LONG TERM CRISIS

The Case for Reforming Medicaid "Personal Care" in New York

by Bill Hammond

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WHAT YOU'LL LEARN IN THIS REPORT

- New York's Medicaid program spends roughly $12 billion per year on in-home "personal care" for the elderly and disabled — nearly as much as the other 49 states combined.
- The state's per capita personal care spending is eight times higher than the national average.
- New York employs 138 home health aides per 1,000 residents over 65, which is more than double the national average. In New York City, the rate is 236 per 1,000.
- Home health aides accounted for two-thirds of the state's net job growth over the past decade and now outnumber the combined total of retail clerks and fast-food counter workers.
- The state's spending on personal care surged 178 percent from 2015 to 2021, which was 10 times faster than the growth of its elderly population.
- Despite heavy investment in home-based care, the share of New Yorkers living in nursing homes has declined more slowly than in other states and remains 29 percent above the U.S. norm.
- New York's per capita Medicaid spending on nursing homes is the highest of any state and double the U.S. average.

A large and rapidly growing share of the state's Medicaid budget is flowing to a service known as "personal care" or "personal assistance" – which consists of non-medical services, such as help with bathing and feeding, provided to the elderly and disabled in their homes.

When used appropriately, this optional Medicaid benefit offers a valuable alternative to institutionalization. It makes it possible for people with serious disabilities to live in the community, closer to family and friends – and often costs less than placement in a nursing home.

New York's huge and expensive version of the program, however, shows increasing signs of dysfunction and waste.

Among the 34 states that cover personal care, New York's program is by far the costliest.[1]

The state currently spends about $12 billion per year on personal care – an amount which has more than doubled since 2016 and is almost as much as the other 49 states' spending combined.[2] Enrollment in Medicaid managed long-term care plans, which handle most personal care claims, has surged from 140,000 in 2015 to 250,000 this year.[3]

Also rapidly growing is the state's workforce of home health aides, who are minimally trained and typically earn between $15 and $18 an hour. Their ranks soared from about 250,000 to almost 480,000 over the past decade, accounting for two-thirds of the state's net job growth during that period.[4] This job category now outnumbers the combined total of retail clerks and fast-food counter workers.

Despite these dramatic trends, the program appears to be falling short of its most important goal – which is to help disabled people avoid being institutionalized. The share of New Yorkers living in nursing homes remains significantly higher than the national norm and has declined more slowly than in the rest of the country.[5]

This startling combination – of extraordinarily heavy investment in home care without a commensurate reduction in demand for nursing home beds – raises concern that New York's personal care program is being overused, abused and defrauded. It also shows that the program is poorly targeted, delivering care to thousands of less needy recipients while failing to reach many of the seriously disabled people it was intended to serve.

Personal care can be especially vulnerable to fraud because the service is delivered by unlicensed caregivers in private residences, usually with no on-site supervision. The risk is heightened when the aide is a friend or family member of the patient, which is allowed under the popular and rapidly growing "consumer-directed" form of personal care.

In a fraud case brought by federal prosecutors, aides were accused of claiming payment for hours when they were busy doing other things, such as taking a Caribbean cruise. In some cases, the aides allegedly shared their paychecks with clients and with officials at the agencies that employed them.[6] Overall, however, New York has made relatively little effort to police for personal care fraud.

Also contributing to the program's growth are eligibility rules that are vague or subject to manipulation. Medicaid is meant to be a safety-net health plan for the poor, but people of means commonly maneuver around the financial screening rules by transferring assets to relatives or putting them in trust.

State officials have periodically tried to exert tighter control over personal care, but they have had little success so far. Their chief proposals have faced stiff and effective opposition, both from the burgeoning ranks of beneficiaries and from others with a stake in the program, including labor unions, home care agencies and long-term care insurance plans that manage the benefit under contract with Medicaid.

Another obstacle over the past two years has been federal policy, which temporarily barred states from tightening Medicaid eligibility rules as a condition of receiving pandemic relief funding.

Although New York lawmakers approved new restrictions on personal care in 2020, the Health Department won't be able to fully im-

plement those changes until after the federal emergency order is officially lifted, which is expected in early 2023.

This year, the Legislature approved a $3 increase in the minimum hourly wage for home health aides, citing what was described as a crisis-level shortage of workers available for the personal care program – a move projected to cost $7.7 billion over the next four years.[7]

The more urgent crisis – and the root cause of hiring challenges – is seemingly bottomless and unchecked demand for a costly Medicaid benefit, which has been rising almost 10 times faster than the growth of the state's elderly population.

Unless the state imposes reasonable limits, personal care will claim an increasingly disproportionate share of the state's resources – diverting money that could be better spent on other priorities and workers who could be more productively used by other parts of the economy.

BACKGROUND

Long-term care refers to support services needed by people with prolonged or permanent disabilities, including disabilities related to advanced age.

There are two main categories: institutional care, delivered in nursing facilities or group homes, and home care, delivered to recipients in their homes and apartments. Both types include a mix of medical services, such as administering medication and providing therapy, and non-medical services, such as helping recipients eat, use the bathroom, get dressed, clean house and shop.

The focus of this report is a non-medical form of home care known as personal care or personal assistance. This service is provided by aides with little or no formal training who are typically paid between $15 and $18 per hour.[8] The average total cost per hour in 2020, including taxes, travel expenses, benefits and administrative costs, was just under $25.[9]

Personal care makes it possible for people who might otherwise be institutionalized to stay in their own homes and communities, in routine contact with friends and family, without the restrictions that come with life in a nursing facility.

The per-patient cost varies widely according to the number of hours of service he or she is allocated. In 2020, the average personal care patient received 144 hours per month at a cost of about $3,600. That was less than half the program's average expense for a nursing home placement, which was $8,300.[10]

However, there is no hard limit on the number of hours of service a patient can receive, and some qualify for around-the-clock care. In 2020, 12 percent of personal-care patients received 320 hours or more per month, or more than 10 hours per day. Their average cost was $16,400, or almost double the price of a nursing home ***(see Figure 1)***.[11]

Personal care has traditionally been provided through agencies that hire and train aides, pay their wages and benefits and coordinate and supervise the care provided to a roster of clients. However, a growing share of recipients are opting for the consumer directed form of personal assistance. Under this program, patients directly hire, train and manage their own aides, who can be friends or family members. In these cases, a business or non-profit organization known as a fiscal intermediary handles the money – collecting revenue from Medicaid and processing the aides' paychecks – but plays little or no supervisory role.

Once a niche program, the consumer-directed option has grown explosively over the past

decade and now represents roughly half of all personal care financed by New York Medicaid.[12]

Ordinary health insurance generally provides little or no coverage for long-term care. This includes the federal Medicare program, which covers no more than 100 days in a nursing home, and then only when a patient is directly admitted from a hospital. Medicare provides some coverage for home health care, but none for non-medical services such as meals, housecleaning or bathing.[13]

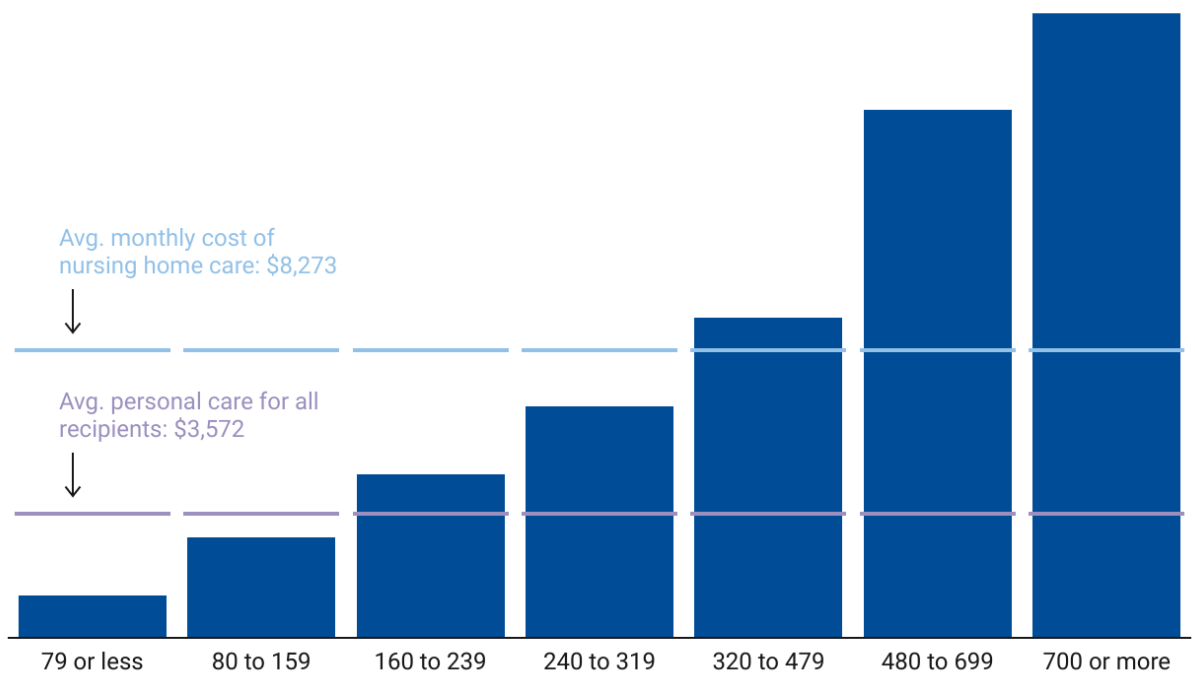
Long-term care insurance is available, but only about 2 percent of Americans have it.[14] As a result, the bulk of long-term care expenses fall on taxpayers through Medicaid, the nation's safety-net health plan for the poor.

Medicaid is jointly operated by the federal and state governments. Washington sets the broad parameters of the program and provides half or more of the funding; the states determine the details of coverage and eligibility and manage its day-to-day operations.

New York's version of Medicaid is unusually broad and expensive, costing more per capita than that of any other state. As of August, it covered 7.6 million people,[15] or a third of the state's population, with a fiscal year 2023 budget of almost $93 billion.[16]

Figure 1: Monthly cost of Medicaid care

Avg. payments by managed long-term care plans in 2020



Source: NYS Health Department Medicaid managed long-term care operations reports • Created with Datawrapper

Unlike most insurance, Medicaid provides open-ended coverage of long-term care. New York's version also covers home-based personal care, which is an optional benefit under federal rules.

Although Medicaid is means-tested and targeted to the poor, people from all walks of life find their way into the program once they become candidates for long-term care.

Many who require home care or a nursing home bed late in life become impoverished after a few months or years of paying the costs – which are heavy enough to exhaust the savings of all but a wealthy few. Others maneuver to become Medicaid-eligible by transferring assets to relatives or putting their money in trust, with guidance from attorneys who specialize in "Medicaid planning."

Younger recipients of long-term care often live in or near poverty due to disabilities that prevent them from working or limit their ability to earn an income.
Thus New York's Medicaid program covered 72 percent of nursing home patient-days in 2020 – and likely a similar proportion of home care.[17]

One of the biggest drivers of New York's high Medicaid spending in recent years has been the rising cost of personal care. In the five years leading into the pandemic, spending on the benefit more than doubled, from $4.6 billion to $11.4 billion,[18] accounting for about 15 percent of all Medicaid spending in the fiscal year ending March 2020.

Spending on personal care has been rising in other states, too, a byproduct of the nation's aging population. But New York's program stands well apart from the rest – raising concern that its Medicaid personal care benefit is being overused, abused and likely defrauded on a significant scale.

SYMPTOMS OF TROUBLE

Extreme spending

One sign of trouble is the extraordinary size and explosive growth of New York's spending on personal care.

In 2019 – the most recent for which nationwide data are available – the state's Medicaid personal care outlays of $10.3 billion were 47 percent of the U.S. total. In other words, New York alone spent nearly as much as the other 49 states combined.[19]

On a per capita basis, New York's spending was well over double that of the No. 2 state, Minnesota, and almost eight times higher than the U.S. average (***see Figure 2, opposite page***).[20]

Also extraordinary is how quickly its spending increased.

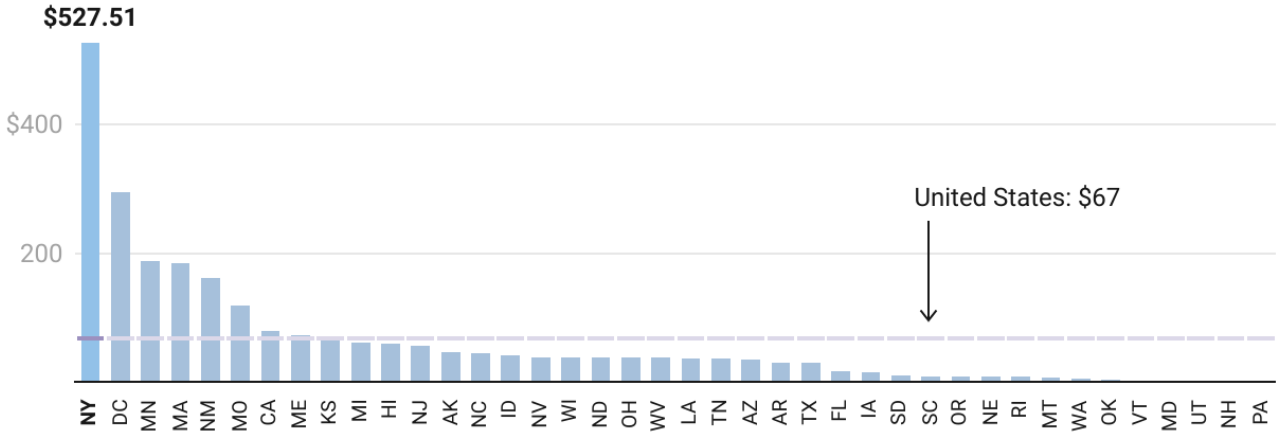
New York was already an outlier in 2009, when it accounted for 24 percent of all Medicaid personal care expenditures and had 6 percent of the U.S. population.[21] Over the next decade, New York's spending on the benefit more than tripled, rising 17 times faster than the growth in the other 49 states. During that period, New York accounted for 85 percent of the nationwide increase in personal care spending.

High employment

New York is unrivaled when it comes to personal care jobs. As of May 2021, the U.S. Bureau of Labor Statistics estimated that there were 478,620 home health and personal care aides employed in the state.[22] That equates to 138 aides for every 1,000 residents who are 65 or older, a level that was 128 percent higher than the national average and 15 percent higher than the No. 2 state, California.[23]

Figure 2: Per capita Medicaid expenditures on personal care

FY 2019



Source: Centers for Medicare & Medicaid Services • Created with Datawrapper

Over the past decade, statewide employment in the field nearly doubled, adding 229,000 jobs, which is more than the population of Rochester.[24]

This robust growth stands in contrast to the rest of the job market, which was sluggish or flat for much of the past 10 years and shrank sharply during the pandemic. As a result, home care aides accounted for 65 percent of the state's net increase in jobs from 2011 to 2021.[25]

By 2016, home care aides outnumbered retail sales jobs in New York. By 2021, they outnumbered retail sales and fast-food counter workers combined ***(see Figure 3, page 8)***.[26]

Continued heavy use of nursing homes

One of the chief goals of personal care is to keep people with disabilities out of nursing facilities where possible – and the benefit clearly works that way in many individual cases.

In aggregate, however, New York's extraordinary investment in personal care has not resulted in a commensurate reduction in its use of institutions.

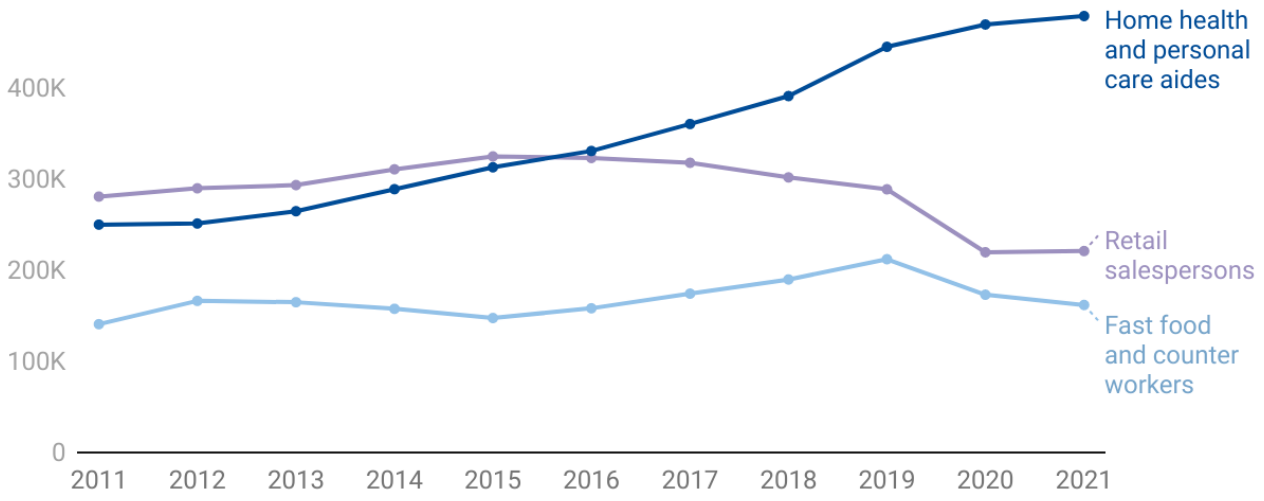
The share of older New Yorkers living in nursing homes is 29 percent higher than the national average and 15th highest among the states.[27] The state's nursing home utilization rate among residents over 65 has been declining, but at the sixth slowest rate in the U.S.[28]

New York's per capita Medicaid spending on nursing homes, meanwhile, is the highest in the U.S. and more than double the national average.[29] New York's Medicaid program is simultaneously a spending outlier on both institutional and home-based long-term care ***(see Figure 4, page 9)***.

Disparity with demographic trends

The rapid growth of New York's personal care program cannot be fully explained by the aging of its population or its level of poverty.

Figure 3: NYS employment in selected occupations



Source: Bureau of Labor Statistics • Created with Datawrapper

Compared to rest of the U.S., New York is not especially old or poor. It ranks 25th among the 50 states by its share of population over 65, and 19th for poverty. The share of its population who report being disabled is 12.3 percent, compared to a national average of 13.4 percent.[30]

The number of New Yorkers who are 65 or older increased 17 percent between 2015 and 2021 – which was almost exactly in line with the national average.[31] Over that same period, its Medicaid personal care spending increased by 178 percent, or 10 times faster.[32]

Concentration in New York City

Another symptom of dysfunction in the state's personal care program is the disparity in utilization patterns between New York City and the rest of the state.

New York City accounts for 43 percent of the state's population, but 69 percent of enrollment in Medicaid managed long-term care, which is the primary vehicle for financing personal care and other non-institutional long-term care.[33]

The disparity is also reflected in the employment numbers. As of May 2021, there were 324,600 home health and personal care aides in the five boroughs, which is 69 percent of the statewide total.[34]

That translates to 236 aides per 1,000 residents aged 65 or older – compared to 74 per 1,000 for the rest of the state and 60 for the United States as a whole.[35] For the U.S. to match New York City's current employment level, the number of care aides nationwide would have to jump by more than 9 million, or roughly the population of New Jersey.

Inattention to the risk of abuse and fraud

Federal watchdogs have warned states that the design of personal care – in which services are delivered in private residences by minimally trained aides with little or no on-site supervision – makes the program vulnerable to fraud while also exposing recipients to neglect and abuse.[36]

In one scenario, aides claim to have provided personal care during hours when they were working somewhere else or not working at all. Recipients might fail to report no-shows out of confusion or fear – or because they are receiving a share of the aides' fraudulent wages.

A scheme of this type was the focus of federal fraud charges announced in December 2020 against 10 employees of two Brooklyn home care agencies. One aide was accused of claiming she provided care on days when she was actually taking a Caribbean cruise.[37]

Prosecutions like that one, however, have been relatively rare in New York.

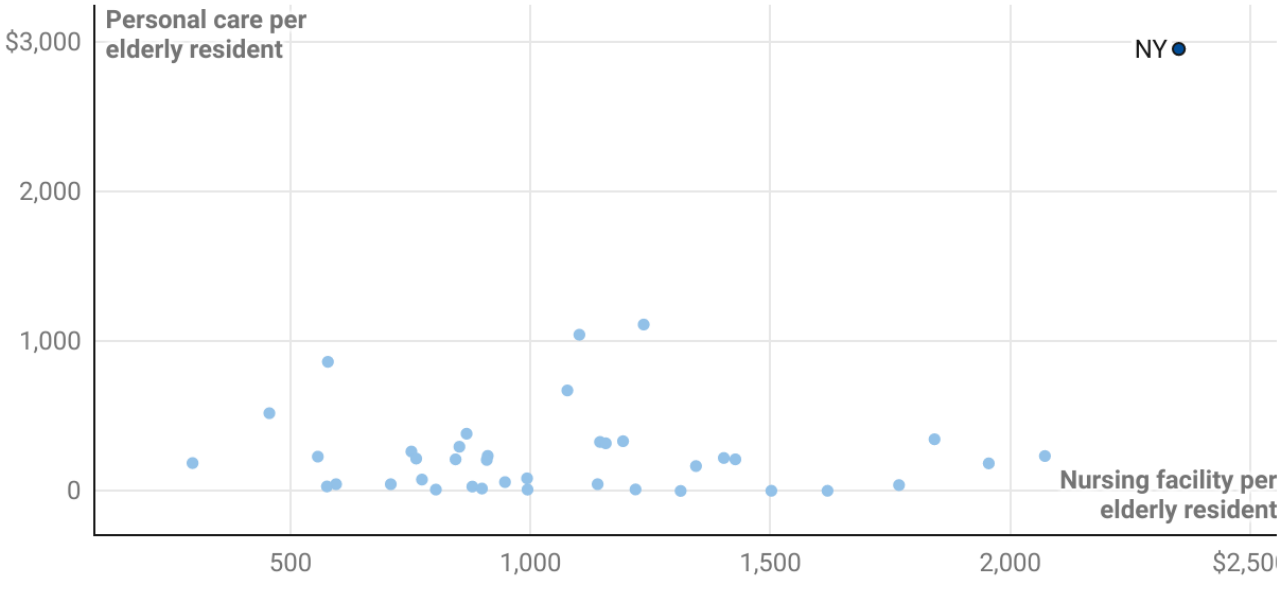
According to data gathered by the U.S. Department of Health and Human Services' Office of the Inspector General, the state's Medicaid Fraud Control Unit, a branch of the attorney general's office, obtained just four convictions for personal care fraud from 2012 through 2015. That was 0.3 percent of the national total during a period when New York accounted for 29 percent of Medicaid spending on personal care.[38]

Persistent hiring challenges

Despite the state's high levels of home care spending and employment, industry officials and consumers have raised an alarm about what they call an "extreme shortage" of avail-

Figure 4: Spending on nursing home care and personal care by state

Medicaid expenditures per state resident 65 or older, FFY 2019



Source: Centers for Medicare & Medicaid Services • Created with Datawrapper

able aides – and argued that Medicaid-funded wage hikes are necessary to address it.[39]

They cited a 2018 analysis by the employment consulting firm Mercer which projected that New York would need to add 83,000 aides by 2023, the largest such "gap" in the U.S.[40]

They also pointed to industry surveys, including one by the Home Care Association of New York State, which found that 31 percent of available personal care jobs were unfilled in late 2021 and early 2022.[41]

The Legislature responded by boosting the minimum wage for home health aides by $2 in October 2022 and another $1 in October 2023[42] – a move that's expected to increase Medicaid spending by $7.7 billion over the first four years.[43]

However, the focus on wages ignores a more significant cause of the industry's recruiting challenge: skyrocketing demand.

As discussed above, the state's home health workforce grew by hundreds of thousands over the past 10 years – nearly doubling in size – and has far surpassed both the fast-food and retail sectors in the competition for low-wage labor.

Any shortages of aides that persist in that context are a sign that New York's personal care program continues to expand at a rapid pace.

DRIVERS OF GROWTH

Across a range of metrics, New York's personal care program shows clear signs of inefficiency.

As discussed above, the program has grown 10 times faster than the elderly population it is primarily intended to serve, and its spending and employment levels are by far the highest of any state. Yet New York still houses a disproportionate share of its aging residents in nursing homes – the exact problem that home-based care was meant to alleviate.

The program has diverted a relatively small number of people from institutions, but in the process it opened Medicaid's long-term care coverage to a much larger and less needy population. New York now effectively operates two parallel long-term care programs – one for nursing homes, the other for home-based care – and spends more per capita on each than any other state.

The factors that led to this situation start with the nature of the personal care benefit itself.

The prospect of entering a nursing home is something people tend to dread and put off as a last resort. Personal care is not always self-limiting in this way. Patients and their families are more likely to welcome periodic help with shopping, cooking and housekeeping, and might seek it out before it becomes strictly necessary.

That dynamic calls for an extra degree of vigilance to screen out applicants who aren't truly disabled or financially needy. However, the program's financial eligibility rules have been less stringent than those applied to nursing home placements.

People applying for Medicaid coverage of institutional long-term care are subject to a review of their financial transactions for the previous five years. If this so-called "look-back" finds that they have transferred money to heirs or family members, or sold assets for less than market value, the applicants could be denied Medicaid coverage for a "penalty period" based on the dollar amount involved.[44]

For people seeking home-based long-term care, by contrast, there is currently no look-back period for asset transfers. Applicants

can shift an unlimited amount of money to family and friends and qualify for Medicaid coverage immediately thereafter – which opens the door to abuse of what is meant to be a safety-net program.

The medical criteria for receiving personal care are also vague in some respects. For example, there has been no formal requirement that applicants demonstrate the need for help with "activities of daily living," or ADLs, such as getting dressed, using the bathroom or feeding themselves. This is a common method of gauging disability that until recently has gone unmentioned in the laws and regulations surrounding personal care.

Lawmakers addressed these two issues in the state budget passed in April 2020. They established a 30-month lookback for community-based long-term care, which is half the standard for nursing home care. They also mandated that recipients of personal care require help with at least two ADLs or, in cases of dementia, at least one ADL.[45]

However, these new requirements have yet to take effect. Under conditions attached to federal pandemic relief aid, states are temporarily barred from tightening their Medicaid eligibility rules.[46] As a result, the new criteria cannot be enforced until the Biden administration declares an official end to the pandemic emergency, which is expected early next year.

The past decade's surge in personal care appears to have been triggered by former Governor Andrew Cuomo's Medicaid Redesign Team. That team's reform scheme, enacted in 2011, called for outsourcing most Medicaid recipients into private health plans, a system known as Medicaid managed care. This included people with permanent disabilities, who were placed in specialized managed long-term care plans.

These plans, which received a monthly premium for each enrollee, were expected to control costs in part by efficiently using home-based care to keep their clients out of nursing facilities. However, the plans were also incentivized to sign up as many clients as possible to increase their market share and maximize premium revenue. Competition was intense, with some plans using fraudulent recruitment tactics.[47] Overall enrollment in Medicaid long-term care plans soared, and demand for personal care rose along with it.

An analysis by the New York City Independent Budget Office (IBO) found that overall home health employment within the city spiked by 65 percent, or 124,000 jobs, from 2010 to 2018, accounting for more than a third of the city's total job growth in the latter two years of that period.[48]

An especially rapid increase was seen in the "consumer-directed" form of personal care, which managed care plans may have preferred because it was less expensive than agency-based personal care. The lightly regulated companies that handle payroll processing for the consumer-directed care, known as fiscal intermediaries, proliferated by the hundreds. They ran advertising campaigns emphasizing that people could get paid for taking care of their family members.

The IBO analysis found that the city's traditional home health agencies grew by a robust 35 percent or 58,000 jobs from 2010 to 2018. Over the same period, employment in the consumer-directed program through fiscal intermediaries soared by a remarkable 250 percent or 66,000 jobs (see Figure 5, opposite page).[49] Amid this trend, lawmakers voted in 2016 to enact a major increase in the state's minimum wage.[50] In New York City, where personal care is concentrated, the hourly rate jumped from $9 to $15 an hour over a three-year period.

The state further committed to reimburse Medicaid providers for their added labor

costs, which mounted quickly. This year, the tab is projected to be about $5 billion – most of which flows to personal care.[51]

As the personal-care industry has mushroomed, so, too, has its influence at the state Capitol. The program's growth has added substantially to the membership lists and revenue of the health-care labor union 1199 SEIU – already a formidable force in Albany – as well as groups representing home health agencies, fiscal intermediaries and managed long-term care plans.

Recipients of personal care have also been well-organized and outspoken, staging protests in Albany at strategic moments[52] and generally working in alliance with industry groups to advocate for more generous benefits and higher spending.

Because of their combined efforts, cost-cutting proposals from the Health Department and Budget Division have often fallen flat, while proposals to increase personal-care spending have gotten a friendly reception in the Legislature.

An example was the "Fair Pay for Home Care" proposal from an coalition of industry groups and allies, which called for paying home health aides at least 50 percent more than the minimum wage in their region.[53] It was likely to cost the state billions and was based on the dubious assertion that New York's personal care program – which employs more care workers per capita than any other state – was facing a crisis-level shortage of aides.[54]

Still, legislation to enact the plan was cosponsored by a majority of the members of both houses, including several Republicans, and was written into the one-house budget proposals of both the Assembly and Senate.[55]

Governor Hochul agreed in the final budget to boost the minimum hourly pay for home care workers by $2 in October 2022 and another $1 in October 2023, which is expected to cost $7.7 billion over the first four years.[56] However, the budget took no major steps to control the personal care program's mushrooming growth, which is the ultimate reason that care aides are in short supply.

A REFORM AGENDA

Although currently on hold during the pandemic emergency, the eligibility reforms adopted in 2020 were steps in the right direction that should help to slow the growth of personal care when fully implemented, which is expected in 2023.

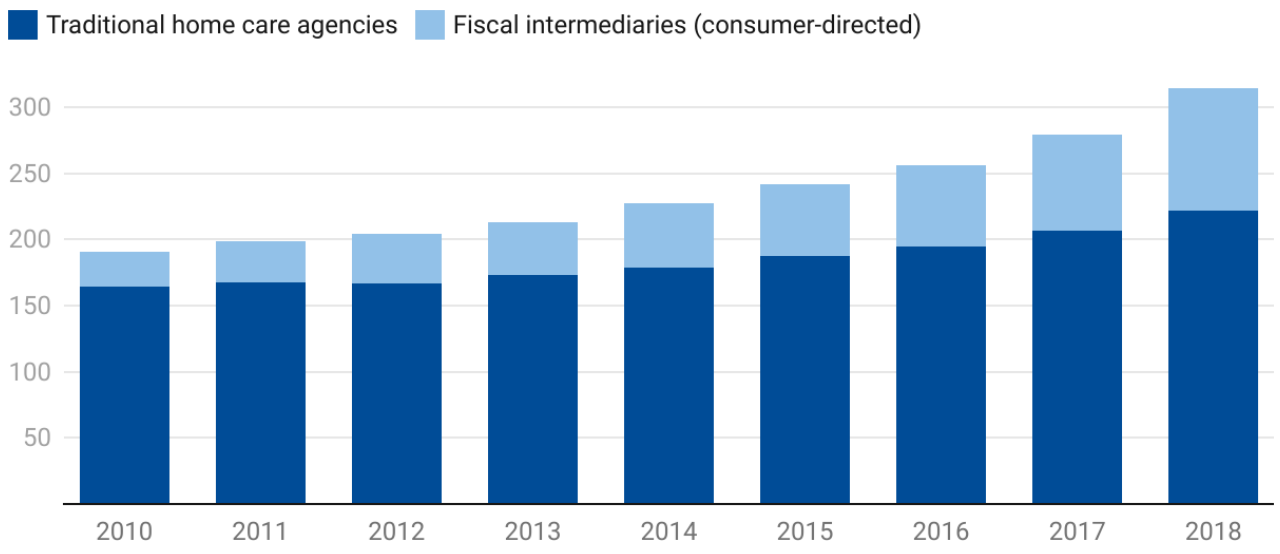
However, given the amount of money at stake – and plentiful evidence of waste – a more thorough review and overhaul of New York's program is warranted.

This should start with an in-depth study – preferably by independent experts – of why the program is so much bigger and more expensive than those in other states. What specific features of New York's rules and procedures are allowing so many people to qualify for such a costly benefit, and how do other states avoid that problem? What is the demographic breakdown of current enrollees by degree of disability, wealth, age, region, etc.? This review should include an audit to estimate the level of fraud.

Next, the state should set and enforce clear goals. Eligible recipients who are currently living in institutions, or at imminent risk of being placed in one, should be prioritized over all other applicants. At the same time, the program should establish limits on how much it will spend on care for any one recipient, especially when the cost significantly exceeds that of a nursing home. Meanwhile, the state should seek to weed out applicants who don't truly need outside help or who can reasonably afford to pay for their own aides.

Figure 5: Home care employment in NYC, 2010 - 2018

(in thousands)



Source: New York City Independent Budget Office • Created with Datawrapper

The state should encourage the purchase of private long-term care insurance. It could start by reviving the New York State Partnership for Long-Term Care,[57] which allowed people who purchased qualified insurance plans to receive Medicaid coverage while retaining certain assets.

This would entail a crackdown on the legal maneuvers that allow Medicaid applicants of substantial means to shield or transfer assets without buying insurance. Few people will be willing to pay insurance premiums if Medicaid is readily available as a fallback.

The state should also review the flow of money – from Medicaid, to managed long-term plans, to home health agencies and fiscal intermediaries, and finally to personal care aides and their clients. It should identify and eliminate rules and procedures that incentivize overuse or abuse of personal care.

The overarching goal should be to downsize the personal care program to a scale more proportionate to the state's demonstrated need. This would not only control costs, but also ease the demand for workers and thereby alleviate labor shortages. A portion of the Medicaid savings could then be reinvested to improve training and working conditions for care aides.

Better, more efficient management of New York's personal care program has the potential not only to save money, but also to reduce dependence on nursing homes and improve working conditions for care aides.

The people with disabilities who depend on personal care – and the taxpayers who finance it – deserve nothing less.

ENDNOTES

[1]Caitlin Murray, et al., "Medicaid Long Term Services and Supports Annual Expenditure Report: Federal Fiscal Year 2019" (Mathematica, Dec. 9, 2021). https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html
[2]Ibid.
[3]New York State Health Department Medicaid managed care enrollment reports. https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/ Managed long-term care enrollment does not include "fee for service" recipients whose personal care costs are directly reimbursed by the state. The Health Department does not publicly report how many overall enrollees receive personal care, making utilization hard to track precisely.
[4]Bureau of Labor Statistics Occupational Employment and Wage Statistics. https://www.bls.gov/oes
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[14]2020 data from the American Association for Long-Term Care Insurance. https://www.aaltci.org/long-term-care-insurance/learning-center/ltcfacts-2020.php#2020total
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[21]Steve Eiken, et al., "Medicaid Expenditures for Long-Term Services and Supports in FFY 2012" (Truven Health Analytics, April 28, 2014), Table K. https://www.medicaid.gov/sites/default/files/2019-12/ltss-expenditures-2012.pdf
[22]Op. cit., Bureau of Labor Statistics.
[23]Author's calculations using data from the Bureau of Labor Statistics and the Census Bureau.
[24]Op. cit., Bureau of Labor Statistics.
[25]Ibid.
[26]Ibid.
[27]Op. cit., KFF State Health Facts.
[28]Author's calculations using data from KFF State Health Facts and the Census Bureau.
[29]Op. cit., Murray et al., Appendix D, Table 7.
[30]Based on data from the Census Bureau.
[31]Ibid.
[32]Bill Hammond, "A Medicaid benefit doubles in 4 years" (Empire Center, Feb. 11, 2020). https://www.empirecenter.org/publications/medicaid-benefit-doubles-in-4-years/
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