NASUAD
National Association of States
United for Aging and Disabilities

1201 15th Street NW
Suite 350
Washington, DC 20005
Phone 202-898-2578
Fax 202-898-2583
www.nasuad.org

March 9, 2017

Hon. Paul Ryan
Speaker
U.S. House of Representatives

Hon. Greg Walden
Chairman
House Energy and Commerce Committee

Dear Speaker Ryan and Chairman Walden:

On behalf of the National Association of States United for Aging and Disabilities (NASUAD), I am writing to you in regards to the American Health Care Act (AHCA). NASUAD is a bipartisan 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 March 6th. As a bipartisan organization, we are not taking a specific stance on the efforts to repeal and replace the Affordable Care Act. However, our review of the AHCA raised a number of specific concerns regarding the policies included and their impact on state budgets, on programs that provide long-term services and supports, and on older adults and persons with disabilities. Below, we provide a summary of our concerns and, where appropriate, provide recommendations for improving these provisions.

Establishment of Per-Capita Caps

Section 121 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 five groups:

- Individuals age 65 or older;
- Individuals who are blind or have a disability;
- Children under the age of 19 who are not eligible via a CHIP program;
- Individuals who qualify as newly eligible for the ACA expansion; and
- Other 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 groups by the average number of monthly enrollees for each group. This policy will create a number of challenges to states, including:

- The policy codifies existing discrepancies in state spending: Those 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 LTSS programming. Similarly, 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;
- 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[1] is likely to require increased staffing ratios at various LTSS providers, which would require increased spending that results in a violation of the caps;
- 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 state expenditures for these populations in Federal Fiscal Year 2016, which ended on September 30, 2016. 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.
- It limits the ability to target Medicaid to the most needy individuals: the policy is based upon historical spending for all individuals within each enrollee category and does not have 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 cost of care and 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.

[1] 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

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 provided to state agencies in exchange for any limitations in Federal funds. Yet this legislation leaves the major Medicaid 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.

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

Section 111 of the legislation repeals the 6% 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. Given the importance of reducing HCBS waiting lists that was discussed in recent House Energy and Commerce Committee, we are surprised to see the elimination of CFC funding in this legislation. We encourage Congress to maintain this important program and the enhanced funding that it provides.

Restriction of the Increased Home Equity Exclusion

Section 114 of the bill repeals the ability of States to elect to increase the amount of money excluded from an individual's home equity when determining their eligibility. Under current law, Medicaid excludes the first $560,000 of home equity during eligibility determinations and provides states with the

option to increase this exclusion to no more than $840,000.[2] The legislation would set the exclusion at the $560,000 level with no option to increase above the Federal minimum.

Because of the way that assets are treated for Medicaid eligibility, this policy is primarily applicable to older adults, persons with disabilities, and individuals who receive LTSS. Some states, particularly those with high property value and cost of living, may wish to keep a higher exclusion in place, especially for individuals receiving HCBS. Home equity is highest in individuals who own their homes outright, so this policy would be predominantly detrimental to older adults who have paid off their mortgage and are living on a fixed income.

We note that our experience with LTSS rebalancing programs demonstrates that the availability of housing is one of the primary factors that determines the success of deinstitutionalization programs and aging in place initiatives. The result of policy could be force some individuals to sell their own homes and then spend down the resulting income on medical supports before they re-establish Medicaid eligibility. Due to the high cost of rent in many locales, particularly those that have elected to apply the higher home equity exclusion policy, divesting of the home and resulting assets could result in individuals becoming homeless or moving into nursing facilities and other institutions simply so that they have a place to live. This would not only be detrimental and disruptive to the individuals, it would also increase Medicaid LTSS expenditures. Thus, we believe states should continue to have flexibility to determine optimal exclusion amounts.

Medicaid Expansion

We note with concern that the legislation lowers the matching rate to states for individuals who enroll in the Medicaid expansion group after 2020 without providing eligibility flexibility, resulting in a cost shift to expansion states. The legislation retains the eligibility category at 1902(a)(10)(A)(ii)(VIII) of the Social Security Act for individuals below 138% of the Federal Poverty Level, but does not appear to provide states with any statutory authority to freeze or otherwise limit new enrollment for beneficiaries after the 2020 date. Medicaid eligibility categories always operate as an entitlement; thus, without explicit statutory authority to freeze new enrollees, states that continue to include the coverage group in the programs will be required to enroll all new eligible applicants after 2020.

States will therefore be faced with a stark choice: either be subject to a large cost-shift from the Federal government or be forced to eliminate the coverage expansion for all individuals, even those previously enrolled.

We also want to highlight a recent study in Health Affairs[3] which found a significant number of individuals eligible under the ACA expansion to have chronic health conditions and/or disabilities. Many of these individuals will not have access to affordable health insurance in the private marketplace, which will create challenges when removing Medicaid coverage. We believe that any ACA replacement should provide states with the tools and funding needed to protect and preserve the health, welfare, and services for individuals with significant health needs and disabilities.

---

[2] These amounts are indexed to the Consumer Price Index for All Urban Consumers (CPI-U) and increase each year.
[3] http://healthaffairs.org/blog/2017/03/06/myths-about-the-medicaid-expansion-and-the-able-bodied/

Removal of Retroactive Eligibility

Section 114 removes the requirement that states finance care provided to individuals during the three months prior to Medicaid application, as long as the individual met all eligibility requirements during such period. This policy will likely lead to significant additional pressures on some participants with high health care needs, including participants who suffer a traumatic injury and disabling condition, as well as older adults with chronic conditions. We recognize that there are instances where a three-month retroactive eligibility period may be unnecessary or inappropriate. However, we believe that this requirement should be converted to an option of the state rather than eliminated completely. We also recommend that Congress provide the option for states to establish retroactive eligibility for certain populations rather than applying it to all groups uniformly.

The State Innovation Fund

We appreciate that your legislation has included funding for states to address the health needs of their populations. However, our analysis indicates that this legislation will establish significant restrictions to services and supports for individuals with disabilities and older adults, but the innovation fund does not include any opportunities to utilize this money for LTSS or HCBS improvement initiatives. We recommend including LTSS improvements as an allowable expense under the innovation fund grants.

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.

Concluding Thoughts

As noted earlier, NASUAD is a bipartisan organization and will not be taking a stance on the efforts to repeal and replace the Affordable Care Act nor will we be endorsing any specific pieces of legislation. However, we have serious concerns about the impact the AHCA may have on state governments, on LTSS programs, and on older adults and persons with disabilities. 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. House of Representatives