Optional Benefits & Waivers

Medicaid law requires that states provide services such as doctor visits, hospitalization, nursing home care, and others. Other critical services for people with disabilities are not required by law (i.e. optional benefits) but are allowed if the state chooses to provide them and follows federal requirements. **These optional and waiver services would be under attack if Congress cuts and caps Medicaid funding. This means that, depending on state responses to lost federal funding, people with intellectual and developmental disabilities (I/DD) are at risk for losing access to community-based supports and states may increase use of institutionalization.**

What are Optional Benefits?

The federal/state Medicaid program allows states to provide a wide variety of optional services in addition to the mandatory services. States provide many different services and supports as optional benefits, such as:

- Personal Assistance services, Prescription Drugs, Clinic services, Physical and occupational therapy, Speech, hearing and language disorder services, Prosthetics, Eyeglasses, Private duty nursing services, Personal Assistance services
- Services in an intermediate care facility for Individuals with Intellectual Disability (ICF/ID) – This includes some large institutions and many large and small group homes that meet federal requirements.
- "State plan" Home and Community Based Services - Typically includes services like respite, case management, supported employment, and environmental modifications. States using this option include: California, Colorado, Connecticut, Delaware, District of Columbia, Idaho, Indiana, Iowa, Louisiana, Maryland, Mississippi, Montana, Nevada, Oregon, Texas, and Wisconsin.
- Self-Directed Personal Assistant Services - Provides personal care and related services and participation in self-directed PAS is voluntary. Participants set their own provider qualifications, train their PAS providers, and determine how much they pay for a service, support, or item.
- Community First Choice Option- Allows States to provide comprehensive home and community-based services and supports under the State Plan as an alternative to facility based care and receive increased federal matching funds. States using this option are California, Maryland, Montana, Oregon, and Texas.

What about "Waiver" Services? Are These Optional?

Waiver services are in a category of their own as states must submit formal requests to have certain federal Medicaid requirements waived and negotiate those changes with federal officials at the Centers for Medicare and Medicaid Services. While waivers offer states a lot of flexibility, they permit states to limit services by permitting states to provide benefits only to specific groups (for example, children with autism) and to cap enrollment (for example, 200 children). **Therefore, there are long waiting lists for many waiver services in states throughout the country.**

The most important waiver for people with I/DD is called the 1915(c) Home and Community-based Services Waiver. States have a variety of different names for the waiver. States use this waiver to provide long term supports and services in home and community settings rather than institutional settings. Waiver services include:

- providing direct support professionals to assist with meals, bathing, dressing, and toileting
- habilitation
- communication and behavioral supports
- assistive technology and supported employment

Per Capita Caps

What are Per Capita Caps?

Under the current Medicaid program structure, the Federal Government pays for a specified share of the cost of medical care for eligible individuals, such as those with disabilities. A per capita cap however, limits the total amount of federal funding reimbursed to states per enrollee. In addition, the cap model fails to account for changes in the costs per enrollee beyond the cost growth limit. Due to the "one-sided" nature of the per capita cap, states will lose under this provision. States would receive reduced federal matched funding if their spending is above the cap in a given year, but would not receive additional federal funding if spending is below. This means that no state would receive additional funding under a per capita cap than under current law in any year.

Why Does This Matter?

The cap will not keep up with our population's needs. Already in difficult financial circumstances, many states will be forced to cut services or limit eligibility for our growing and aging population. Furthermore, caps pegged to a more restrictive rate would have severe consequences for states and beneficiaries. It is estimated that per capita caps indexed to overall inflation, as proposed in the Better Care Reconciliation Act (BRCA) would result in a $772 billion reduction in Federal Medicaid spending over a 10-year period. The Congressional Budget Office estimates that 15 million more people would be uninsured under BCRA and states would have to discontinue their expansion of eligibility, as provider rates continue to rise. States would be forced to scale-back or eliminate optional services that support people with disabilities and other vulnerable populations. This would certainly end the Federal Government's 50-year, open-ended commitment to support all Medicaid populations by capping the amount they pay to each state.