NASUAD
National Association of States United for Aging and Disabilities

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September 21, 2017

Hon. Mitch McConnell
Majority Leader
U.S. Senate

Hon. Orrin Hatch
Chairman
Senate Finance Committee

Dear Majority Leader McConnell and Chairman Hatch:

On behalf of the National Association of States United for Aging and Disabilities (NASUAD), I am writing to you in regards to the current efforts to repeal and replace the Affordable Care Act. NASUAD is a nonpartisan association of state government agencies and represents the nation's 56 state and territorial agencies on aging and disabilities. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services for older adults and individuals with disabilities. Our members administer a wide range of services and supports for older adults and people with disabilities, including Medicaid long-term services and supports (LTSS), the Older Americans Act (OAA), and a variety of other health and human services programs. Together with our members, we work to design, improve, and sustain state systems delivering home and community-based services and supports for people who are older or have a disability and for their caregivers.

We have reviewed the text of the legislation released on September 13th by Senators Cassidy (R-LA), Graham (R-SC), Heller (R-NV), and Johnson (R-WI). As you know, the legislation would transform the ACA coverage expansions, including the Medicaid Childless Adult Group, the Advance Premium Tax Credits, the Cost Sharing Reductions, and the Basic Health Plan, into a block grant to states. The legislation would also provide the opportunity for states to apply for waivers of ACA insurance regulations, such as community rating and essential health benefits. Additionally, the legislation would make significant changes to the core Medicaid program by establishing a per capita limitation on total federal funding for each state. As a nonpartisan organization, we are not taking a stance on the efforts to repeal and replace the Affordable Care Act. However, as administrators of Medicaid long-term services and supports, as well as other programs for older adults and persons with disabilities, we have concerns about several of the policies included in the bill text. We specifically have concerns that this legislation seeks to impose a per capita cap on Medicaid expenditures, which is outside the scope of ACA's coverage expansion and insurance regulations. Below, we provide a summary of our concerns and, where appropriate, provide recommendations for improving these provisions.

Establishment of Per Capita Caps

Section 124 of the legislation sets an upper limit of Federal match that a state may receive based on the number enrollees in Medicaid. The per capita caps are established using state FY2016 expenditures for four groups:

- Individuals age 65 or older;
- Individuals who are blind or have a disability;
- Children under the age of 19 without disabilities who are not eligible via CHIP; and
- Adults who are not included in the prior groups.

An aggregate cap is then placed on total Medicaid spending by multiplying the per capita spending limits for each of the groups by the average number of monthly enrollees within the group. As we have previously discussed in our comments on prior ACA repeal and replace proposals, this policy will create a number of challenges to states, including:

- It prevents states from targeting Medicaid to individuals with the highest level of need: Under this policy, states do not have the ability to target individuals with the highest need because the spending caps are based upon historical spending for all individuals within each enrollee category without any risk-adjustment provisions. This will create challenges if states experience budget pressure and look to restrict eligibility in a way that preserves services for individuals with the highest level of need. For example, if a state experiencing a budget shortfall increases the level of care requirements for LTSS eligibility, the new eligibility policy would ensure that services remain available for individuals with the highest level of need. However, the resulting higher acuity of individuals who remain in the program would result in a higher per-person cost of care which would likely create challenges with the per capita caps. In short, the policy creates incentives to serve a larger number of individuals with lower care requirements instead of focusing supports on those with the most significant health and LTSS needs.
- The policy limits states' ability to expand benefits: States without optional benefits would find it difficult to add additional services that could be valuable for participants, such as adult dental care; expanded rehabilitation benefits; or enhanced HCBS programming. Many states have made efforts to broaden benefits in order to improve the overall health and well-being of their Medicaid beneficiaries while simultaneously reducing the need for institutional LTSS and reducing hospitalization. Since these high-cost services are often financed by Medicare, any savings generated from the expanded Medicaid benefits would not be reflected in the cap calculations. Thus, benefit enhancements that result in improved health and reduced overall expenditures would be unworkable under this bill;
- The policy forces states to freeze or reduce provider rates: Freezing spending based on historic levels undermines efforts to increase provider rates, as provider payments constitute the vast majority of Medicaid spending. Thus, increases to payment rates will violate the spending caps. Additionally, states that were forced to implement payment rate reductions or benefit restrictions during economic downturns would be prevented from restoring those cuts once state finances rebound. CMS has been working with states to promote access to services, which has included review of state reimbursement rates

compared to other health insurance programs.[1] Implementation of these caps on spending will undermine these efforts and prevent states from any upward adjustment of provider rates;

- It limits the ability of states to respond to new requirements: Medicaid spending is often driven by factors beyond state control, such as new and costly treatments and technology, increases to provider payments due to wage growth and staffing changes, or changes to federal requirements. For example, complying with the 2014 Home and Community-Based Services final rule[2] is likely to require increased staffing ratios at various LTSS providers, which requires increased spending that results in a violation of the caps. Similarly, the Department of Labor has modified FLSA rules in a manner that continues to increase LTSS expenditures and will likely exacerbate the challenges to remain compliant with the caps;[3]
- It creates competition between spending for different populations in Medicaid: The per capita caps are calculated independently for each population, but they are applied in an aggregate manner. Thus, increased spending for one category of enrollees would need to be offset by other groups. Given that older adults, people with disabilities, and LTSS participants represent a disproportionate portion of the total Medicaid spend, they are likely to be places where spending constraints are applied and felt most acutely.
- It uses a base-year that is already completed: The calculation is based upon prior state expenditures for these populations, allowing states to select baseline expenditures from fiscal year quarters that fall between the first fiscal quarter of 2014 and the third fiscal quarter of 2017. This policy would not be responsive to changes that have been made since that date, nor would it account for mid-year modifications that could have altered expenditures for a period of less than the entire fiscal year. States would effectively be limited to policies in place during a previous period, and any improvements to services, reimbursement increases, or other policies with a fiscal impact would need to be undone. For example, states that have aggressively moved to address the opioid epidemic through in calendar year 2017 their Medicaid program would need to either roll-back any of those increased expenditures or find offsetting reductions in other parts of the program.

Due to all of these challenges, we recommend that Congress remove the per capita cap policies included in this legislation. States have a vested interest in the fiscal sustainability of the program and must ensure that they have balanced budgets each year. The existing financing arrangement where states establish the appropriate eligibility, benefits, and reimbursement policies based upon their unique characteristics and available finances should be maintained.

Lack of Flexibility for States

The legislation includes significant new restrictions to Federal financing for states but does not offer any corresponding state flexibility. When discussing the value of Medicaid reform proposals, state flexibility is the most significant benefit that policymakers propose to give state agencies in exchange for limitations in Federal funds. Yet this legislation leaves the major Medicaid

[1] https://www.federalregister.gov/documents/2015/11/02/2015-27697/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services

[2] https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

[3] https://www.dol.gov/whd/homecare/agencies-what-are-requirements.htm

requirements that drive state spending intact. This includes retaining all mandatory Medicaid eligibility categories, mandatory services, the early and periodic screening, diagnostic, and treatment (EPSDT) benefit, and the Medicaid drug rebate coverage requirements. We specifically note that in the LTSS space the legislation does not address Medicaid's institutional bias or provide opportunities to reduce expenditures by rebalancing LTSS towards home and community-based services. In fact, some of the policies, as discussed below, actually reduce the ability of states to provide HCBS in their Medicaid programs.

We note that the Flexible Block Grant option does provide some greater ability of states to modify their programs; however, in some cases it actually includes more expansive benefit requirements than the 1905(a) services. Similarly, it maintains all mandatory Medicaid populations without including much opportunity to adjust for enrollment changes. This creates a challenging dynamic that may make it challenging for states to effectively leverage the flexibilities that a block grant could otherwise provide.

All of these requirements place significant responsibilities on states regarding the individuals and services that must be covered. Thus, keeping them in place will severely limit the ability of states to respond to the bill's funding limitation by implementing flexible, innovative, and targeted reforms that reduce the spending growth in Medicaid while maintaining the health of individuals covered. Without corresponding flexibility to accompany the limitation in Federal funding, the legislation will simply serve as a cost-shift from the Federal government to states rather than a reform that strengthens the program.

Repeal of the Community First Choice Matching Increase

The legislation repeals the six percent increase in matching funds provided to state programs established under 1915(k) of the Social Security Act. These programs, called "Community First Choice" or "CFC," provide valuable and necessary attendant care services to older adults and individuals with significant disabilities that enable them to live in the community. The most beneficial parts of the CFC program are that the program does not include limitations on the number of individuals served and the increased Federal matching funds. These increased funds are one of the major factors that enable states to use CFC as a mechanism to reduce waiting lists for home and community-based services (HCBS). Repealing this increased funding will likely result in states needing to re-establish waiting lists for HCBS due to the reduction in available resources.

Several other important programs that promote the use of HCBS in lieu of institutional services have lapsed during the past several years, including the Balancing Incentives Program (BIP) and the Money Follows the Person Program (MFP). The expiration of MFP and BIP are already reducing the Federal government's support of deinstitutionalization activities, and the repeal of enhanced funding for these important CFC services will further exacerbate the lack of funding. Ultimately, this will be detrimental to both the states and the people served in LTSS programs. We encourage Congress to maintain this important program and the enhanced funding that it provides.

HCBS Provider Payment Adjustment Grant

We appreciate that the legislation includes $8 billion in funding to address HCBS quality and access

issues. We request clarification regarding how the payment adjustments will be calculated, as well as the limitation on individual providers. Lastly, we note that the legislation does not appear to specifically exclude these payment adjustments from the calculation of 1903A per capita caps. In the event that the per capita cap policy is retained, we request clarification regarding how the increased payments under this provision would interact with the aggregate limit on expenditures.

Medicaid Expansion and Market-Based Health Care Grant Program

We note that the legislation creates a new block grant using funding derived from repealing the ACA's Medicaid expansion, advance premium tax credits, cost sharing reduction payments, and Basic Health Plan. While we appreciate the way that these programs focus on state flexibility, we are concerned with the long-term sustainability of the fund. Current ACA provisions are responsive to growth in population, medical inflation, and increased eligibility due to economic downturns. In contrast, the block grants grow at a defined rate without regard to these factors. The block grants also do not take into account regional in cost of living and health care expenses. Lastly, the block grants would necessitate transitioning individuals from Medicaid into the private marketplace, which historically has higher per-person costs. Since the grant allocations are based upon current spending under the ACA, this shift could increase expenses beyond what the grants are funded to cover. We are concerned that, without appropriate funding, these programs will have the unintended consequences of reducing coverage for individuals while increasing out of pocket costs.

This concern is particularly relevant to individuals with disabilities and health conditions who may struggle to secure affordable care in the private marketplace. A study published in Health Affairs[4] found a significant number of individuals eligible under the ACA expansion to have chronic health conditions and/or disabilities. We believe that any ACA replacement should provide states with the funding needed to protect and preserve the health, welfare, and services for individuals with significant health needs and disabilities.

Repeal of the Public Health Prevention Fund

While we recognize and understand Congress' concerns with the broad scope of activities that can be included in this fund, we wish to highlight the value of some of its activities. The public health and prevention fund has been used to support a number of programs that are crucial to assisting older adults with chronic conditions and other health needs. The Administration for Community Living has used resources from this fund to support several important activities, including chronic disease self-management, falls prevention, and Alzheimer's education and outreach. Other programs through this fund have focused on diabetes and stroke prevention, which are significant for older adults. Repealing the bill would represent a step backwards for preventive care, research, and health promotion of older adults. We believe that some of Congress' concerns could be alleviated through stringent monitoring and evaluation of grant activities, instead of repealing the fund completely.

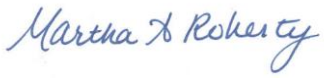
[4] http://healthaffairs.org/blog/2017/03/06/myths-about-the-medicaid-expansion-and-the-able-bodied/

Concluding Thoughts

As noted earlier, NASUAD is a nonpartisan organization and will not be taking a stance on the efforts to repeal and replace the Affordable Care Act nor will we be endorsing or opposing any specific pieces of legislation. However, we have serious concerns about the impact the bill may have on state governments, on LTSS programs, as well as on older adults, persons with disabilities, and their caregivers. We would be pleased to work with Congress to find ways to improve the legislation in a manner that supports and promotes the health, welfare, and community living of the individuals we serve.

If you have any questions regarding this letter, please feel free to contact Damon Terzaghi of my staff at dterzaghi@nasuad.org or (202) 898-2578.

Sincerely,



Martha A. Roherty
Executive Director
NASUAD

Cc:

Members of the U.S. Senate