NASUAD
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United for Aging and Disabilities

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Hon. Orrin Hatch
Chairman
Senate Committee on Finance



**Re: Health Reform Recommendations**

Dear 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 request you disseminated on May 12th seeking input on health reform policies. 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 appreciate the opportunity to provide feedback and suggestions on efforts to repeal and replace the Affordable Care Act (ACA). As a bipartisan organization, NASUAD is not taking a stance on overall ACA repeal efforts; however, as an association of state officials that administer a wide range of health care programs, we believe that we have valuable experience and insight to provide on ways to strengthen supports and services to older adults and people with disabilities.

Due to the responsibilities of our members, we will focus our comments and recommendations on issues that specifically relate to Medicaid and LTSS. Although we realize that the Senate is developing its own health reform package, we also recommend

that you review our previously submitted comments on the American Health Care Act.[1] Those comments provide specific feedback on discrete policies included within the AHCA that may be considered in the Senate.

We would like to stress the importance of Medicaid in the delivery of LTSS to some of the most vulnerable populations in our nation. As you know, Medicare does not provide long-term supports and private LTSS insurance is largely unavailable and unaffordable to most Americans. As a result, Medicaid is the predominant payer of these types of services, accounting for over 60% of all LTSS expenditures in 2012.[2] The role of Medicaid in the lives of individuals who require LTSS is multifaceted and irreplaceable. Without such supports, many older adults and persons with disabilities would not be able to live in the community, work, or engage in regular activities throughout their daily lives.

We recommend that the final health reform package support the following goals:

- Maintain coverage and access to Medicaid and LTSS for individuals who require these supports;
- Encourage and promote rebalancing from institutional settings to home and community based services (HCBS) while promoting community integration;
- Provide states with flexibility to deliver person-centered LTSS; and
- Refrain from shifting costs for LTSS onto state governments.

We also believe that there is substantial opportunity to improve services and supports as part of your broader examination of the health care system. As you begin to evaluate whether to restructure Medicaid policy, we believe that you can remove outdated legacy policies that result in the institutional bias of the program. NASUAD suggests that legislation you develop could modify the Medicaid LTSS structure to include the following components:

- Eliminate the institutional bias through parity in financial and clinical eligibility between HCBS and institutional services, removing the requirement that institutional services are the Medicaid entitlement, and eliminating the constraint forcing states to secure a waiver to provide HCBS;
- Establish eligibility criteria and service designs that promote early intervention and diversion strategies and that enable states to tailor benefits packages that respond different levels of assessed participant need;
- Enhance strong options counseling supports that provide clear information about and assistance with accessing available services, supports, residences, and other programs for individuals currently enrolled in Medicaid as well as those who are at risk of entering Medicaid-funded LTSS in the near future; and

[1] The comments are available at: http://www.nasuad.org/policy/federal-advocacy/advocacy-alerts/nasuad-letter-congress-regarding-american-health-care-act

[2] http://www.nhpf.org/library/the-basics/Basics_LTSS_03-27-14.pdf

- Strengthen protections and safeguards against abuse, neglect, and exploitation while simultaneously reducing the risk of fraud, waste, and abuse in the system.

Within these broad principles, we believe that there are a number of specific items that you should consider during the drafting of your legislation. Where appropriate, we make recommendations on policies that could promote and support the overall delivery of LTSS and HCBS in our country.

**Eligibility for Participants**

We believe that the Medicaid program should continue to provide a baseline eligibility for seniors and adults with disabilities as it exists today. The current system sets a minimum financial eligibility threshold for older adults and individuals with disabilities at the Supplemental Security Income (SSI) amount[3] with a number of options for expanded eligibility. Current law also enables states to establish functional and clinical criteria for LTSS in a manner that targets the populations most in need and delivers services appropriate to the eligibility standards. Given how crucial the Medicaid program is for individuals with chronic conditions, disabilities, and those who require LTSS, we believe that Congress should endeavor to protect and maintain existing eligibility standards and levels for these populations as well as retaining the option for states to expand eligibility where appropriate.

Yet, within these policies there are distinct challenges that can result in institutional bias for participants who require LTSS. For example, states can allocate certain costs towards institutional spenddown that cannot be counted towards HCBS spenddown. This inequity results in some individuals being forced into institutions instead of accessing HCBS, resulting in increased expenses to the system as well as overriding the personal preferences of many consumers. We recommend that the final legislation include a state option to create financial eligibility standards that are completely equitable between institutional and LTSS.

We also believe that states should have the option to establish differentiated level of care criteria for HCBS eligibility than for institutional. The state plan option created by section 1915(i) of the Social Security Act and the associated eligibility category at 1902(a)(10)(A)(ii)(XXII) of the Act provides this on a limited basis; however, it has distinct challenges that prevent many states from adopting and implementing such option. We recommend creating statutory authority for individuals to receive HCBS at a lower level of care than the institutional alternative while receiving the same services and supports, and providing states with the same cost containment mechanisms, as are available through waivers under section 1915(c) of the Act.

Lastly, we want to highlight a recent study in Health Affairs[4] which found that a significant number of individuals eligible under the ACA expansion have chronic health conditions and/or disabilities. Many of these individuals will not have access to affordable health insurance in the

[3] Some states use different standards than SSI under section 1902(f) of the Act, which is also known as 209(b) eligibility. For the sake of simplicity, we are using SSI as the baseline for eligibility despite this technical distinction.

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

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.

**Medicaid Financing**

As this morning's FY2018 HHS budget release notes, older adults and persons with disabilities represent 23% of program enrollment yet comprise 56% of overall Medicaid expenditures. Thus, any proposals that drastically reduce the funding available to states for their Medicaid programs runs the risk of limiting services and supports for these populations. Since most individuals are unable to secure any alternate source of LTSS expenditures, future Medicaid financing should ensure that there are adequate protections in place to ensure that individuals who require LTSS have access to such supports and services.

We noted in our comments on the AHCA that the proposed per-capita cap policy would 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[5] 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

[5] 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

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.

We therefore strongly encourage the Senate to reconsider this financing mechanism and evaluate alternative methodologies that protect the integrity of Medicaid expenditures; promote individualized and person-centered services; refrain from shifting additional costs onto states; and do not result in unintended consequences for older adults, people with disabilities, or other vulnerable populations in the program. We believe that the most effective manner to achieve this would be to increase state flexibility while continuing the current Federal matching arrangement. This enables each state to establish reasonable funding levels for their Medicaid program based upon local needs and finances.

**State Flexibility**

We strongly believe that state flexibility should be a hallmark of the Medicaid program, and that states should be given the opportunity and flexibility to develop programs that both meet the unique needs of their populations and that also allow for experimentation with unique and innovative approaches. We encourage the Senate to evaluate ways to increase flexibility within the Medicaid program, beyond what was provided in the AHCA. Specifically, we suggest providing states with more flexibility to manage their institutional benefits, such as removing it as a mandatory service, allowing the option to establish waiting-lists, and providing equity between HCBS and institutional eligibility and financing.

We also believe that this could be promoted through flexible benefits packages that enable states to provide necessary supports and services on an individualized basis. This could include a wide range of benefits that states might elect to provide in lieu of institutional supports and services. Some of this flexibility already exists within HCBS waivers; however, there are also limitations that prevent states from addressing some pressing issues with transition. Notably, this includes the limitations placed on housing supports. Additionally, benefits flexibility should allow states to provide services and supports in the most appropriate setting for individuals, such as inpatient psychiatric settings. The current prohibition on funding supports in these settings is outdated and inefficient. It also reduces available options for person-centered supports and hinders the ability of states to serve these individuals in some HCBS programs due to outdated cost-neutrality requirements.

Additionally, we believe that states should have the flexibility to provide care on both a person-centered and family-centered basis. Approximately 80% of LTSS is unpaid and delivered by family and friends; thus, Medicaid services that promote and extend the availability of these natural supports is a value-added proposition. Services that enable these informal caregivers to adequately take care of the individuals, such as training, respite, telemedicine, and other supports will prevent caregiver burnout and ultimately reduce the number of individuals who enter paid LTSS in institutional settings. Currently, Medicaid has limited ability to support these caregivers. We believe that benefits flexibility should include options that enable states to provide support to caregivers in order to delay or prevent entry into more comprehensive publicly-funded LTSS.

**Promote LTSS Rebalancing to HCBS**

As we discussed earlier, there are options to rebalance LTSS away from institutional settings and towards HCBS in a manner that reduces costs, increases state flexibility, and promotes person-centered care. We believe that health reform efforts should continue the rebalancing of LTSS. This includes recommendations noted above regarding eligibility and service flexibility. We also recommend reauthorizing and extending programs that support rebalancing, such as the Money Follows the Person program as well as the Balancing Incentives Payment Program. We also want to express our strong support for the Community First Choice (CFC) Program, established by section 1915(k) of the Social Security Act. The AHCA proposes eliminating increased funding provided by CFC, which we believe would be detrimental to the overall efforts of states to provide community-based LTSS. We recommend maintaining the program as it is currently structured in statute.

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

Martha A. Roherty
Executive Director
NASUAD

Cc:

Members of the U.S. Senate Committee on Finance