**MEDICARE AT RISK?**
Exploring the Implications of Medicaid Per Capita Caps for Medicare and Its Beneficiaries

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**Key Insights**

» 1 in 5 Medicare beneficiaries also rely on Medicaid. These 11 million enrollees tend to have more complex care needs and account for greater expenditures than the average Medicare beneficiary. They are often referred to as dually eligible beneficiaries.

» State Medicaid programs are now investing in significant reforms of care for this dually eligible population, focused on substituting improved care coordination and less-intensive, more person-centered interventions, including home- and community-based services (HCBS), for the major expenses associated with future, downstream hospital and specialty care.

» Medicaid per capita cap legislation would result in a gap between each state’s statutorily determined capped amount and the changing cost of care—generating greater overall budget pressure on state Medicaid programs.

» Under this pressure, states would have an incentive to roll back their ongoing investments in these Medicaid reform initiatives—shifting costs and utilization back toward the Medicare programs’ hospital and post-acute benefits.

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**Introduction**

Today, the United States Congress is considering significant structural changes to the Medicaid program, including caps on the federal financial commitment to Medicaid commonly known as per capita caps or per capita allotments. This proposed change is advancing as part of the legislation aimed at repealing the Affordable Care Act. With attention and debate focused on repeal of the 2010 law, per capita caps’ impact on the 11 million Medicare beneficiaries who also receive Medicaid benefits has seen less attention and consideration than it otherwise might.

As part of an ongoing series of educational briefings, the National Coalition on Health Care (NCHC) convened a panel discussion entitled Medicaid Per-Capita Allotments: Exploring Implications for Medicare Beneficiaries on April 10, 2017. Panelists and an audience of stakeholder representatives and Congressional staff participated in a 90-minute discussion.

At the event, panelist Melanie Bella, Former Director of the Medicare-Medicaid Coordination Office at Centers for Medicare and Medicaid Services (CMS), offered her unique perspective on the challenges associated with serving duals across both programs, the reforms now underway, and the impact of per capita caps on those ongoing reform initiatives. Panelist Ann Hwang, MD, is a practicing primary care physician and the Director at Center for Consumer Engagement in Health Innovation. As part of her presentation, Dr. Hwang explained how the budgetary impact of caps might affect services to the dually eligible beneficiaries. Finally, Cindi B. Jones, Director of the Department of Medical Assistance Services in the Commonwealth of Virginia, gave her assessment of caps’ impact on Virginia, which is engaged in reform of its Medicaid program and has not expanded Medicaid under the Affordable Care Act. The panelists’ presentations were followed by a robust audience question and answer session.

This NCHC issue brief provides background and analysis on the topic addressed at the April 10th forum. It draws upon relevant publications, the panelists’ presentations, and subsequent audience discussion.
What is Medicaid?

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.¹

Medicaid Financing Basics

Under the current federal Medicaid statute, certain state Medicaid program expenditures are matched by the federal government. The rate at which the federal government matches most expenditures by states, known as the Federal Matching Assistance Percentage (FMAP), is based on each state’s per capita income relative to per capita income nationwide. FMAPs range from a low match rate of 50% to 74.63%.² A state with an FMAP of 60% would receive 60 cents of federal support for every 40 cents of state expenditures on qualifying Medicaid benefits and services. These benefits are determined by the state within federally established guidelines. Certain expenditures, notably those for eligibility determination, enrollment activities, and coverage of the Affordable Care Act’s Medicaid expansion population, are reimbursed at higher enhanced FMAP, or E-FMAP, rates. But for all qualifying Medicaid expenditures, the federal government’s commitment to match state services consistent with federal law and regulation is open-ended.

Per capita cap legislation would place a cap on that open-ended federal financial commitment. States would continue to draw down federal matching funds at the appropriate FMAP rate. But in the event a state’s Medicaid spending exceeded the cap, it would be responsible for some of or all of the overage. In general, per capita cap proposals set the cap by multiplying the number of enrollees for a given year by an amount equal to an earlier base year’s per capita expenditure trended forward using a measure of inflation or cost growth. It should be noted that per capita cap proposals, including that of the American Health Care Act as passed by House of Representatives, acknowledge the differences in spending between beneficiary categories (e.g. aged/blind/disabled, low-income parents, or pregnant women) by establishing separate base year per capita expenditure amounts for each category of enrollee.

The exact impact on states would vary based on the level of spending for each beneficiary category during the base year and magnitude of the trending factor. Per capita cap systems may also exclude certain categories of beneficiaries or expenditures. For example, the American Health Care Act passed by the House excludes Medicaid Disproportionate Share Hospital (DSH) payments. However, to the extent per capita caps limit the federal contribution to Medicaid, they would create budgetary pressure on states. As detailed below, that pressure would have significant implications for the Medicare program, its beneficiaries who are also enrolled in Medicaid, and ongoing reform efforts targeted at this population.
Who are the Dually Eligible? Medicare Beneficiaries Also Enrolled in Medicaid

Among the 57 million Americans enrolled in Medicare, approximately 11 million also receive Medicaid benefits. In 17 states, ranging from Alaska, California, and New Mexico in the West to the Delta and Appalachian regions of the South, to New York and most of New England, the percentage of Medicare beneficiaries who are dually eligible ranges from 20-31%. These numbers will swell as Baby Boomers continue to age and need more long-term services and supports (LTSS).

These dually eligible beneficiaries represent nearly one in five Medicare enrollees, but their demographic profile has significant differences from their fellow Medicare beneficiaries. Dually eligible beneficiaries are, on average, older than the average Medicare beneficiary. Dually eligible beneficiaries are more likely to be living on very low incomes; 61% earn less than the federal poverty level compared to just 9% of the non-dual Medicare-only population. 61% of dually eligible beneficiaries are women, compared to 55% of the overall Medicare population.

Dually eligible beneficiaries also tend to face more health challenges than other Medicare beneficiaries. They are three times more likely to report being in poor health. They are twice as likely to have mental or cognitive impairment and nearly twice as likely to require help with one or more activities of daily living [i.e. eating, bathing, dressing, toileting, transferring (walking), and continence]. They are 10% more likely to face five or more chronic conditions. Each of these challenges contributes to increased needs for care, and consequently, increased costs to both Medicare and Medicaid. In 2011, for example, dually eligible beneficiaries accounted for 20% of Medicare enrollment but 35% of Medicare expenditures, and 14% of Medicaid enrollment but 33% of Medicaid spending.
What Medicaid benefits are provided to Dually Eligible Medicare Beneficiaries?

Medicare remains the primary payer, or source of health coverage, for medical, hospital, and drug benefits for dually eligible beneficiaries. However, Medicaid does furnish a range of assistance that wraps around Medicare’s Part A and B medical benefits and Part D drug benefit. For some beneficiaries, this assistance is limited to help with Medicare premiums or cost-sharing through Medicare Savings Programs. But for approximately six million dually eligible beneficiaries, it means access to the full array of Medicaid benefits and services not normally covered by Medicare. These full-benefit dually eligible individuals are often referred to as full duals. The details of their Medicaid coverage may vary by state but must include the aforementioned cost-sharing and premium assistance, inpatient hospital care when Medicare benefits are exhausted, non-emergency transportation, and nursing home expenses not covered by Medicare. The largest Medicaid expense for full duals are long-term services and supports including both nursing home services and home and community-based services (HCBS) such as personal attendants or home modifications.

Spending on these long-term services and supports is trending towards HCBS across all populations. As part of ongoing rebalancing initiatives, significant progress has been made transitioning developmentally disabled populations out of institutions. However, LTSS dollars for older adults and people with physical disabilities—two populations that comprise a majority of duals—go towards more expensive nursing home care at a higher rate than other populations.

Barriers to Higher Value for Dually Eligible Beneficiaries

Given the cost of caring for dually eligible beneficiaries, efficient delivery and coordination of benefits across the two programs is a topic of significant concern for policymakers. Efforts to deliver better outcomes at lower costs encounter two principal barriers for this population.

The first barrier is the lack of integration and coordination between the two programs. Medicare and Medicaid are separate programs, each with a different statutory and legal structure, history, and politics. Unsurprisingly, the financing structures, quality metrics, and benefit designs that govern Medicaid and Medicare services have diverged as well. As a result of this divergence, the incentives for Medicaid policymakers at the state level and the federal policymakers responsible for Medicare are poorly aligned with respect to dually eligible beneficiaries. For example, when faced with budget pressure, state Medicaid programs are free to reduce home- and community-based or mental health services that prevent hospitalization or specialty care, effectively shifting those costs onto Medicare. The state faces no disincentive or penalty for such actions. Similarly, federal law generally prohibits Medicare plans and providers from furnishing basic long-term services and supports with Medicare dollars—even when those services would improve outcomes or lower costs.

The second barrier is Medicaid’s bias toward institutional care versus home- and community-based services (HCBS). Institutional care in a nursing home or other facility is a mandatory benefit under federal Medicaid statute—for those beneficiaries who meet certain criteria. HCBS could allow dual eligible enrollees and other Medicaid beneficiaries to remain in their home or in the community while reducing the growth in overall Medicaid spending. Yet these home- and community-based services remain an optional benefit for states.

Under current law, state and federal efforts are now underway to address these barriers.

Medicaid Reform Under Current Law: Rebalancing

Since the enactment of American with Disabilities Act in 1990, Congresses and succeeding administrations of both parties as well as state and local governments have pursued efforts to transition care that historically had been
delivered in nursing homes and other institutions to the home and community setting. This process is sometimes referred to as rebalancing. Today, despite the bias toward institutional care that remains inherent in the Medicaid statute, HCBS has grown to represent a slim majority of Medicaid LTSS expenditures.\(^{10}\)

As noted above, progress has been greater across some LTSS-eligible populations than others. Care for the developmentally disabled population has shifted largely to the community setting with 75% of LTSS expenditures devoted to HCBS in FY 2014. But in the same year, only 41% of LTSS spending for beneficiaries who were over 65 or physically disabled went to HCBS.\(^{11}\) Progress on rebalancing has also varied among the state Medicaid programs. In 2014, the top 5 states with the highest share of LTSS expenditures for the over-65 and physically disabled populations devoted to HCBS spent an average of 64% on HCBS. The 5 states with the lowest shares had HCBS expenditures that averaged just 17% of their total LTSS expenditures.\(^{12}\)

**INSIGHT FROM Q & A:** The panelists agreed that making institutional care mandatory while HCBS is optional was an outdated approach. If this distinction ever made sense, there appeared to be consensus at the forum.

**Medicaid Reform Under Current Law: Integration**

Working with the federal government, states are also currently pursuing efforts to integrate care and services for dual eligibles.

*Financial Alignment Initiative:* The Financial Alignment Initiative enables states to test new approaches for aligning financing for dual eligibles. States have two options: a Capitated Model wherein states, CMS, and selected health plans enter into a three-way contract providing for a single prospective blended payment, and a Managed Fee-for-Service (MFFS) Model that permits states to share in the savings if they improve quality and reduce costs for duals who receive care through fee-for-service arrangements. So far 10 states (CA, IL, MA, MI, NY, OH, RI, SC, TX, and VA) have launched capitated demonstrations, and two have launched MFFS demonstrations (CO and WA). Total enrollment in the capitated and MFFS model demonstrations was nearly 450,000 in February 2017.\(^{13}\) Preliminary data from Washington state’s MFFS model, relying on health homes for beneficiaries, yielded 6.1% Medicare savings—a level that exceeded payments for health home services under the demonstration. Evaluations of other states with sufficient savings information have yet to be released.

*Dual Eligible Special Needs Plan (D-SNP) + Managed Long-Term Services and Support (MLTSS) models:* Another approach is to permit beneficiaries to enroll in D-SNP plans, while those plans simultaneously but separately contract with the state to provide Managed Long-Term Services and Supports (MLTSS) and other Medicaid benefits for the same enrollees. As of February 2017, five states (HI, IL, NM, TN, and TX) have closely aligned their D-SNPs with MLTSS plans, and eight states (AZ, CA, ID, MA, MN, NJ, NY, and WI) offer Fully-Integrated Dual-Eligible SNPs, which, combined, enroll nearly 250,000 dually eligible beneficiaries.\(^{14}\) An earlier test of this model in Minnesota yielded a 48% decrease in hospitalizations and 6% lower emergency department use among enrollees.\(^{15}\)

*Program for All-Inclusive Care for the Elderly (PACE):* The PACE program provides provider organizations capitated payments from both Medicare and Medicaid for the provision of benefits to dual eligibles who qualify for nursing home level of care but instead participate in day services while remaining in the community. As of February 2017, there are 123 PACE organizations operating in 32 states that enroll 37,890 individuals.\(^{16}\) The program has yielded strong evidence of reduced hospitalizations and indications of improved quality and reduced mortality, without significant increases in Medicare costs. It has however been shown to increase Medicaid expenditures.\(^{17}\)
Caps Could Disrupt States’ Rebalancing and Integration Initiatives

Supporters of per capita caps have argued that caps will encourage state-level innovation in a way that current law does not. However, the very cap-driven, budgetary pressure that proponents tout as a means to spur innovation by states could in fact cripple the already ongoing rebalancing and integration reforms discussed directly above.

At the April 10th forum, Ms. Bella argued that per capita cap models fail to account fully for three important drivers of Medicaid spending: changes in technology, aging changes, and heterogeneous care needs. We elaborate upon Ms. Bella’s points below and then proceed to explore their implications for states, beneficiaries, and ongoing Medicaid reform initiatives.

Changes in Disease Prevalence and Technology: Over any given period of time, the prevalence of disease or the expense of treating diseases can increase. Most recently, a rapid increase in costs associated with opioid use disorder has stressed state Medicaid budgets. Health care technology changes can also rapidly increase costs. 2015 saw Medicare and Medicaid devote a combined $9.2 billion to two Hepatitis C medications—Sovaldi and Harvoni. A failure to respond to either the rise in opioid abuse or the advances in Hepatitis C treatment would have increased mortality and generated future expense for state and federal taxpayers. These unanticipated spending requirements could not have been reflected in states’ per capita caps had such a system been in place.

Aging Changes: Per capita cap proposals typically base each state’s capped amount on its Medicaid spending in a base year. That base year spending is then trended to account for some measure of inflation. While this may account for enrollment and price growth to an extent, the use of a single base year incorporates a particular beneficiary age distribution into a state’s capped amount indefinitely. However, all other things being equal, the large cohort of relatively healthier 65-74-year-old Baby Boomers today will translate to a large cohort of 75-84-year-old dual eligibles in 10 years, with commensurately greater needs and associated expenditures. Per enrollee Medicaid spending for the 85 and older population is even greater, more than doubling that of a 65-74 age cohort. As a result we will see an increasing gap between the actual per person cost of providing existing services and the state’s cap.

Heterogeneous Care Needs: Even within a beneficiary category, different spending patterns prevail among various sub-populations. For example, a given capped amount may exceed the cost of care for a low-income, but non-disabled 65-year-old who receives Medicaid-funded help with Medicare premium and cost-sharing expenses. This same per-person capped amount may not be adequate to fund the current level of services provided to an 85-year-old nursing home resident.
Increasing the Frequency of the Base Year Calculation

The Senate leadership may be considering an adjustment to the per capita cap mechanism in the House-passed American Health Care Act. This adjustment would allow for recalculation of each state program’s base year every two years. Such an approach appears to better account for the impact of long-term changes in age demographics, disease prevalence, and technology. However, it has its own design flaws.

Recalculation of the baseline every two years would fail to account for emergent changes in prevalence and technology—like an outbreak of communicable disease, such as the Zika virus, or a public health emergency—that occur within that two year period. Without additional federal matching funds to cover those unanticipated costs, states could be forced to restrict services or coverage in other areas of their Medicaid programs.

Implications of Per Capita Caps for Medicaid’s State-Federal Partnership

If caps fail to account for any of three factors discussed above, the result will be budgetary pressure on the state Medicaid program as a whole and on high-cost populations within that program. A per capita cap system that relies on a single base year, like the House-passed American Health Care Act, fails to account for changes in technology, disease prevalence, aging, and heterogeneous care needs, ensuring the capped federal payment to states will fall below the cost of providing existing services for its existing beneficiary population. States would confront even tougher Medicaid budget choices than they do today—choices with troubling implications for the Medicare program and for dually eligible beneficiaries.

Due solely to their magnitude, Medicaid expenditures on duals are likely to receive especially strong scrutiny from state policymakers confronting those tough choices. Dual eligible beneficiaries accounted for 33% of all Medicaid spending in FY 2012.20 While this percentage has decreased somewhat as a result of Medicaid expansion in many states, services for duals continue to account for a substantial share of state spending.

However, there is another reason services for duals would face potential cutbacks under per capita caps: many of those services are optional, not mandatory benefits under federal statute. A report from the Kaiser Family Foundation indicates pressure from per capita caps would drive states to examine optional benefits like home- and community-based services and dental and vision services.21 Yet another analysis released subsequent to the April 10th event notes that 88% of Medicaid spending on optional services went to LTSS, and that the majority of that service spending was devoted to LTSS for dually eligible seniors and disabled enrollees.22

These findings echo the discussion at the April 10th forum. As part of her presentation, Ms. Bella identified several possible negative consequences that she believed would result from this budgetary pressure:

- Risk of optional services being cut is high, especially HCBS services
- Reversed gains made in rebalancing LTSS provision from institutions toward home and community settings
- Stifled innovation by states, plans, and/or providers that are forced to scale back investments in longer-term transformation to manage short-term funding and program challenges
- Further perpetuated shifting of costs by states onto beneficiaries through increased cost sharing or benefit cuts, by providers through reductions in reimbursement, and by plans through lower per beneficiary per month (PMPM) payments
- Driving up Medicare costs
In addition to restricting services for dually eligible enrollees, another possible state policy response could be to restrict Medicaid coverage altogether for optional dually eligible populations. These enrollee populations are not eligible due to their participation in Supplemental Security Income (SSI) or a Medicare Savings Program, and states may choose to discontinue their eligibility. These optional populations account for the majority (51%) of the current full-benefit dually eligible population. They consist of the following groups:

- **Poverty-related**: states may cover individuals whose income exceeds the SSI limit but is equal to or below the federal poverty level; 42 states and the District of Columbia avail themselves of this pathway
- **Special income limit**: states may cover individuals who need institutional care at income levels up to 3 times the SSI limit; 23 states and the District of Columbia offer this pathway to eligibility
- **Medically-needy**: states may cover individuals whose medical expenses exceed their income, when they have spent down their assets to a certain level; 8 states offer this pathway to eligibility

Insofar as states have incentive to restrict coverage and availability of LTSS services to these populations, it could have the same effect discussed above—shifting of state costs onto Medicare.

### Can a Different Growth Rate Effectively Protect Medicare Beneficiaries Under Per Capita Caps?

Some per capita cap advocates have sought to protect services for dual eligibles within per capita cap arrangements by increasing the growth rate for aged and disabled populations who make up the duals. For example, the House-passed American Health Care Act was amended to set the growth rate for seniors and disabled beneficiaries at inflation plus 1%, beginning in 2020. However, as noted by the Center for Budget and Policy Priorities, “In the per capita cap, states receive an overall amount of federal Medicaid funding that is the sum of the products of each population’s per capita cap and actual enrollment in that eligibility group.” The risk of state cutbacks on services to duals would be driven by the overall cap on state Medicaid spending, not solely by the growth rate for one category of beneficiaries.

### Consumer Implications of Per Capita Caps

In her presentation on April 10th, Dr. Hwang enumerated some of the potential consequences for the actual patient care of dually eligible beneficiaries that could result from per-capita caps:

- Personal assistance reduced or eliminated
- In-home innovative primary care no longer sustainable
- Adult day center support, crucial for keeping certain frail elders in their home, reduced or eliminated
- Non-Emergency Medical Transportation benefits, critical for beneficiary access, eliminated or cut back
- Medical equipment and supplies, currently accessible to patients, replaced by lower-cost, inadequate alternatives
- Access to needed specialty consultation impeded, either through imposition of tougher new utilization management procedures or because fewer providers accept Medicare

Dr. Hwang articulated a concern that these consequences could ultimately mean a return to institutionalization as the first and primary response to aging and disability for vulnerable beneficiaries. This conclusion aligns with previous analysis from her organization suggesting that per capita cap proposals reinforce institutional bias in the Medicaid program.
INSIGHT FROM Q & A: Many commentators have noted that per capita cap legislation could shift federal costs onto state budgets, but discussion at the April 10th forum suggested that some of those costs could be shifted back to Medicare. Panelists and audience members alike predicted that reductions in home- and community-based services ensuing from per capita caps would not necessarily mean all patients would go untreated. Rather, in many cases, it would result in substitution of higher-priced services, avoidable hospitalizations, ER visits, and post-acute care. For dually eligible individuals, these services are covered primarily by Medicare. In this way, capping the federal contribution, in reality, could result in shifting some of the savings from reduced Medicaid expenditures back onto the Medicare program and the federal taxpayers and beneficiaries who support it.

State Implications of Per Capita Caps

Ms. Jones’ April 10th presentation provided a specific illustration of the consequences that per capita caps could have on ongoing state-level reform initiatives. In recent years, Virginia has pursued an aggressive reform agenda. Virginia has participated in Financial Alignment Demonstration testing a Capitated Model for its dually eligible beneficiaries. In 2018, Virginia will be transitioning to a care program of its own design relying on MLTSS (under current law). Virginia’s Medicaid program conducted its own analysis of the impact of the per-capita cap included in the American Health Care Act. The analysis found that AHCA’s anticipated per capita cap amount for aged/disabled ($279) would fall below average costs for both the HCBS and nursing home beneficiary populations. Ms. Jones concluded that sustaining the investment in transformation initiatives like its Financial Alignment Demonstration participation and its new MLTSS program would become far more challenging. Indeed, Ms. Jones explained that any such shortfall would actually create an incentive for states to consider reductions in non-mandatory services and enrollment of the most vulnerable beneficiaries.

Looking Ahead

At the close of the April 10th Forum, moderator and NCHC President and CEO John Rother articulated three implications of particular relevance to policymakers.

First, while touted as a vehicle for reform, per-capita cap legislation serves primarily to shift costs from one payer, the federal government and its taxpayers, to another, state governments and their taxpayers, without considering how to establish systems of care and services that are more efficient.

Second, per capita caps fail to answer the central questions: who (states, Medicare, or some combination of the two) will take responsibility for improving outcomes and curbing costs for this often vulnerable dually eligible population? How will they do it? In fact, through new pressure imposed on state budgets, caps could cripple ongoing state-led integration and rebalancing initiatives that could help answer those questions.

Finally, the elephant in the room, usually under-acknowledged in the Medicaid per capita cap debate, is demographics. An aging Baby Boom generation is approaching its 80s and will require more services and incur more costs—particularly in long-term care. Medicaid was not designed to meet the need for long-term care across the population; yet, it has assumed the role of default long-term care payer for the majority of Americans receiving those services. These are serious problems. They call for a serious, long-term care financing solution, not simply shifting the burden to states and state taxpayers.
Conclusion

In sum, per capita caps for Medicaid raise very serious problems for the Medicare program and its beneficiaries. The proposed caps would, over time, shift federal costs to states and state taxpayers rather than achieve real, system-wide cost savings. They would undermine important advances in more responsive, effective, and value-based care delivery systems that benefit seniors. Lastly, they offer no real solution for the major demographic challenge we face as the Baby Boomer generation enters its most vulnerable years. Medicaid per capita cap legislation, rather than solving the problems facing Medicare, Medicaid, and our increasingly costly health care system, would likely make matters worse.

April 10th Per Capita Allocations Forum Presentations


Citations

7 Medicare Part D Low-Income Subsidy covers cost-sharing and premium costs for beneficiaries whose income and financial assets are below certain thresholds. A range of Medicare Savings Programs, funded by Medicaid, provide different levels of premium and cost-sharing assistance for qualifying low-income Medicare Part A and B beneficiaries. The Qualified Medical Beneficiary program helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments. The Specified Low-Income Medicare Beneficiary and the Qualified Individual Program help pay Part B premiums. The Qualified Disabled and Working Individuals Program pays the Part A premium for certain people who have disabilities and are working.
8 “Section 4: Dual Beneficiaries Spending.”
11 Ibid.
12 Calculation based on information from “Exhibit A9—Choice of Setting and Provider: Indicator Performance, Ranking, and Change,” Appendix A of Picking Up the Pace of Change: A State Scorecard on Long-Term Services and Supports for Older Adults, People with


“Update on Medicare-Medicaid Integration.” The thirty two states are AL, AR, CA, CO, DE, FL, IA, IN, KS, LA, MA, MD, MI, MO, NC, ND, NE, NJ, NM, NY, OH, OK, OR, PA, RI, SC, TN, TX, VA, WA, WI, and WY.


“What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicare?”


Jacobson, Neuman, and Musumeci, “What Could a Medicaid Per Capita Cap Mean.”

Solomon and Schubel, “Medicaid Cuts.”

Jacobson, Neuman, and Musumeci, “What Could a Medicaid Per Capita Cap Mean.”
