

Estimating the Expense of a Mandatory Home- and Community-Based Personal Assistance Services Benefit Under Medicaid

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ABSTRACT. Personal assistance services (PAS) are essential for many people of all ages with significant disabilities, but these services are not always available to individuals at home or in the community, in large part due to a significant bias toward institutions in the Medicaid program. This study aims to provide an estimate of the expense of a mandatory personal assistance services (PAS) benefit under Medicaid for persons with low incomes, low assets, and significant disability. **Design and methods:** We use year 2003 data from the Survey of Income and Program Participation to estimate the number of people living in households who would be eligible, based on having an institutional level of need and meeting financial criteria for low income and low assets, combined with additional survey data on annual expenditures under Medicaid programs providing PAS. **Results:** New expenditures for personal assistance services are estimated to be \$1.4-\$3.7 billion per year (in 2006 dollars), depending on the rate of participation, for up to half a million new recipients, more than a third of whom would be ages 65 and older. These estimated expenditures are a tenth of those estimated by the Congressional Budget Office for implementing the Medicaid Community-Based Attendant Services and Supports Act (MiCASSA). **Implications:** Creating a mandatory PAS benefit for those with an institutional level of need is a fiscally achievable policy strategy to redress the imbalance between institutional and community-based services under Medicaid.

Keywords: long-term care, personal assistance services, Medicaid, MiCASSA, expenditures

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INTRODUCTION

The Americans with Disabilities Act (ADA; PL 101-336), the Supreme Court's Olmstead decision (Olmstead v. L.C., 527 U.S. 581), and the New Freedom Initiative (Executive Order 13217) have created an imperative for the government to improve access to personal assistance services (PAS) at home and in the community for people with disabilities of all ages. The Supreme Court ruled that unnecessary institutionalization of qualified individuals with disabilities is a form of discrimination under the ADA, and states may not administer their public programs so that institutions are an individual's only recourse (Rosenbaum, 2005).

Home- and community-based services (HCBS) are an alternative to institutional care. Medicaid provides HCBS to low-income persons with disabilities primarily through two optional programs: the personal care services (PCS) *benefit* and the Section 1915(c) *waivers* (Smith et al., 2000). If a state uses the PCS option, it establishes a benefit under its state plan and must provide services that are adequate in amount, duration, and scope, and may not vary according to an individual's diagnosis or condition or where a person lives. In contrast, under the 1915(c) waivers, also called HCBS waivers, states are waived certain requirements in their state plan and can target specific subpopulations, limit the number of persons served, and maintain waiting lists for services. HCBS waivers are used for a variety of populations besides those needing PAS, including individuals with HIV and children with special health care needs, but, in all cases, individuals must require an institutional level of care, whether a nursing home, an intermediate care facility for persons with mental retardation and other intellectual or developmental disabilities (ICF-MRs), or a hospital. In addition to these programs, states must provide home health services—medical/nursing services oriented toward bodily care—to persons

who are nursing-home eligible. The PCS option and HCBS waivers provide personal assistance services oriented toward fulfilling a person's essential activities at home and in the community.

About 12% of Medicaid expenditures on HCBS are for home health services, 23% for PCS and 65% for HCBS waivers (Burwell, Sredl, & Eiken, 2005). While 32 states have added the PCS option (Crowley, 2006), all states have one or more HCBS waivers. HCBS waivers have been adopted with enthusiasm by the states because of their flexibility and fewer requirements (Kitchener, et al. 2005), but almost twice as many people receive PAS under the PCS optional benefit than under HCBS waivers (683,000 persons in PCS and 352,000 persons in HCBS waivers) (Kitchener, Ng, & Harrington, 2006).

Nursing home services, in contrast, are a *mandatory benefit* for all categorically needy Medicaid populations and must be provided adequately by all states. The disparity between nursing home services being mandatory and HCBS being optional has become known as the "institutional bias" in Medicaid (Smith et al., 2000). Medicaid's financial eligibility rules further add to the institutional bias, since it is easier for a person to qualify financially for institutional care than for personal assistance services. For nursing home care, Medicaid allows states the option of permitting income levels up to 300% of the SSI federal benefit rate using what is called the "special income rule." Most of the 39 states that use this rule for nursing homes also use it for their HCBS waiver programs, but they are not allowed to use the rule for the PCS benefit. Thus, Medicaid-eligible individuals are assured of having access to nursing homes and other institutional long-term care services, but, in potential conflict with the ADA and the Olmstead decision, their access to HCBS can be quite limited, depending on the state and community in which they live and their income level.

In the past two decades, access to HCBS has grown relative to institutional care under Medicaid: In 1988, only 12% of long term care expenditures were for HCBS, including the PCS option, HCBS waivers, and home health; as of 2004, that figure had tripled to 36% (Burwell, Sredl, & Eiken, 2005). However, much of the expansion of Medicaid community services has been fueled by the de-institutionalization of persons with intellectual and developmental disabilities (ID/DD) from large state-run institutions (Lakin, Prouty, & Coucouvanis, 2004).

The Centers for Medicare and Medicaid Services (CMS) continue to promote HCBS, facilitated by new authority under the Deficit Reduction Act (DRA) of 2005 (Crowley, 2006). Beginning in 2007, the DRA allows states to provide HCBS as an optional benefit, establishing a new precedent by allowing states to change fundamental aspects of their state plan without having to apply for a waiver. The option will be limited to persons with incomes below 150% of the poverty level. The CBO has estimated, using administrative data and data from the Survey of Income and Program Participation, that the HCBS option will create \$766 million in new spending from 2006-2010 and \$1.8 billion more from 2011-2015 (U.S. Congressional Budget Office, 2006). The DRA and existing optional initiatives present new opportunities, but they have been described as piecemeal solutions (Crowley, 2006) that will only redress the institutional bias of the Medicaid program in states that respond favorably.

A specific legislative proposal intended to redress the institutional bias nationwide is the Medicaid Community-Based Attendant Services and Supports Act (MiCASSA). It would create a *mandatory benefit* for PAS under Medicaid (U.S. Senate, 2005). All financially eligible persons would be able to receive PAS if they have an institutional level of need. MiCASSA was first introduced in the 105th U.S. Congress in 1997 (HR 2020) and has been re-introduced three times. Although the bill enjoys widespread sponsorship and support, it has not come up for a

floor vote, largely due to its perceived price tag. In 1997, the Congressional Budget Office (CBO) estimated, in a letter provided to then-Speaker of the House Newt Gingrich, that MiCASSA would result in \$10-20 billion annually in new federal expenditures (U.S. Congressional Budget Office, 1997). Most of the expense, CBO said, would be for people demanding the service who live in families, fueling fears of a so-called “woodwork effect” wherein the government would end up paying for services now provided by family members. Many major disability, aging, and personal care advocates and organizations support the legislation, but the American Health Care Association, representing nursing and ICF-MR facilities, does not (American Health Care Association, 2004).

PAS are defined in the act as paid help with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health related functions—for example, transfusion maintenance—provided through hands-on assistance, supervision, or cueing. MiCASSA will not require states to pay for other services that may be provided under HCBS waivers and excludes room and board, special education, assistive technology devices and services, durable medical equipment, and home modifications. States would be obligated to provide PAS adequately, and services may not vary according to an individual’s diagnosis or condition or where a person lives.

Certainly, a mandatory benefit for PAS under Medicaid will require greater expenditures than an optional benefit, but it could save money by keeping more people out of institutions. However, as we explain below, the CBO substantially overestimated the number of people with an institutional level of need, thereby greatly inflating the potential expense of MiCASSA. In this paper, we present a newer, alternative estimate using more recent data and a more sound measure of the number of persons who would be eligible.

ESTIMATING EXPENDITURES FOR A MANDATORY PAS BENEFIT

The main drivers of annual expenditures for a mandatory PAS benefit are the number of persons living in the community who would be served by the benefit and the expenditures for each person served. Persons who would be served are those who (1) meet basic Medicaid financial eligibility requirements of low income and assets, (2) have an institutional level of need, and (3) want the services. We do not consider any expenses for persons who transition from institutions to live in the community. While such transitions are included in the existing MiCASSA legislation, they are already being addressed by other laws, such as the Money Follows the Person Demonstration authorized in the Deficit Reduction Act. We first discuss the CBO estimate and the factors that would influence expenditures.

The CBO Estimate

The critical element of the CBO estimate, and its main flaw, is the size of the low income population with an institutional level of need, which the CBO grossly overestimated at 8 million people. The CBO based its estimate on the number of individuals residing in the community who cannot perform activities of daily living—either ADLs or IADLs—without help from another person, using data from the 1994 National Health Interview Survey on Disability (NHIS-D). However, it is not appropriate to consider persons who need help only with IADLs as having an institutional level of need. ADLs are a small set of activities that are essential for biological survival, and include bathing, dressing, getting up from or into a chair or bed, toileting, and eating (Katz & Akpom, 1976). IADLs are a larger set of activities that are instrumental to living independently in the community, including such activities as walking, shopping, paying bills, and preparing meals (Lawton & Brody, 1969).

Using the NHIS-D, a previous analysis found that 13.2 million adults need help in any IADLs or ADLs (LaPlante, Harrington, & Kang, 2002), so it is not unreasonable that 8 million may have low incomes. However, as we argue below, only the subset of persons who need help with multiple ADLs can reasonably be said to have an institutional level of need, and, as we show, that number is far less than 8 million persons. The CBO assumed people would receive from 20 to 40 hours of services a week at \$8 per hour, concluding that even if just 25% of those eligible were to receive services, the federal expense would be \$10-\$20 billion per year.

DATA AND METHODS

We discuss how eligibility for institutional level of need and income and assets are operationalized, then we discuss the datasets we use to estimate the number of people who would meet the criteria and the anticipated expenditures required to serve them.

Nursing Home Level of Need

Numerous studies have found that the more ADLs with which an individual requires help, the greater the chance of being placed in a nursing facility (Miller & Weissert, 2000). Most people in nursing homes have multiple ADL limitations. The average number of ADLs among the 1.7 million nursing home residents is 3.1 out of 5 (Jones, 2002). Most states require a person to need help with at least two ADLs (Tonner & Harrington, 2003), although some states are more or less restrictive than that. Thirty-one states use a variety of supplemental criteria including nursing, medical, and other functional and psychosocial criteria in different combinations. Lacking a uniform definition of “institutional level of need” for nursing home eligibility, we make a reasonable choice of operationalizing it as needing help from another person in two or more of the five basic ADLs, which is also the standard used to certify long-term care insurance plans as federally tax-qualified.

ICF-MR Level of Need

To be eligible for Medicaid-covered ICF-MR services, a person must have an intellectual disability and need services to improve or maintain functioning (Smith et al., 2000). Receptive and expressive communication ability, community living skills, social skills, and control of health and safety are also considered. In Medicaid-certified ICF-MR facilities, at least two-thirds of residents receive help or supervision with bathing and dressing and thus, most do in fact require help with two or more ADLs (Lakin et al., 1989). While the two or more ADL criterion may miss some people with ICF-MR level needs living in households, the number is not likely very large. Further, given the large growth in ID/DD waivers, it is likely that many, if not most, with an ICF-MR level of need are already being served under Medicaid and would not present a significant additional expense under a new, mandatory PAS benefit.

Financial Eligibility

Individuals would also need to meet Medicaid basic financial eligibility criteria in order to qualify, with incomes up to 100% of SSI eligibility or the federal poverty level, depending on the state. Assets can be no more than \$2,000 for a single person or \$3,000 for a couple, excluding a primary residence and a car. We also consider income up to 300% of SSI eligibility under the “special income rule,” which we call “expanded eligibility.” We do not consider medically needy spend-down to be an option for persons living in the community because the spend down levels are so low (133 1/3% of the state’s pre-welfare reform AFDC payment levels) that most people would not be able to pay for their food and housing with their remaining income and would be unable to live on their own (Smith et al., 2000).

Expenditures per Recipient

Medicaid has experience with expenditures for persons with an institutional level of need under the HCBS waivers. PCS expenditures include persons with a lower level of need (Summer & Ihara, 2005). We therefore use the latest data available on expenditures per recipient in waiver programs providing personal assistance services. These data are obtained from an annual survey of Medicaid waiver programs conducted by the University of California, San Francisco (Kitchener, Ng, & Harrington, 2006).

Participation Rate

Unfortunately, we cannot predict which persons will want Medicaid-paid PAS, so we consider a range from roughly 30 to 80% participation. Because demand is sensitive to living arrangements, we make an adjustment for this. People who live alone, a group with more unmet need for PAS than those who live with others, will be more inclined to want Medicaid-paid PAS (LaPlante et al., 2004). Also, people with nursing home level needs who live with others can be reluctant to apply to Medicaid, instead depending on Medicare home health services and extensive help from family members (Long et al., 2005). In consequence, we set participation rates about 25 percentage points lower for people who live with others than those who live alone.

Federal Matching Rate

We use a higher average Federal Medical Assistance Percentage (FMAP) of 70%, compared to the CBO rate of 57%. MiCASSA allows states an enhanced match rate of 70% if they take additional actions to improve their service systems.

The Survey of Income and Program Participation

We use the Survey of Income and Program Participation (SIPP) to estimate the number of eligible persons. The SIPP is a nationally representative panel survey of approximately 40,000

households conducted by the Census Bureau. Respondents are asked whether they need the help of another person with any of five basic ADLs: taking a bath or shower, dressing, getting in and out of bed or a chair, using or getting to the toilet, and eating. We use data from Wave 8 of the 2001 panel collected in June-September 2003 (we have also used Wave 5 data for June-September 2002 with very similar results). We operationalize institutional level of need as needing help in two or more of the five basic ADLs. We exclude persons with low income and assets who are already getting paid PAS. For these persons, Medicaid is the likely payer, and they would represent expenditures under existing programs for which a mandatory PAS benefit would not entail additional expenditures. However, SIPP only determines whether help is paid for the first two caregivers mentioned, and not all people receiving paid help will be identified in this way.

The SIPP is advantageous because it obtains detailed information about income and resources and also has state identifiers that can be used to tailor income and resource eligibility to the state in which a person resides. For *basic financial eligibility*, depending on the state of residence, an individual would be financially eligible if he or she had either (1) income below 100% of the year 2003 SSI federal benefit rate (SSI FBR) of \$552 a month for someone living alone or \$829 combined income per month if living with a spouse, or (2) income below 100% of the federal poverty level (FPL; \$748 a month for an individual); in addition, in all states, the individual can have no more than \$2,000 in assets (\$3,000 for a couple), excluding the primary residence and one car. For *expanded financial eligibility*, an individual could have income below 300% of the SSI FBR in any state that uses the “special income rule.” Income of a spouse is not considered under this rule. Asset limits are the same as for basic eligibility.

Detailed income data for the individual and his or her spouse are available in the SIPP and can be used to determine basic eligibility. Following SSI rules, spousal income is first allocated to the spouse and any children, with any remainder deemed to the individual. Earnings, minus \$65, are then divided by two and combined with all other non-transfer income to obtain the counted income, which is compared with the FBR or FPL for an individual or couple, as appropriate. Income data are collected in every wave of the SIPP, but assets are asked about less frequently. Asset data collected in Wave 9 (late 2003), is used except for respondents who left the sample between Waves 8 and 9, for whom asset information from Wave 6 (late 2002) was substituted. Using limited information and some simplifying assumptions, we approximated the person's or married couple's resources, following SSI rules as closely as possible. The amount of money in all types of bank accounts; value of retirement accounts; value of stocks, bonds, and mutual funds; life insurance greater than \$1,500 and other financial investments; equity in businesses owned; and business or property loans owed to the respondent are combined. Ownership of a second property is assumed to put the respondent over the asset limit. In a simplification of SSI rules (which allow for ownership of a single vehicle of limited value), motor vehicles are not included in the asset calculation.

University of California Annual Survey of Waiver Programs

In a continuation of an annual survey begun in 1999, state officials responsible for each Medicaid waiver were surveyed in the spring of 2002 to obtain data on policies and expenditures. Responses were obtained from 97% of the operating waivers (Kitchener et al., 2005). Not all waivers provide PAS. In 2002, 158 out of the 252 operating waivers provided PAS to 352,000 persons, with an average expenditure of \$9,536 per person (Kitchener, Ng, & Harrington, 2006). Because the wages of personal assistance workers have kept pace with the CPI (Kaye et al.,

2006), we inflate the 2002 amount by the annual rate of increase in the Consumer Price Index (U.S. Bureau of Labor Statistics, 2006), which comes to \$10,753 per participant in 2006 dollars.

Our estimate of expenditures for MiCASSA is then the number of eligible persons who are not already receiving paid PAS multiplied by the average expenditure of \$10,753 per person. Using the average enhanced Federal Medical Assistance Percentage (FMAP) of 70% yields the federal-state split.

RESULTS

We estimate that 2.7 million adults have an institutional level of need, of whom 739,000 meet *basic financial eligibility* requirements and just over one million meet *expanded financial eligibility* requirements (Table 1). About 16% of both financial eligibility groups receive paid help, as do about 22% of those living alone. Excluding persons who are already getting paid help, who are likely already to be receiving Medicaid HCBS, we estimate that 607,000 people at the basic financial level and 886,000 people at the expanded level would be newly eligible for benefits under MiCASSA. Assuming participation of 30% overall, expenditures for a mandatory PAS benefit would be \$2.0 billion, with \$1.4 billion of that allocated to the federal government and \$0.6 billion to the states. At the highest rate of participation, 80% overall, expenditures would total \$5.2 billion, with \$3.7 billion federal and \$1.6 billion state. At the expanded financial eligibility level, expenditures would increase by 45% over basic eligibility, with federal expenditures of \$2.0-\$5.4 billion federal and \$0.9-\$2.3 billion state, depending on the level of participation.

Table 1

The SIPP provides additional information about the makeup of this population. At the basic financial eligibility level, 20% of the 607,000 eligible persons live alone, slightly more

than half are women, one-third are ages 65 and older, and three-fourths are covered by Medicaid (Table 2). Eligible persons who live alone are older and more likely to be female than those living with others. At the expanded eligibility level, a higher percentage are 65 years of age and older than at the basic eligibility level (40.1 vs. 31.6%), and a lower percentage are on SSI or covered by Medicaid.

Table 2

DISCUSSION

The age characteristics of eligible persons may be surprising. Of all people needing help with two or more ADLs (2.7 million adults), ignoring their income and assets, 55% are ages 65 and older, consistent with prior studies (LaPlante, Harrington, & Kang, 2002). However, the application of both low-income and low-asset rules tends to rule out older adults at a higher rate than working-age adults, especially at the basic level of financial eligibility. Working-age adults needing help with ADLs are more likely to be poor and to have fewer assets than their older counterparts. This is not so unexpected given the low rates of employment among working age adults with ADL needs (McNeil, 2000) that hinders their accumulation of assets.

Most of those who are eligible are already covered by Medicaid, but are not getting paid help with their personal assistance needs. This situation can arise because personal assistance services for individuals residing in the community are optional under Medicaid. As a result, some individuals with physical disabilities may not be able to obtain the personal assistance services they need. However, some persons may be reluctant to take up the benefit, especially if they live with their families, even when services are available. About 80% of eligible persons live with others.

Comparison to the CBO Estimate

Our estimate of federal expenditures for a mandatory PAS benefit at \$1.4-3.7 billion is much lower than the CBO estimate of \$13-\$25 billion (both in 2006 dollars). The CBO estimate of the eligible population—8 million low-income persons needing help in IADLs or ADLs—was not based on an appropriate criterion of institutional need and is more than 10 times as large as our estimate. Our estimate is based on persons needing help in two or more of five basic ADLs, and that population with low incomes and assets and no paid help is only 607,000 persons.

We assumed the expenditure per recipient would be \$10,753 in 2006 dollars, based on the current expenditures of Medicaid HCBS waivers offering personal assistance services. The CBO used a range of annual per capita expenditures from \$9,000-\$18,000 in 2006 dollars. The latter, however, would provide approximately 40 hours of help per week, which is far higher than what the states currently provide under the waivers or the personal care option. We are more certain than the CBO about how many hours of help people would likely get, so we use one estimate of that expense, not a range.

The CBO made no adjustment for services people are already receiving. This is an important consideration, given the substantial growth in HCBS under Medicaid. We excluded people who are already receiving paid help under existing programs, which is 15-18% of otherwise eligible recipients. However, because not all people who may be receiving paid help are identified in our data, our estimate may be higher than it should be. If the NHIS-D data, which indicate that 30% of all persons needing help with two or more ADLs actually get paid help, is a guide (LaPlante, Harrington, & Kang, 2002), the expense we estimate could be reduced by some 20%.

The CBO assumed that 25% of the eligible population would participate, leading to a federal share of \$13-25 billion in 2006 dollars. If we match that assumption of a 25% participation rate, we estimate the federal share to be \$1.1 billion for those with low incomes. Again, the difference is due to a smaller and more realistic estimate of the population with an institutional level of need. However, we do not believe that it is likely that only 25% would enroll under a mandatory PAS benefit. Our middle estimate assumes a participation rate of 55% overall, generating \$2.5 billion in federal expenditures, and the highest estimate assumes a rate of 80% participation, generating \$3.7 billion federal expenditures.

As the CBO claimed, most people eligible for benefits under MiCASSA would live in families (about 80%). About 60% of those at the basic level of eligibility are of working age and living with others (51% at the expanded level), while the rest live alone or are elderly. While this may arouse fears of a “woodwork effect” for some policymakers, MiCASSA limits the financial impact to persons with the most intense PAS needs. This feature constrains expenditures while providing potential relief to families having a member with an institutional level of need for services. Family members provide an average of 60 hours a week of help to individuals needing assistance with two or more ADLs (LaPlante, Harrington, & Kang, 2002), indicating that many families do everything they can to keep a family member out of an institution.

Medically Needy Spend Down

Because MiCASSA would establish a mandatory benefit, states could cover PAS for medically needy persons if the state uses that option. We have assumed that medically needy spend down would not result in significant expenditures under MiCASSA for the reason that, as Smith and colleagues (2000) discuss, one’s remaining income after spending down would be insufficient to pay other essential bills, including food, rent, property insurance and taxes,

making it difficult to maintain oneself in the community. Spend down remains an issue that is more important for persons in nursing homes because the daily expense of a nursing home far exceeds the expense of PAS in the community.

Enhanced Federal Matching Rate Cost-Shifting Incentive

MiCASSA provides an enhanced matching rate for states that adopt its provisions early and that enhance and promote the use of HCBS, for example, by assuring consumer control and involvement. It is possible that the higher match rate might provide an incentive for states to shift individuals from their PCS and HCBS waiver programs to the mandatory benefit to get the higher FMAP. Such a shift would be limited to persons who have an institutional level of need who are receiving services under PCS or HCBS waivers. In 2002, it is estimated that 352,000 persons with an institutional level of need received PAS in HCBS waivers, but the number of such persons under the PCS option is not known. In the worst case scenario, the federal government could assume 13% more of what is already spent on PCS and HCBS waivers that provide PAS, which totaled \$9 billion in 2002 (Kitchener, Ng, & Harrington, 2006). Thus, the cost-shifting potential could come to \$1.1 billion, but that is unlikely since only persons on PCS who have institutional levels of need could be shifted to a MiCASSA benefit and only among states that adopt MiCASSA early. However, as this cost-shifting potential could rival the expense of MiCASSA itself, it may be prudent to establish mechanisms to limit any unintended impact.

Strengths and Limitations of the Analysis

The strength of this analysis is the use of a large nationally representative survey with detailed information on personal assistance needs and on income and assets, combined with the latest data on Medicaid expenditures for persons receiving PAS under the HCBS waivers.

The chief limitation of this analysis is our inability to predict the rate at which people will take up Medicaid personal assistance services, forcing us to provide a range of estimated expenditures. However, even if everyone eligible were to receive such services, the expense still falls far short of what the CBO has previously estimated for the MiCASSA legislation.

Another limitation is that we have not fully identified persons already receiving paid services under the Medicaid waivers and personal care programs, causing us to overestimate the expense of a mandatory PAS benefit by perhaps as much as 20%.

Since we are using data from a household survey to estimate the eligible population, we do not include persons living in group housing. This would lead to underestimating the eligible population. However, most low-income persons in group housing who would be eligible for MiCASSA are likely to have their services paid by existing Medicaid programs.

The estimated annual expense per recipient of \$10,753 could lead to overestimating the expense of a mandatory PAS benefit because the figure includes some services that may not be allowed under MiCASSA. Lastly, there remains some uncertainty in the number of eligible persons because of the variation by state in Medicaid institutional level of need criteria.

CONCLUSION

By mandating a PAS benefit for individuals with an institutional level of need, MiCASSA would redress the institutional bias in the Medicaid program and further the goals of the ADA, the Olmstead decision, and the New Freedom Initiative. MiCASSA would require that Medicaid-eligible persons with the greatest need be assured formal personal assistance services regardless of age, diagnosis, or residence, instead of the current policy that allows states to limit personal assistance services according to these factors.

The prior CBO estimate cast MiCASSA as a new entitlement that would be unaffordable, but that assessment was based on an indefensibly high estimate of the number of persons who could be eligible. It is not the intent of MiCASSA to make PAS available to all persons who need it. Rather, the intent of MiCASSA is to reduce greatly, if not eliminate, Medicaid's institutional bias. By design, it is the restriction to persons with an institutional level of need that limits MiCASSA's expense. We hope this finding will inform policy discussion of the affordability of eliminating the bias between institutional and community services under the Medicaid program.

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TABLE 1
Estimated Expenditures for the Medicaid Community-Based Attendant Services and Supports Act (MiCASSA) in 2006 Dollars, by Level of Financial Eligibility and Living Arrangement

Living arrangement	Persons with institutional level need ¹			Expenditures for eligible persons					
	Total (1000s)	Excluded ² (1000s)	Eligible (1000s)	Low estimate		Medium estimate		High estimate	
				Partici- pation rate	Expen- diture (Billions)	Partici- pation rate	Expen- diture (Billions)	Partici- pation rate	Expen- diture (Billions)
Basic financial eligibility: Income < 100% of SSI OR 100% FPL & low assets									
Living alone	154	35	119	50%	\$0.6	75%	\$1.0	100%	\$1.3
Living with others	585	97	488	25%	\$1.3	50%	\$2.6	75%	\$3.9
Total	739	131	607	30%	\$2.0	55%	\$3.6	80%	\$5.2
Federal share of expenditure					\$1.4		\$2.5		\$3.7
State share of expenditure					\$0.6		\$1.1		\$1.6
Expanded financial eligibility: Income < current state waiver threshold & low assets									
Living alone	241	52	189	50%	\$1.0	75%	\$1.5	100%	\$2.0
Living with others	807	109	697	25%	\$1.9	50%	\$3.7	75%	\$5.6
Total	1,048	162	886	30%	\$2.9	55%	\$5.3	80%	\$7.7
Federal share of expenditure					\$2.0		\$3.7		\$5.4
State share of expenditure					\$0.9		\$1.6		\$2.3

¹ Persons needing help with 2 or more of 5 ADLs (bathing, dressing, transferring, toileting, eating)

² Persons already receiving paid assistance services

Data Sources: University of California Annual Survey of Waiver Programs, 2002 and authors' tabulations from the Survey of Income and Program Participation, 2001 panel, Wave 8, June-September 2003

TABLE 2
Population Eligible for Services Under MiCASSA, By Level of Financial Eligibility
and By Living Arrangement, Gender, Age, and SSI or Medicaid Coverage

Living arrangement	Total	Male	Female	Non-elderly	Elderly	On SSI or Medicaid
Basic financial eligibility: Income < 100% of SSI OR 100% FPL & low assets						
				<i>Thousands</i>		
Living alone	119	33	87	57	63	89
Living with others	488	245	243	359	129	380
Total	607	278	329	415	192	469
				<i>Percent</i>		
Living alone	100	27.5	72.5	47.6	52.4	74.8
Living with others	100	50.2	49.8	73.5	26.5	77.9
Total	100	45.8	54.2	68.4	31.6	77.3
Expanded financial eligibility: Income < current state waiver threshold & low assets						
				<i>Thousands</i>		
Living alone	189	46	143	80	108	109
Living with others	697	314	383	450	247	442
Total	886	402	591	531	355	550
				<i>Percent</i>		
Living alone	100	24.4	75.6	42.6	57.4	57.5
Living with others	100	45.1	54.9	64.6	35.4	63.4
Total	100	40.7	59.3	59.9	40.1	62.1

Note: Eligible persons are those with an institutional level of need (needing help in 2 or more of 5 ADLs), who are not already receiving paid personal assistance and meet Medicaid financial eligibility criteria

Data Source: Authors' tabulations from the Survey of Income and Program Participation, 2001 panel, Wave 8, June-September 2003