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Top 10 Changes to Medicaid Under House Republicans' ACA Repeal Bill: Implications for California

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On March 6, House Republicans introduced the American Health Care Act (AHCA) to repeal the Affordable Care Act (ACA) and eliminate the current financing structure of Medicaid. It has been amended numerous times in March and April and it keeps getting worse for low-income people across the country. The bill makes many draconian changes to Medicaid. Overall, the Congressional Budget Office estimates that several major provisions affecting Medicaid would decrease direct spending by $880 billion over the 2017-2026 period and result in 14 million individuals losing Medicaid.[1] In California, 4.1 million people enrolled in the Medicaid Expansion could lose their coverage.[2] The State's own analysis concludes that the current federal proposal represents a significant shift of costs from the federal government resulting in nearly $6 billion in costs to California in 2020, growing to $24.3 billion by 2027.[3] The State General Fund share is estimated to be $4.3 billion in 2020, increasing to $18.6 billion in 2027.[4] This fact sheet addresses how AHCA impacts Medicaid, and what those impacts could mean for California.[5]

1. **Implements a Per-Capita-Cap or Block Grant on Medicaid Funding.** Since 1965, Medicaid has operated as a federal-state partnership where states receive on average 63% of the costs of Medicaid from the federal government. The federal share is based on actual costs of providing services. AHCA proposes to restructure Medicaid by implementing a per-capita-cap, cutting the federal contribution per Medicaid enrollee based on a state's 2016 expenditures inflated at a rate that is projected to grow slower than yearly Medicaid health care costs.[6] The AHCA was also amended to allow states to choose a block grant instead of a per-capita-cap to fund their traditional adult and children populations for a ten year lock-in period (block grants would not apply to people who are elderly or those with disabilities).[7] Both "capped" programs radically curtail, or cut, federal spending. Funding for state Medicaid programs will shrink over time, resulting in

states cutting coverage and services for all enrollees.[8]

***California Impact*:** California would be disproportionately impacted by a Medicaid cap because the State already spends much less per Medicaid enrollee than most other states.[9] Moreover, the federal government already pays only 50% of Medicaid costs in California.[10] Thus, if health care costs in one area increase— for example, due to public health emergencies like an opioid epidemic or a natural disaster—the State will have very little room to balance those costs against expenses in other areas.[11] NHeLP issued a separate fact sheet on this issue. In addition, the number of low-income seniors and people with disabilities in California is growing faster than the national average. California's over-65 population is expected to be 87 percent higher in 2030 than in 2012, an increase of more than 4 million people.[12] The cost of health care services, on average, doubles between age 70 and age 90.[13] Thus, as California's population lives longer, it will be difficult for California to keep its costs under the capped amount, resulting in deeper cuts to Medicaid over time. Finally, California is already facing budget cuts in the upcoming fiscal year. If California doesn't raise taxes or cut other budget areas by $45 billion over ten years to maintain Medi-Cal, the State will be forced to cut Medicaid eligibility, benefits or payments to hospitals and physicians.[14]

2. **Repeals Medicaid Expansion.** AHCA effectively repeals the Medicaid Expansion on January 1, 2020 by eliminating the enhanced federal funding for states to enroll expansion-eligible adults. It also requires those in the Medicaid Expansion population to submit eligibility renewal paperwork every six months just to stay on Medicaid, beginning October 1, 2017. Thus, states can continue to cover this group, but only at regular matching rates and, this, coupled with the stringent re-determination requirements for this group, will effectively repeal the coverage (the Congressional Budget Office estimates only 5 percent will be left in this group by 2024). NHeLP issued a separate fact sheet on this issue.

   California Impact: California's Medi-Cal Expansion has brought coverage to over 3.7 million low-income State residents.[15] In addition, it has produced a $15 billion or greater investment in the State each year.[16] That investment has directed an estimated $2.2 billion per year into California's health care safety net.[17] By changing the funding formula for the Expansion, AHCA would require California to increase State General Fund spending by over $13 billion to keep the Medi-Cal Expansion open to new enrollees.[18] In addition, California law contains a "trigger" that directs the State to address the funding reduction through the State Legislature.[19] It is not entirely clear when or how this proposal

would go into effect if AHCA is enacted as currently proposed. But if the State moved forward with a repeal of the Expansion, over 4 million low-income Californians stand to lose their coverage.[20]

3. **Repeals Mandatory Medicaid Coverage for Children ages 6-19 over 100% FPL**. The ACA requires states to provide Medicaid coverage to all children from birth to age 19 under 138% of the Federal Poverty Level (FPL). Prior to the ACA, states had to cover children ages 0-5 years old up to 133% FPL but states only had to cover children ages 6-19 (or up to 21 at state option) up to 100% FPL. AHCA lowers the eligibility level for children ages 6-19 from 133% FPL back to 100% FPL. This means that (in some states) children may lose their Medicaid coverage and can only be enrolled in the Children's Health Insurance Program (CHIP) or be uninsured. These children may get fewer benefits than they would on Medicaid and may not receive all services they need to correct or ameliorate their medical or mental health conditions.

   California Impact: Before the ACA, California covered children 6 and over with income between 100 and 250% FPL in its CHIP, known as Healthy Families.[21] In 2013, California began the process of integrating the separate Healthy Families Program into Medi-Cal, and now all children up to 250% FPL are served through Medi-Cal.[22] Thus, in California, children should not experience any disruptions in coverage as a result of this change, and will be able to stay in Medi-Cal. Importantly, however, funding for CHIP is currently only authorized through September 30, 2017.[23] Thus, if AHCA is enacted and Congress fails to reauthorize CHIP funding, California could face significant budget shortfalls, and might be forced to consider cutting 1.3 million children off of coverage.[24]

4. **Repeals Presumptive Eligibility for the Medicaid Expansion Population and Repeals Hospital Presumptive Eligibility for Everyone**. In addition to repealing the Medicaid Expansion, AHCA prevents states from using "presumptive eligibility" for expansion-eligible adults after January 1, 2020 even if a state chose to continue covering expansion-eligibile adults under its regular Medicaid funding. Further, AHCA repeals the ability of states to permit their hospitals to use presumptive eligibility for any potential Medicaid enrollee.

   California Impact: California implemented its Hospital Presumptive Eligibility (HPE) program in January 2014 for the expansion-eligible adults, as well as children under the age of 19, parents and caretaker relatives, pregnant women, and former foster youth up to age 26.[25] Approximately 25,000 individuals are offered coverage in Medi-Cal each month through this process.[26] In 2017-18

California's expenditures on HPE are estimated at nearly $400 million.[27] More than one hundred thousand applicants applied for Medi-Cal coverage through HPE in the first six months of 2016 alone.[28] Taking away this critical pathway for eligible adults, children and former foster youth to obtain immediate Medi-Cal coverage when they end up in emergency rooms or hospitalized for treatment without insurance means they will remain uninsured and in medical debt.[29] In addition, those hospitals are likely to experience financial losses, as the chances of these low-income uninsured individuals' being able to pay for their care in full are very low.[30]

5. **Eliminates Retroactive Eligibility.** Medicaid currently provides coverage up to three months before the month an individual applies for coverage. This "retroactive coverage" protects individuals from medical expenses they incurred before they apply for Medicaid. An individual may not be able to apply for Medicaid immediately due to hospitalization, a disability, or other circumstances and retroactive coverage provides that critical coverage and ensures providers can get reimbursed for their costs and low-income individuals do not end up facing severe medical debt or bankruptcy due to these medical expenses. AHCA repeals this coverage for all Medicaid enrollees starting October 1, 2017.

   California Impact: Both before and after the enactment of the ACA, individuals who incur medical expenses in any of the three months prior to the month of Medi-Cal application can apply for coverage for those months by requesting the retroactive coverage before a year from the date of service.[31] The process for requesting and determining retroactive coverage is fairly simple.[32] This significant and longstanding legal entitlement has enabled millions of individuals to be insulated from significant medical debt due to medical bills incurred in the months just prior to applying for Medi-Cal. The loss of this available coverage could result in financial ruin for millions of individuals who will no longer get these months of coverage at the time of application, or during any gaps in coverage due to falling off coverage during the renewal process. It will also mean that hospitals and other health care providers will have to absorb more costs due to an absence of payer sources.[33]

6. **Allows States to Impose Work Requirements.** Currently, nearly 8 in 10 Medicaid enrollees are part of a working family.[34] Another 14% of Medicaid enrollees are currently looking for work.[35] AHCA would give states the option to impose work requirement to many Medicaid enrollees. If states take up this option, they could require individuals who are too sick to work to obtain employment before they could access health care--this policy is likely to drive

more low-income people to go without routine and preventive care and delay treatment until they are so sick they must seek care in the emergency room.[36] As a result, health care costs will increase, but it is unlikely that many more low-income people will obtain employment that lifts them out of poverty.

California Impact: In California, almost half of Medi-Cal Expansion enrollees are currently working, and another 12% are actively looking for work.[37] In 2015, almost one in five California workers between the ages of 18 and 65 was enrolled in Medi-Cal.[38] Workers in agricultural, restaurant, and other service industry jobs are most likely to have coverage through Medi-Cal.[39] Medi-Cal enrollees who are not engaged in paid labor may have an illness or disability that prevents them from working, may be engaged in unpaid work taking care of young children or children with disabilities, or may be looking for work but unable to find employment. Imposing a work requirement on these individuals is unlikely to result in changing their employment status. Rather, it could cause them to lose access to coverage they need, making them sicker and more likely to incur medical debt.

7. **Imposes New Financial Limits on Medicaid Waivers.** States may seek waivers from the federal government allowing a state to stop having to follow certain federal Medicaid requirements so it can test experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program. Normally, states would have to ensure that these proposals would be "budget neutral" to the federal government over the course of the waiver period (typically five years). Thus, they can spend more federal funds up front to build new infrastructure or provide more intensive services. AHCA takes away states' flexibility to spend these waiver funds up front by imposing yearly budget caps.

   California Impact: California is currently a little over one year in to a five-year Medicaid 1115 waiver.[40] The State has nine other approved Medicaid waivers in various stages of progress, covering areas from services for people with developmental disabilities, to requiring managed care delivery for specialty mental health services, to providing palliative care to terminally ill children.[41] It is not clear whether AHCA would impact funding for Medicaid waivers that have already been approved, or only waivers approved after its passage. If AHCA applies to approved waivers, California could stand to lose millions on its various waivers that are currently underway.[42]

8. **Repeals Essential Health Benefits for Medicaid Expansion Enrollees**. Under the ACA, states that expanded coverage to expansion adults had to provide

coverage in at least the 10 "essential health benefit" (EHB) categories. AHCA repeals this requirement, which will no longer apply after December 31, 2019, resulting in enrollees losing services such as mental health and substance use disorder services, and losing access to some free preventive health services.

California Impact: California has aligned the benefits the Medi-Cal Expansion population receives with the State's approved state plan benefits. This means that *all* Medi-Cal populations receive the same benefits. Since the State's essential health benefits benchmark plan for the private market offered additional mental health and substance use disorder services from those offered in Medi-Cal, as of January 1, 2014, the State added the additional benefits to the coverage received by all Medi-Cal populations, not just the Expansion.[43] Without the EHB requirement for the Medi-Cal Expansion, Medi-Cal enrollees could lose these additional mental health and substance use disorder services, including individual and group psychotherapy, psychiatric consultations, and intensive outpatient treatment for substance use.[44]

9. **Repeals Enhanced Funding for States for Community First Choice (CFC) Attendant Supports.** Established under the ACA, the "Community First Choice Option" allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their State Medicaid Plan. CFC funds assist individuals with Activities of Daily Living (ADLs), habilitative services and emergency back-up systems like electronic indicators. CFC also gives states the option to cover many of the costs of transitioning individuals from institutional care to supported community living, including rent deposits, moving expenses and some non-medical transportation. Some of these services complement the transition services. AHCA repeals the 6% increase in funds established to cover these services starting January 1, 2020.

   ***California Impact*:** California was the first State approved to enact the Community First Choice Option, which allowed the State to take advantage of the 6% enhanced match to provide In-Home Supportive Services (IHSS) to certain Medi-Cal enrollees who otherwise would need institutional care.[45] Over 500,000 Californians have received services through the Community First Choice Option since 2011.[46] Taking up the option brought the State an estimated $573 million in additional federal funds during the first two years of implementation.[47] Eliminating the enhanced match provided by the Community First Choice Option will place financial strain on California's already struggling IHSS program, taking an estimated $400 million in federal funds from the program by 2020.[48] This loss of

federal funds could cause the State to cut provider payment rates or curtail eligibility for IHSS.

10. **Limits Home Equity Exclusions.** Currently, individuals needing nursing home or other long term care services must have home equity below a certain limit to qualify for those Medicaid services. States can exclude up to $750,000 of these individuals' home equity.[49] AHCA prohibits states from exceeding $500,000 of home equity, starting 6 months after the bill is enacted into law, potentially limiting the availability of nursing home and other long term care services to individuals who may live in high-cost areas and have substantial home equity but limited income and other assets.

    ***California Impact*:** This proposed change would require that as a condition of eligibility for nursing home and other long term care services under Medi-Cal, the home equity value for applicants and enrollees who own a home not exceed $500,000. Currently, the median home price in California is just under the $500,000 point, at $493,800; the median price is much higher in large metropolitan areas like San Francisco and Los Angeles.[50] Lowering the home equity limit to 500,000 would result in some current Medi-Cal enrollees losing access to long term care services, such as nursing facility services and home and community based services, including the Multipurpose Senior Service Program, assisted living waiver, and other Medicaid waiver programs and disqualifying some new Medi-Cal applicants who need long term care services and supports.

CONCLUSION

Changing the financing of Medi-Cal from a guarantee (or "entitlement") to a per capita-cap and the other proposed changes to Medi-Cal threaten not only the over 13.5 million Medi-Cal enrollees, but the entire State and its economy. As a result of the State's already low Medi-Cal per enrollee spending (and low provider reimbursements rates), the State's growing low-income aging population as well as other factors, the proposed federal changes will impact California harder than many other states. In jeopardy is the State's huge federal funding of Medi-Cal (approximately $17 billion) and health care coverage for up to 4 million individuals from Medi-Cal (not including losses in the State Marketplace, Covered California). The State of California and its residents cannot afford these changes.

NOTES

[1] CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE: AMERICAN HEALTH CARE ACT 6 (2017), https://www.cbo.gov/publication/52486.
[2] CAL. LEG. ANALYST'S OFFICE, ANALYSIS OF THE MEDI-CAL BUDGET 9 (2017) (estimated enrollment in Medi-Cal Expansion for 2017-2018 fiscal year), http://www.lao.ca.gov/reports/2017/3612/medi-cal-budget-030917.pdf.
[3] Letter from Jennifer Kent & Mari Cantwell, Cal. Dept. Health Care Servs., to Diana Dooley, Cal. Dept. Health & Hum. Servs. (Mar. 21, 2017) http://www.dhcs.ca.gov/Documents/3.21.17_AHCA_Fiscal_Analysis.pd.pdf.
[4] *Id*.
[5] This fact sheet is current as of April 26, 2017 and analyzes the bill that was voted out of the House Budget committee with the manager's amendment.
[6] EDWIN PARK, CTR. ON BUDGET & POLICY PRIORITIES, MEDICAID PER CAPITA CAP WOULD SHIFT COSTS AND RISKS TO STATES AND HARM MILLIONS OF BENEFICIARIES 2 (2017), www.cbpp.org/sites/default/files/atoms/files/2-24-17health.pdf; JULIA PARADISE, KAISER FAMILY FOUND., RESTRUCTURING MEDICAID IN THE AMERICAN HEALTH CARE ACT: FIVE KEY CONSIDERATIONS 2 (2017), http://files.kff.org/attachment/Issue-Brief-Restructuring-Medicaid-in-the-American-Health-Care-Act (Explaining per-capita-caps would be based on 2016 Medicaid expenditures trended forward to 2019 by the medical CPI, locking states into past Medicaid expenditures and omitting consideration for state variation in spending growth).
[7] COMM. ON ENERGY & COMMERCE AND COMM. ON WAYS & MEANS, MANAGER'S AMENDMENT SECTION-BY-SECTION SUMMARY 4-5 (2017), https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/20170320AHCA_SBS.pdf (Explaining that states that chose a block grant would have considerable flexibility in determining which populations to cover and the services provided to them. Block grants must cover hospital care, surgical care and treatment, medical care, obstetrical and prenatal care and treatment, prescribed drugs, medicines and prosthetics, other medical supplies and services, and care for children under 18 years of age).
[8] MARA YOUDELMAN, NAT'L HEALTH LAW PROG., PER CAPITA CAPS IN MEDICAID UNDER THE HOUSE REPUBLICANS' ACA REPEAL BILL (2017), http://www.healthlaw.org/publications/browse-all-publications/per-capita-caps-in-medicaid-under-republicans-aca-repeal-bill; *see also, e.g.,* JANE PERKINS & MARA YOUDELMAN, NAT'L HEALTH LAW PROG., AHCA'S BLOCK GRANT OPTION AND EPSDT (2017), http://www.healthlaw.org/publications/browse-all-publications/ahca-block-grant-option-and-epsdt.
[9] PARADISE, *supra,* note 6, at 3; *see also* KATHERINE YOUNG ET AL., KAISER COMM'N MEDICAID & UNINSURED, MEDICAID PER ENROLLEE SPENDING: VARIATION ACROSS STATES 9 (JAN. 2015), http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states.
[10] ASS'T SECT'Y PLANNING & EVAL., U.S. DEP'T HEALTH & HUM. SERVS., ASPE FMAP 2017 REPORT 5 (2015), https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages.

[11] CTR. BUDGET & POLICY PRIORITIES, HOUSE REPUBLICAN HEALTH PLAN WOULD MEAN MORE UNINSURED, COSTLIER COVERAGE IN CALIFORNIA 2 (2017), www.cbpp.org/sites/default/files/atoms/files/4-13-17health-factsheets-ca.pdf
[12] LAUREL BECK & HANS JOHNSON, PUB. POLICY INST. OF CAL., PLANNING FOR CALIFORNIA'S GROWING SENIOR POPULATION 2 (2015), www.ppic.org/content/pubs/report/R_815LBR.pdf.
[13] MARIACRISTINA DE NARDI *ET AL.,* MEDICAL SPENDING OF THE U.S. ELDERLY 1 (2015), http://arno.uvt.nl/show.cgi?fid=139768.
[14] CTR. BUDGET & POLICY PRIORITIES, s*upra,* note 11, at 1.
[15] CAL. DEP'T HEALTH CARE SERVS., MEDI-CAL MONTHLY ENROLLMENT FAST FACTS (2017) (3,771,358 enrollees in the Expansion as of November, 2016), http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_Nov_2016.pdf.
[16] *See* CAL. LEG. ANALYST'S OFFICE, RISKS TO FEDERAL HEALTH CARE FUNDING 2 (2017), http://www.lao.ca.gov/handouts/health/2017/Health-Care-Funding-022217.pdf.
[17] *See* CAL. PUB. HOSPITALS & HEALTH SYSTEMS, IMPACT OF MEDI-CAL EXPANSIONS: CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS 1 (2017), http://caph.org/wp-content/uploads/2017/02/ca-phs-aca-impact.pdf.
[18] *See* Letter from Jennifer Kent, *supra*, note 3; *see also* LAUREL LUCIA *ET AL.,* U.C. BERKLEY LABOR CTR., MEDI-CAL EXPANSION UNDER AHCA: SEVERE COVERAGE AND FUNDING LOSS UNLESS STATE BACKFILLS BILLIONS IN FEDERAL CUTS 4 (2017), http://laborcenter.berkeley.edu/medi-cal-expansion-under-ahca/.
[19] CAL. WELF. & INST. CODE § 14103(a).
[20] *See* CAL. LEG. ANALYST'S OFFICE, *supra*, note 16, at 2.
[21] *See, e.g.,* CAL. HEALTH CARE FOUND., CALIFORNIA HEALTH CARE ALMANAC 12 (2013), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalFactsAndFigures2013.pdf.
[22] *See* CAL. WELF. & INST. CODE § 14005.27(e); CAL. DEP'T HEALTH CARE SERVS., FINAL COMPREHENSIVE REPORT 2-4 (2014), http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/AppendixCHFP.PDF.
[23] 42 U.S.C. § 1397dd(a)(20)(B).
[24] *See* CAL. DEP'T HEALTH CARE SERVS., *supra,* note 16, at 2.
[25] *See* Cal. Dep't Health Care Servs., HPE Program Overview, http://files.medi-cal.ca.gov/pubsdoco/presumptive_eligibility/HPE_landing.asp (last visited Mar. 18, 2017).
[26]See Letter from Jennifer Kent, *supra*, note 3.
[27] *Id*.
[28] See CAL. DEP'T HEALTH CARE SERVS., QUARTERLY ELIGIBILITY REPORT 11 (2016), http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/ABX1_1CA_Eligibility_Enroll_Data_Apr-June2016.pdf.
[29] This change would not eliminate Presumptive Eligibility for pregnant women, Deemed Eligibility for infants, Accelerated Enrollment for Children through the Single Point of Entry, or immediate and simplified eligibility for former foster youth through the counties.
[30] *See, e.g.,* STAN DORN *ET AL*., THE FINANCIAL BENEFIT TO HOSPITALS FROM STATE EXPANSION OF MEDICAID 7 (2013), http://research.urban.org/UploadedPDF/412770-The-Financial-Benefit-to-Hospitals-from-State-Expansion-of-Medicaid.pdf.
[31] Individuals can request retroactive coverage whether or not they apply for ongoing coverage and whether or not their application for ongoing Medi-Cal coverage is approved or denied.

[32] *See* Letter from Tara Naisbitt, Chief Medi-Cal Eligibility Division, Cal. Dept. Health Care Servs., to All Cnty. Welf. Dirs. (May 15, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-27.pdf.
[33] See, e.g., STAN DORN *ET AL*, *supra*, note 30.
[34] *See* RACHEL GARFIELD *ET AL.,* UNDERSTANDING THE INTERSECTION OF MEDICAID AND WORK (2017), http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work.
[35] Leighton Ku & Rachel Brantley, Medicaid Work Requirements: Who's At Risk?, Heath Aff. Blog, Apr. 12, 2017, http://healthaffairs.org/blog/2017/04/12/medicaid-work-requirements-whos-at-risk.
[36] *See, e.g., id.*; JANE PERKINS & IAN MCDONALD, NAT'L HEALTH LAW PROG., MEDICAID WORK REQUIREMENTS - LEGALLY SUSPECT 4 (2017), http://www.healthlaw.org/publications/browse-all-publications/medicaid-work-requirements-legally-suspect; Robert Rector, Heritage Found., Work Requirements in Medicaid Won't Work. Here's a Serious Alternative., Mar. 19, 2017, http://www.heritage.org/health-care-reform/commentary/work-requirements-medicaid-wont-work-heres-serious-alternative.
[37] MIRANDA DIETZ *ET AL.*, ACA REPEAL IN CALIFORNIA: WHO STANDS TO LOSE? 2 (2016), http://laborcenter.berkeley.edu/pdf/2016/ACA-Repeal-in-California.pdf.
[38] LAUREL LUCIA *ET AL.*, WHICH CALIFORNIA INDUSTRIES WOULD BE MOST AFFECTED BY ACA REPEAL AND CUTS TO MEDI-CAL? 3 (2017), http://laborcenter.berkeley.edu/pdf/2017/Which-CA-Industries-Most-Affected-by-ACA-Repeal-and-Cuts-to-Medi-Cal.pdf.
[39] *Id.*
[40] *See* Letter from Andrew M. Slavitt, Ctrs. Medicare & Medicaid Servs., to Mari Cantwell, Cal. Dep't Health Care Servs. (Dec. 30, 2015) (approving waiver through Dec. 31, 2020), http://www.dhcs.ca.gov/provgovpart/Documents/Letter_to_State-CA_Redacted.pdf.
[41] *See* Cal. Dep't Health Care Servs., List of Medi-Cal Waivers, http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalWaiversList.aspx (last visited Mar. 16, 2017).
[42] *See* CAL. DEP'T HEALTH CARE SERVS., 2017-18 GOVERNOR'S BUDGET HIGHLIGHTS 8, 11-12, 14-15 (2017) (estimating spending on various waivers for 2017-18), http://www.dhcs.ca.gov/Documents/FY-2017-18_GB_Highlights_011017.pdf.
[43] *See* CAL. WELF. & INST. CODE § 14132.03; Letter from Gloria Nagle, Ctrs. Medicare & Medicaid Servs., to Toby Douglas, Cal. Dep't Health Care Servs. (Mar. 28, 2014) (approving state plan amendment to implement California's Alternative Benefits Plan), http://www.dhcs.ca.gov/formsandpubs/laws/Documents/13-035_ACA_Alt_Benef_Plan.pdf.
[44] *See* sources cited *supra,* note 43.
[45] *See* Letter from Gloria Nagle, Ctrs. Medicare & Medicaid Servs., to Toby Douglas, Cal. Dep't Health Care Servs. (Aug. 31, 2012) (approving state plan amendment to implement Community First Choice option), http://www.cdss.ca.gov/agedblinddisabled/res/CFCO/CFCO-CA-SPA11-034ApprovalSignedLtr.pdf; Letter from Gloria Nagle, Ctrs. Medicare & Medicaid Servs., to Toby Douglas, Cal. Dep't Health Care Servs. (July 31, 2013) (approving revised state plan amendment to implement Community First Choice option in congruence with federal regulations), http://www.cdss.ca.gov/agedblinddisabled/res/CFCO/CFCO-SPA_13-007FINAL(8-06-13).pdf.
[46] *See* SYLVIA MATHEWS BURWELL, U.S. DEP'T HEALTH & HUM. SERVS., COMMUNITY FIRST CHOICE: FINAL REPORT TO CONGRESS 19 (2015), https://www.medicaid.gov/medicaid/hcbs/downloads/cfc-final-report-to-congress.pdf.
[47] CAL. DEP'T SOC. SERVS., CALIFORNIA RECEIVES FIRST-IN-THE-NATION APPROVAL OF NEW COMMUNITY-

BASED CARE OPTION FOR AT-RISK SENIORS AND PERSONS WITH DISABILITIES (2012), http://www.cdss.ca.gov/agedblinddisabled/res/CFCO-PressRelease.pdf.

[48] *See* Letter from Jennifer Kent, *supra*, note 3.

[49] This amount is currently $840,000 based on increases to the Consumer Price Index for All Urban Consumers (CPI-U). *See* CTRS. MEDICARE & MEDICAID SERVS., 2017 SSI AND SPOUSAL IMPOVERISHMENT STANDARDS (2016), https://www.medicaid.gov/federal-policy-guidance/downloads/cib120216.pdf.

[50] Zillow.com, California Home Prices & Values, https://www.zillow.com/ca/home-values (last visited Apr. 25, 2017).