to implementation will lead to confusion and increased administrative burdens for Medicaid beneficiaries, particularly those individuals with disabilities.

Increased Eligibility Barriers for People with Disabilities

- Despite the fact that intellectual and developmental disabilities are life-long, easily diagnosed and verifiable conditions, people with I/DD must successfully navigate complex systems and application processes in order to establish and maintain ongoing eligibility for supports provided through Medicaid. Compliance with eligibility verification requirements for these programs pose significant challenges including difficulty with comprehending complex eligibility instructions and notices, navigating multi-step instructions without support, communication and physical limitations that create barriers to timely response, and lack of transportation and other supports required for in-person appointments.

- Proposals to delay implementation and enforcement of regulations that streamline eligibility and enrollment processes would pose additional challenges for many people with I/DD who already struggle to comply with eligibility requirements and would place them at greater risk for losing their Medicaid-funded supports. For example, the following disability-related protections would be delayed: prohibiting states from requiring in-person interviews for individuals whose eligibility is based on being 65 or older or having blindness or disability; allowing states to use projected predictable medical expenses incurred by people living in the community for purposes of deducting these expenses from the applicant's income when determining financial eligibility; and establishing specific guidelines for states to check available data prior to terminating eligibility when a beneficiary cannot be reached due to returned mail.