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Federal Update on Long-Term Services and Supports Policy

**National HCBS Conference
Baltimore, MD**

August 29, 2017

Autumn Campbell, Director of Public Policy & Advocacy



— Celebrating 20 Years —

Connecting You to Community Services



Aging and Disability
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Planning and Capacity Bdg.

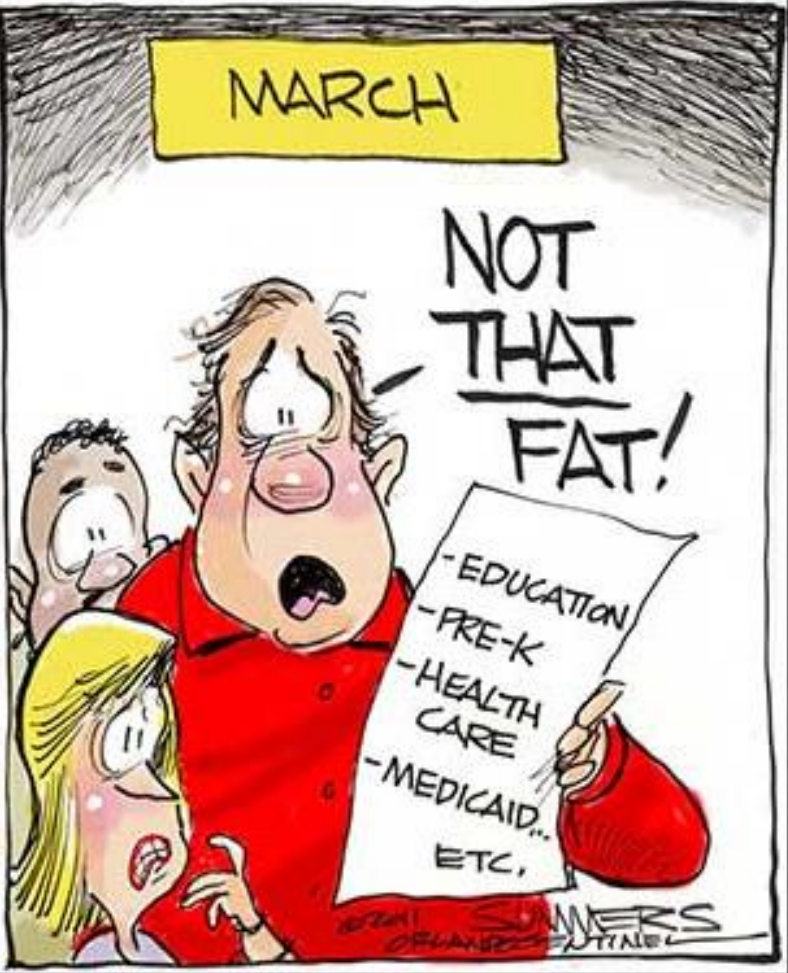


Aging and Disability Partnership

for Managed Long-Term Services and Supports

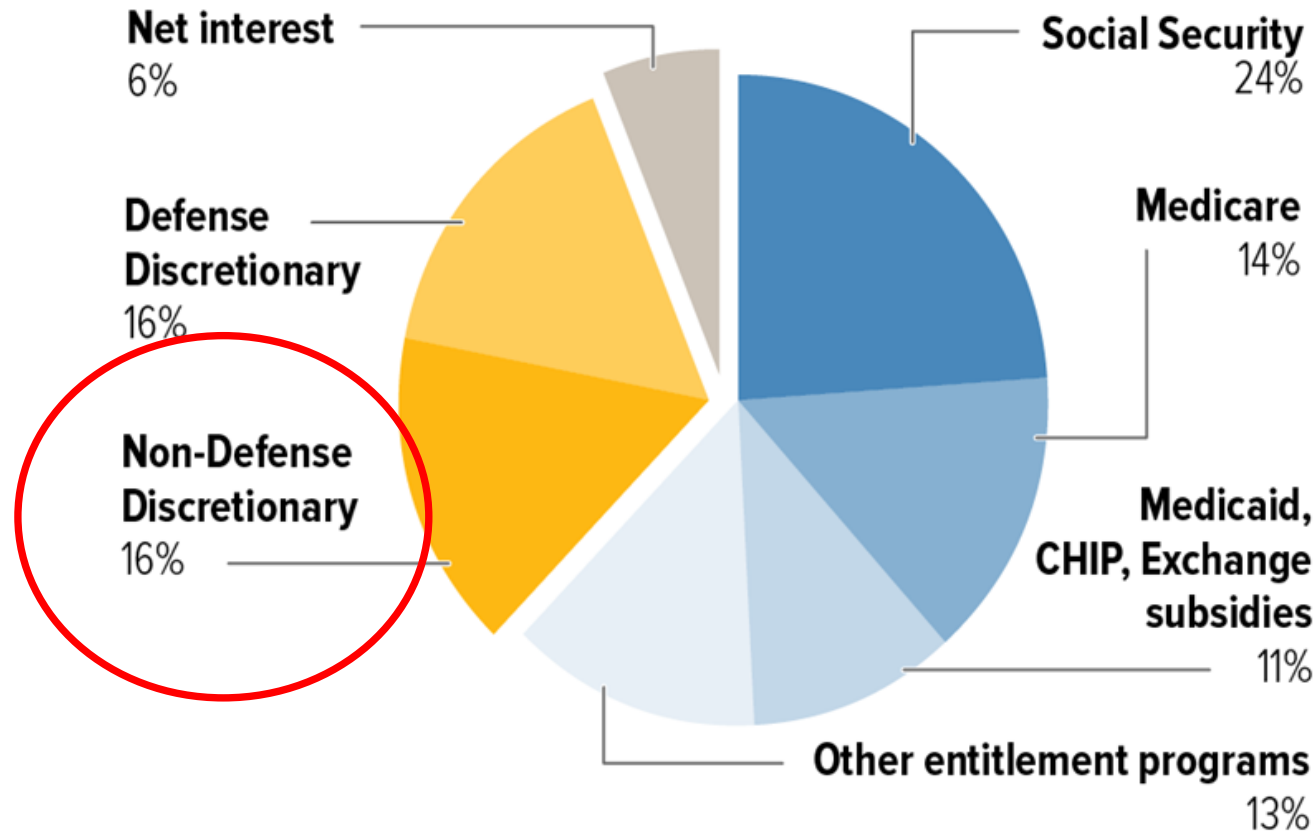
The Federal Budget and Appropriations Update

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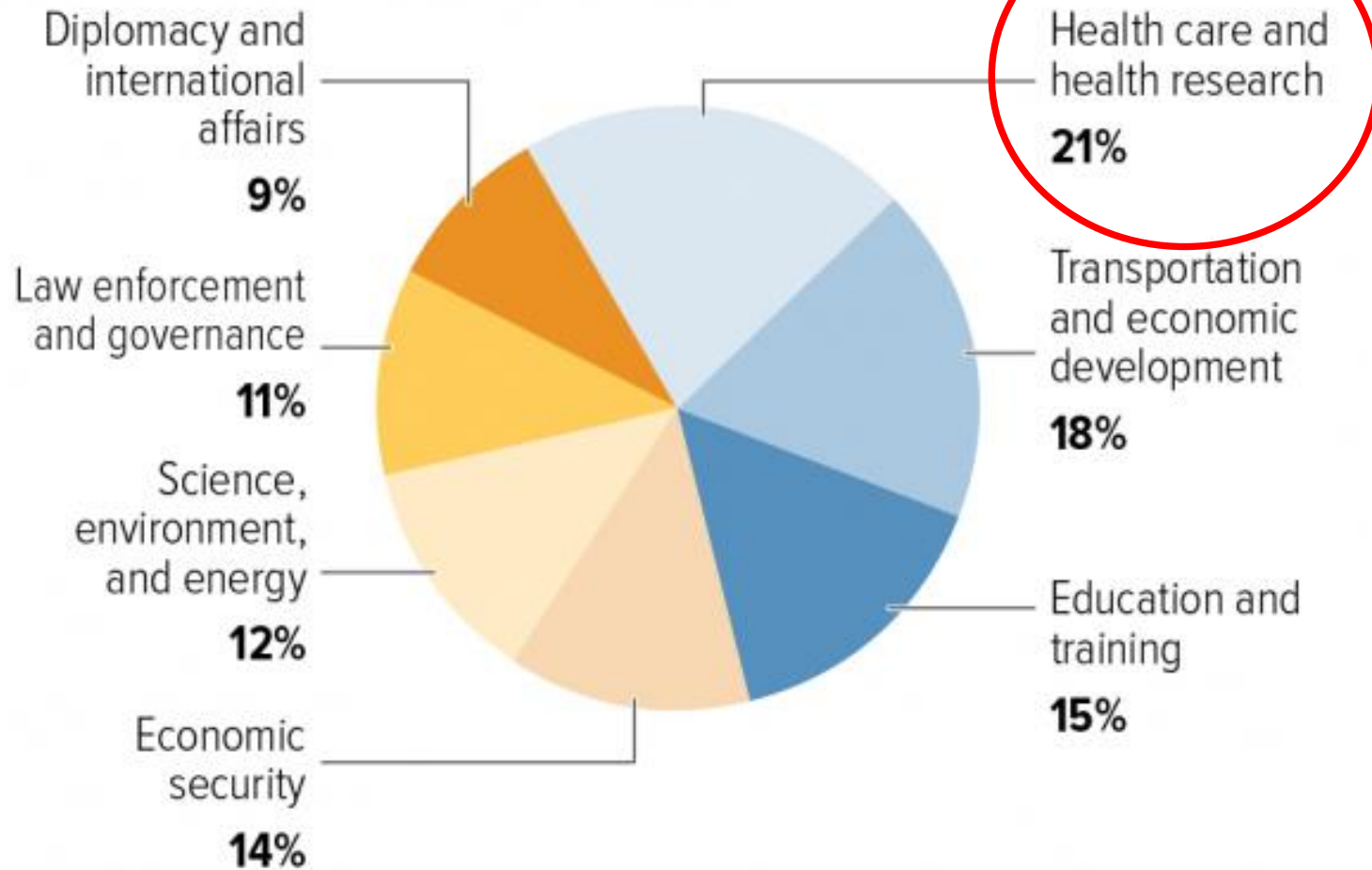
Dana Summers-Tribune Media Services dicate

Most of the Federal Budget Goes Toward Defense, Social Security, and Major Health Programs



Source: Congressional Budget Office

Non-Defense Discretionary Spending, FY 2015



Source: CBPP calculations using Office of Management and Budget data

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Federal Budget Snapshot

In FY 2016...

- Total Federal Spending = **\$3.9 Trillion**
- Total Non-Defense Discretionary Spending = **\$600 Billion (~15.4 percent)**
- Total Budget for ACL = **~\$2.0 Billion**
- Total ACL Spending as percentage of Federal Budget = **.049 percent**

The Federal Budget Process

- Early Feb: President Releases Budget Request to Congress
- House and Senate Budget Committees draft Budget Resolutions
 - No force of law
 - Sets big-picture spending targets
 - Can also include larger budget goals, including changes to mandatory programs, revenues, etc.
 - Due by April 15
 - Bicameral budget resolution is often is not achieved

NDD Programs are Funded through the Appropriations Process

- With budget resolution target numbers in hand, Appropriations Committees set 302(a) and 302(b) allocations (subcategories of budget)
- 12 Appropriations Subcommittees
- Hold hearings in February/March
- Bills generally begin to move in the Spring, continue into Summer
- Deadline is September 30; rarely achieved

Consequences of Austerity

A Look Back:

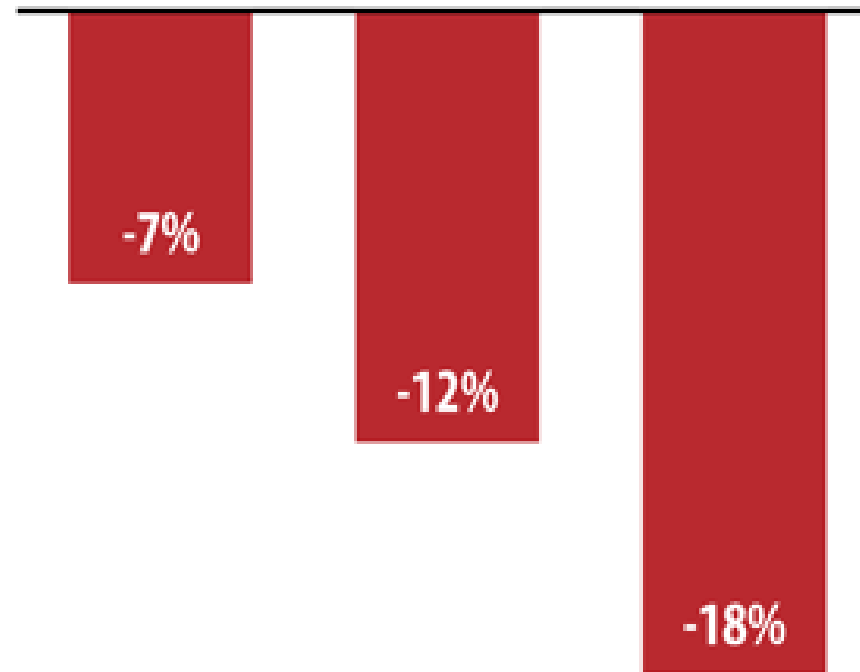
Budget Battles, 2011-2016

- Recession, changes in politics drove louder conversation about federal debt (and deficit)
- July 2011: Budget Control Act = caps, threat of sequestration, Super Committee, debt ceiling relief
- March 2013: Sequestration
- October 2013: Shutdown
- Series of two-year budget deals (FY14-15/FY16-17), partially offset sequester/caps
- Result? More than \$4 trillion in deficit reduction

Three Waves of Cuts in Non-Defense Discretionary Programs Since 2010

Percent cut in non-defense discretionary programs relative to 2010 appropriations, adjusted for inflation

FY11 appropriations (adjusted for inflation) *BCA level for FY14 pre-sequestration *BCA level for FY14 post-sequestration



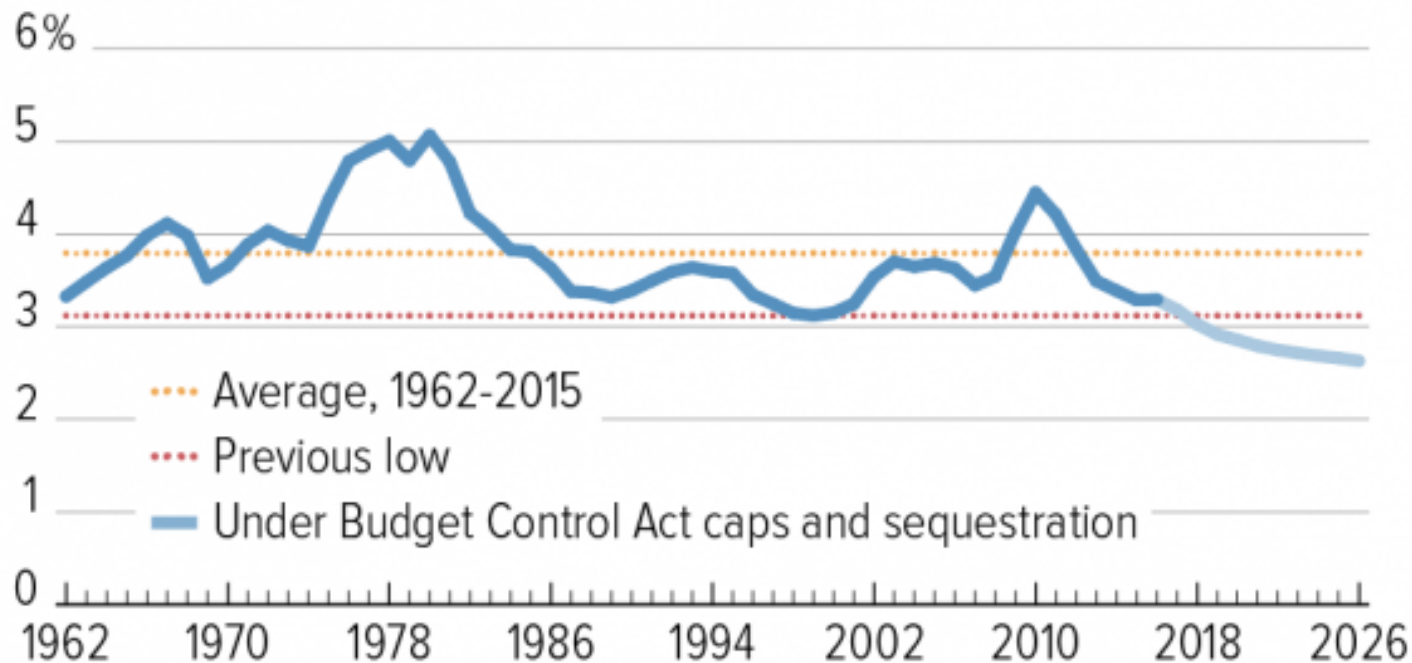
*Budget Control Act of 2011.

Source: CBPP calculations based on Congressional Budget Office data

[Center on Budget and Policy Priorities | cbpp.org](http://cbpp.org)

Non-Defense Discretionary Spending Falling to Historic Lows

Spending as a percent of gross domestic product



Note: Data available only back to 1962. Sequestration refers to budget cuts required under the 2011 Budget Control Act and includes modifications to it in the Bipartisan Budget Acts of 2013 and 2015.

Source: CBPP based on Office of Management and Budget and Congressional Budget Office data.

Bipartisan Agreement for FY 2017

Highlights

- Adhered to budget caps in law
- Rejected major cuts to NDD programs President requested
- Some policy concessions on each side
- **Older Americans Act Programs**
 - Mostly “flat-funded”
 - Modest increases for Title III Supportive Services and Nutrition Programs
 - Modest increase for Elder Justice Initiative
 - Concerning cuts to:
 - Health Insurance Counseling Program (SHIP)
 - Senior Workforce Development Programs (SCSEP)

FY 2018 Budget...

Where Are We Now?

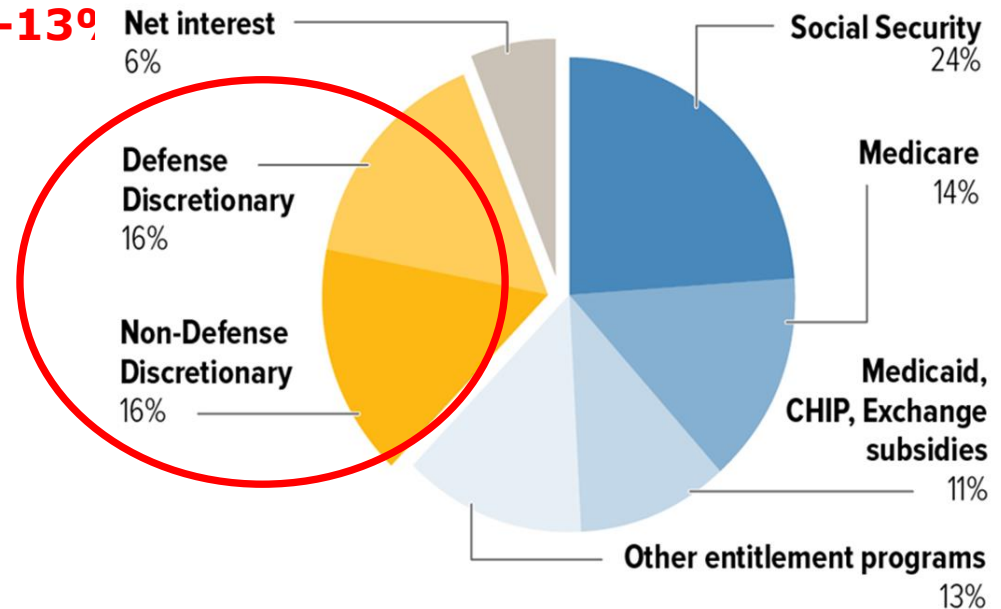
- Trump Administration released two rounds of FY 2018 budget requests
- House and Senate budget resolutions delayed
- Facing the end of a two-year bipartisan budget agreement
- Congressional Appropriators working on spending bills

What's in the FY 2018 Trump Budget?

- Deep cuts to Non-Defense Discretionary (domestic) programs
- Deep cuts/reforms to Mandatory Programs targeted at low-income beneficiaries
- Tax breaks targeted toward high-income earners/corporations
- Ambitious assumptions about economic growth necessary to balance budget in 10 years

Trump Budget: Discretionary Programs

- State Department -33%
- Environmental Protection Agency- 31%
- Agriculture Department -21%
- **Labor Department -21%**
- **Dept. Health and Human Services -18%**
- Commerce Department -16%
- Education Department -14%
- **Dept. Housing and Urban Development -13%**
- **Department of Transportation -13%**
- Interior Department -12%
- Energy Department -6%
- **Winners:**
 - Vets Affairs +6%
 - Homeland Security +7%
 - Defense Department +9%



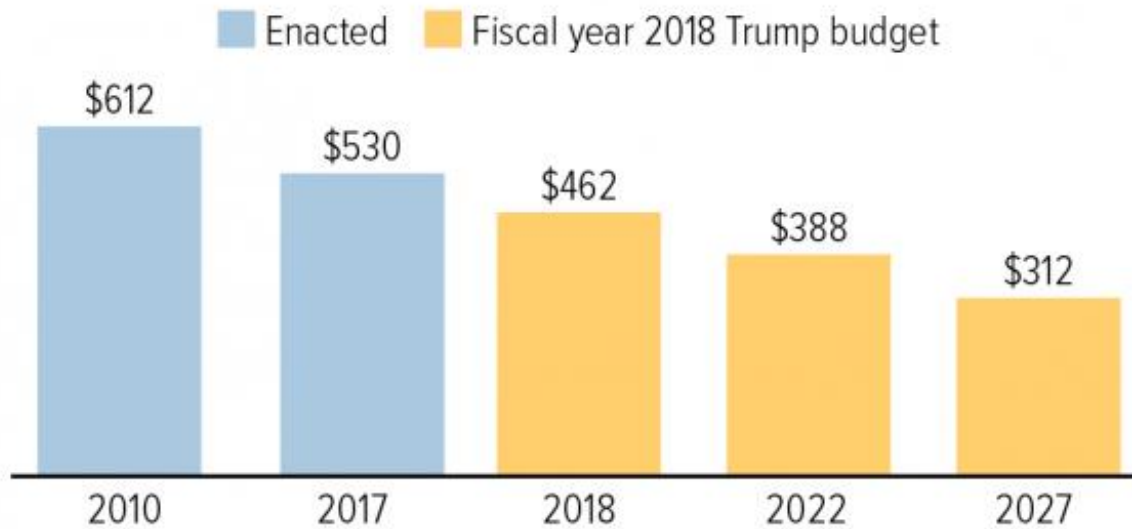
Source: Congressional Budget Office

Trump Budget Hurts Low-Income Older Adults

- “Flat” funds most core OAA programs
- Cuts/eliminates critical domestic programs serving older adults
 - SCSEP, SHIP, SSBG, CDBG, CSBG, LIHEAP, Housing, Transportation
- Guts Medicaid (states will limit HCBS)
- Repeals ACA (higher premiums, double uninsured rate among pre-Medicare population)
- Nutrition assistance eliminated for 1 million seniors
- Cuts SSDI for 6 million people over 55

Non-Defense Appropriations in 2027 Would Fall to Half Their 2010 Level Under Trump

In billions of 2018 dollars



Note: All amounts exclude funding for disasters, emergencies, program integrity, and Overseas Contingency Operations (OCO).

Source: CBPP analysis of data from Congressional Budget Office and Office of Management and Budget

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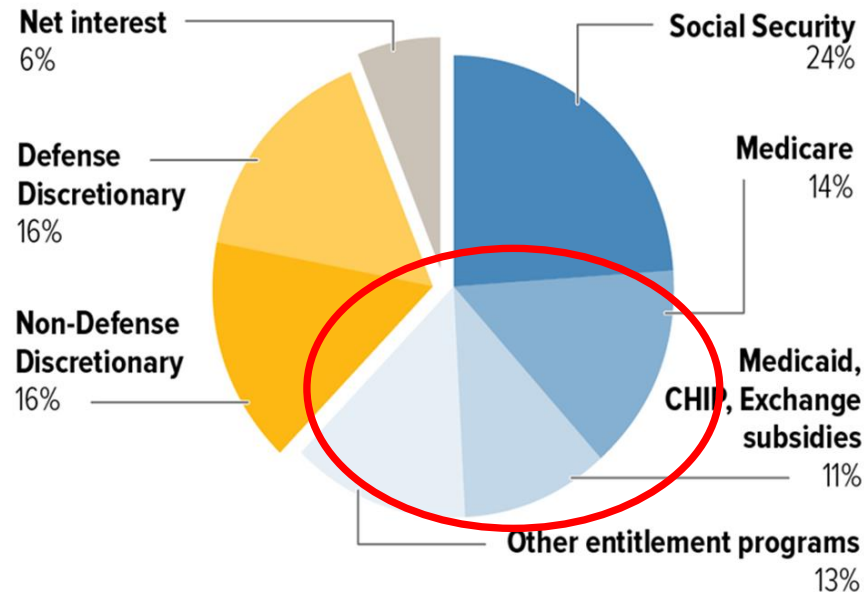
Under **current law**, FY 2018 NDD funding is scheduled to fall **16 percent** below 2010 levels, adjusted for inflation.

This budget proposal would deepen that cut to **25 percent** in FY 2018 and **by half** in 2027.

Trump Budget: Mandatory Programs

(cuts over 10 years)

- **Medicaid -\$610 billion (25%)**
- SNAP (food stamps)-\$193 billion (>25%)
- SSDI/SSI (disability) -\$72 billion
- TANF (welfare) -\$22 billion (13%)



Source: Congressional Budget Office

Trump Budget DOA?

Not Necessarily...

	Trump Budget	Past Ryan and House GOP Budget
Repeals Affordable Care Act, adding tens of millions to the ranks of the uninsured	✓	✓
Targets Medicaid for deep cuts beyond the severe cuts in ACA repeal	✓	✓
Targets SNAP and other low-income assistance for deep cuts	✓	✓
Slashes non-defense discretionary funding (economic development, job training, medical research, etc.)	✓	✓
Cuts taxes for the richest	✓	✓
Uses gimmicks to hide true cost of tax cuts and claim balanced budget	✓	✓

FY 2018 Spending Up to Congress...



Status of Funding Bills

- Delayed by months
- House ahead of Senate, also imposing stringent caps on domestic funding
- House Labor-HHS bill:
 - Topline is \$5 billion lower than FY 2017
 - Rejects many cuts proposed by Administration
 - Flat-funds most OAA and ACL programs
 - Eliminates SHIP
 - Cuts SCSEP, Elder Justice
- **Advocacy Opportunity is in the Senate!**
- Where will this all end up??

Where Will FY 2018 Funding End Up?





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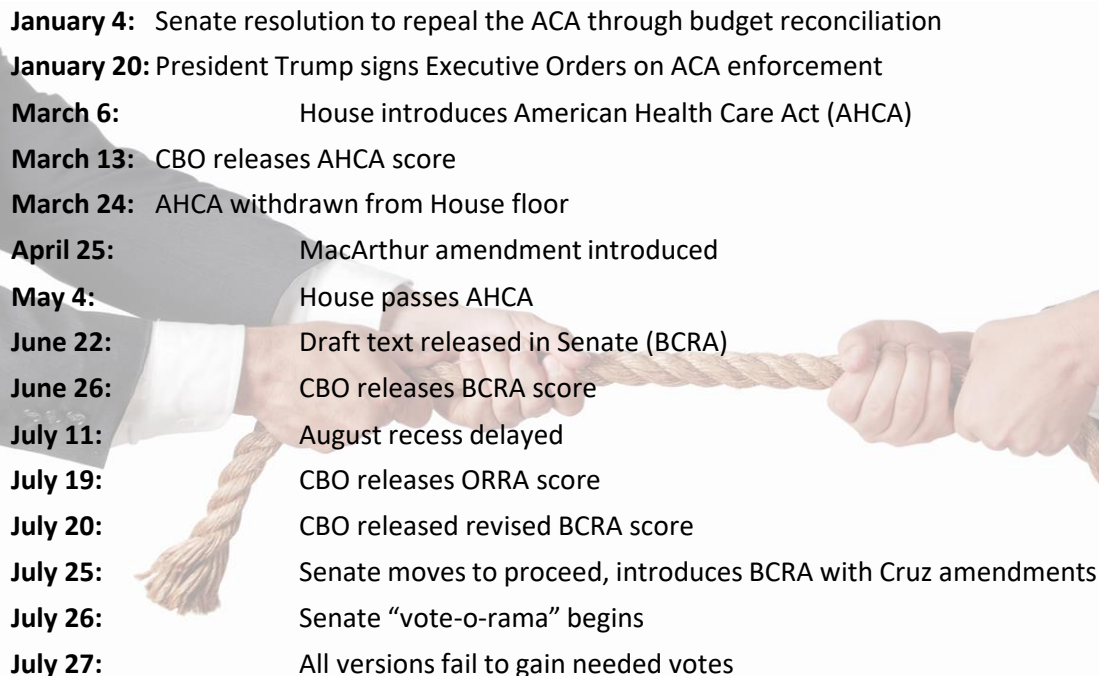
Federal Policy & Regulatory Update

HCBS Conference
August 29, 2017

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ACA Repeal & Replace

A Timeline (2017)

- 
- January 4:** Senate resolution to repeal the ACA through budget reconciliation
 - January 20:** President Trump signs Executive Orders on ACA enforcement
 - March 6:** House introduces American Health Care Act (AHCA)
 - March 13:** CBO releases AHCA score
 - March 24:** AHCA withdrawn from House floor
 - April 25:** MacArthur amendment introduced
 - May 4:** House passes AHCA
 - June 22:** Draft text released in Senate (BCRA)
 - June 26:** CBO releases BCRA score
 - July 11:** August recess delayed
 - July 19:** CBO releases ORRA score
 - July 20:** CBO released revised BCRA score
 - July 25:** Senate moves to proceed, introduces BCRA with Cruz amendments
 - July 26:** Senate “vote-o-rama” begins
 - July 27:** All versions fail to gain needed votes

ACA Repeal & Replace

American Health Care Act (AHCA)	Better Care Reconciliation Act (BCRA)	Obamacare Repeal Reconciliation Act (ORRA)	Health Care Freedom Act (HCFA) (aka "skinny repeal")
<ul style="list-style-type: none"> • Deep Medicaid cuts (\$834B) • Per capita caps • Fixed growth rate stays at CPI-M+1 • Eliminates Medicaid expansion • Removes EHB protections • Eliminates CFCO • 23 million people lose coverage <p>Status – passed the House 5/4/17</p>	<ul style="list-style-type: none"> • Deep Medicaid cuts (\$756B) • Per capita caps • Growth rate starts at CPI-M+1, then drops to CPI-U • Eliminates Medicaid expansion • Removes EHB protections • Replaces CFCO with 4 year waiver for certain states • 22 million people lose coverage <p>Status : Failed (43-57)</p>	<ul style="list-style-type: none"> • No per capita caps • Repeals ACA • Eliminates Medicaid expansion • Removes EHB protections • Eliminates CFCO • 32 million people would lose coverage <p>Status: Failed (45-55)</p>	<ul style="list-style-type: none"> • Repeal individual & employer mandates, tax on medical device companies • Allows states to opt out of some ACA regulations., so long as people are covered at same levels • 16 million people would lose coverage <p>Status: Failed (49-51)</p>

ACA Repeal & Replace

What's at stake?

- Permanent change to the structure of Medicaid funding
 - Locked in base rate based on prior spending levels reduces state flexibility and creates unfair disparities between states
 - Growth rate that will fall short of actual costs
 - No guarantee that money brought in under disability rate will be required to be spent on disability services
- HCBS waivers and state plans, along with many other services that people with disabilities depend on, are optional services within Medicaid; states may be forced to cut them first
- As states make hard choices about what to cut and where to find efficiencies, pressure will be on providers to do more with less
- All other federal, state, and local laws and rules still must be complied with – with less funding to do so (OIG, *Olmstead*, HCBS, FLSA), setting up conflicts between what is required, what is desired, and what is possible

ACA Repeal & Replace

What's next?

McConnell: Still exploring costs of legislative reforms, including those proposed by Portman, Graham, Cassidy, and Cruz

HELP Committee: Plans to hold bipartisan hearings in September focusing on stabilizing individual market

Cost-Sharing Subsidies: President Trump has said he may discontinue the payments

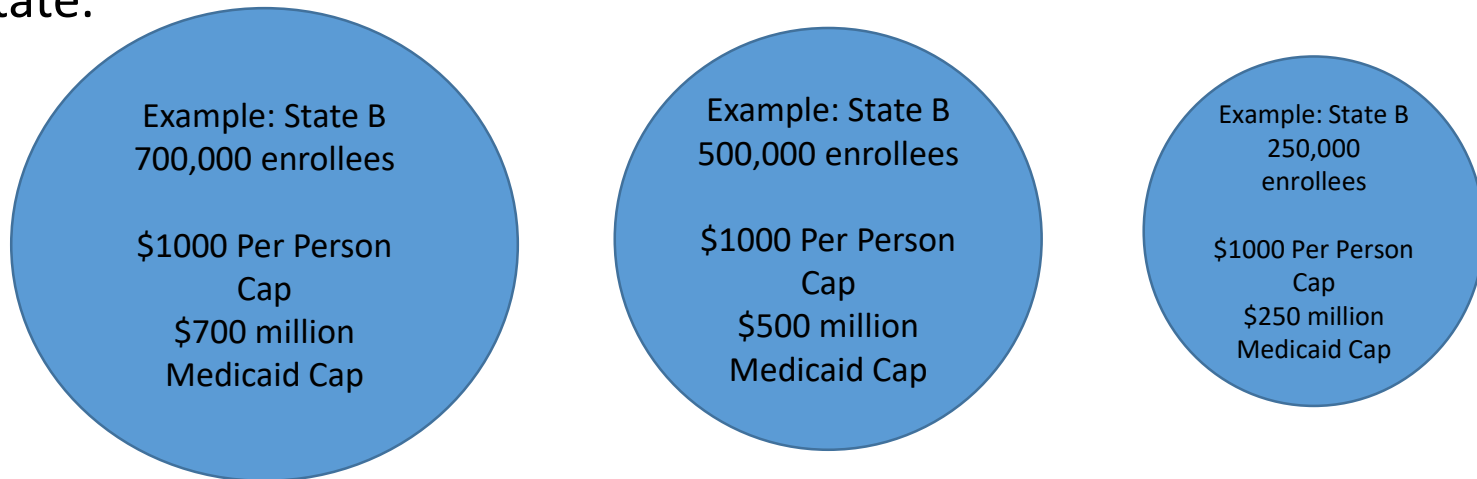
Problem Solvers Caucus: About 40 centrist House members formed a bipartisan working group and recommended changes to the ACA (*e.g.* changing definition of “large employer”, 40 hour workweek, continuing cost-sharing subsidies)

Medicaid: Expect that Medicaid will continue to be on the table as a pay-for for parts of the Republican agenda: future attempts at health care reform, tax reform, the wall, infrastructure

Per Capita Cap

Per Capita Cap

A per capita cap is a per-enrollee limit on Medicaid expenditures by state.



Size of the pie grows or shrinks with enrollment – but per person caps generally remain static

NASDDDS

National Association of State Directors of Developmental
Disabilities Services

What is a Per Capita Cap?

- Under a Medicaid per capita cap, the federal government would set a limit on how much to reimburse states per enrollee.
- The amount of the per capita cap discussed often varies by enrollee group. For example, a higher cap might be set for the elderly and a lower cap for children.



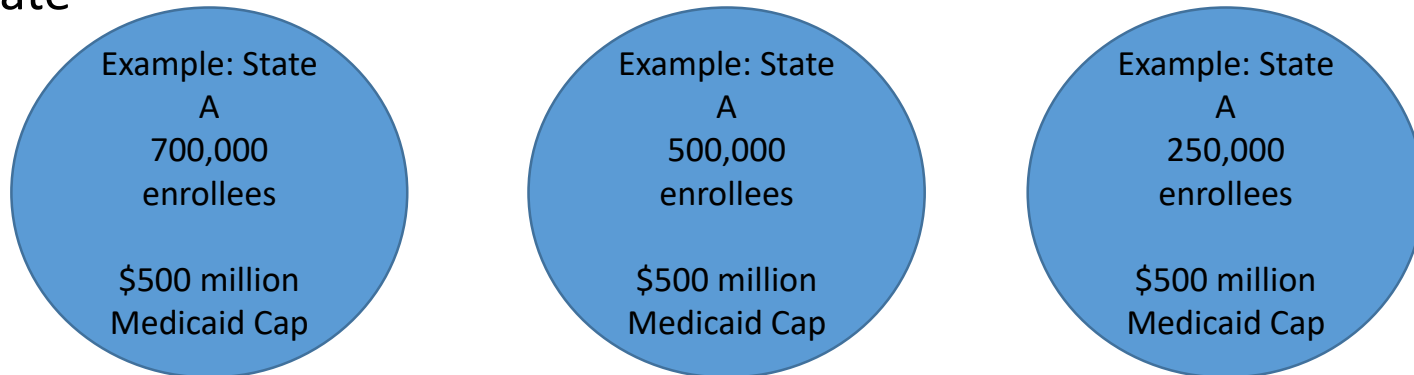
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Medicaid Block Grants

Block Grant

An overall limit on federal Medicaid spending and an overall cap by state



Size of the pie will typically stay the same (with inflationary increases TBD)

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Block Grants

- Block grants would set a national cap on federal Medicaid funding and an aggregate cap for each state
- Block-grant proposals vary on how the fixed amount would be determined, but typically a national Medicaid spending amount would be set each year, and a formula would be used to determine each state's share of that allotment
- Current block grant discussions have not landed on specific formulas and have focused on individual state spending levels in the most recent year (s), with adjustments possible



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Block Grant vs. a Per Capita Cap

The key difference between a block grant and a per capita cap is that federal funding provided through a block grant would generally not change in response to program enrollment, whereas federal funding provided through a per capita cap would increase or decrease in accordance with changes in Medicaid enrollment levels (the number of people enrolled in the program in the state)

Important to keep in mind:

As the purpose of proposed reforms include cost containment and/or bending the cost curve – Many analysts indicate full savings will only be achieved if the caps (per beneficiary costs) or fixed amounts (block grant overall costs) are set below projected costs. Will state flexibilities be enough? What should we watch for and questions should be asked?



Key Considerations: Per Capita Caps

- How will the base and future year per-capita-caps be established?
- Will caps vary by eligibility groups or more discrete populations (e.g., persons with I/DD and individuals over age 65, 75, 80)?
- What data would be used to set the levels?
- What are requirements for coverage (eligibility groups and services)?

Key Considerations: Per Capita Caps, Continued

- What are the potential intended or unintended consequences?
- What is the strategy/triggers for rebasing, if any?
- What policies/practices will enable movement between per capita caps (PCC) “rate” cells?
- Will there be any catastrophic coverage considerations (i.e., natural disasters, economic downturns, pandemics, etc.)?

Key
Considerations

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What happens to Medicaid Rules in a Block Grant or Per Capita Allotment?



- Medicaid currently has a significant array of both operational and payment rules that govern operations (e.g., Sections 1902 and 1903)

https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

https://www.ssa.gov/OP_Home/ssact/title19/1903.htm

- In addition, Medicaid has minimum requirements for who and what states must cover (e.g. Section 1905(a)). b States have to cover certain “mandatory” eligibility groups and benefits

https://www.ssa.gov/OP_Home/ssact/title19/1905.htm#act-1905-a

https://www.ssa.gov/OP_Home/ssact/title19/1905.htm#act-1905-b

- States have the option of covering additional populations, such as children with incomes above the minimum levels, and also can cover optional benefits

Within a block grant or per capita cap proposal, states would be afforded flexibility around some or all of these requirements. The extent and impact of any modifications to Medicaid rules will have to be carefully considered.

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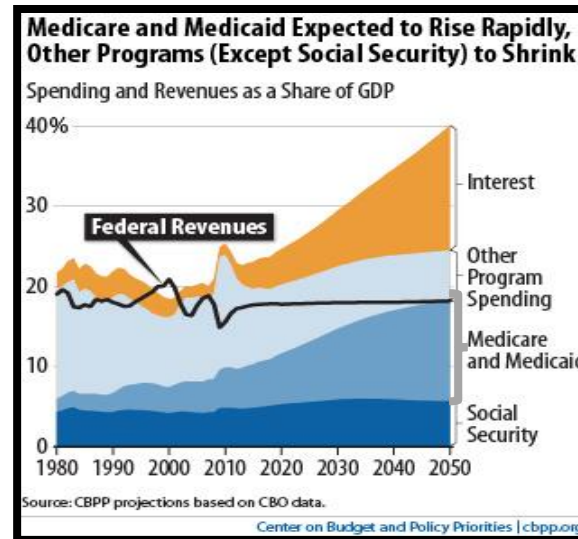
National Association of State Directors of Developmental
Disabilities Services

ACA Repeal & Replace

What's next?

- Prospects for large-scale AHCA/BCRA- like Medicaid reform?
- Medicare for all
- Medicaid for all
 - Medicaid serves as ACA “Public option,” which could stabilize markets and lower premiums
 - State level reforms
- Other reforms
 - Money Follows the Person
 - Standardized buy-in
 - Single HCBS authority

Competition for Funds in the Future

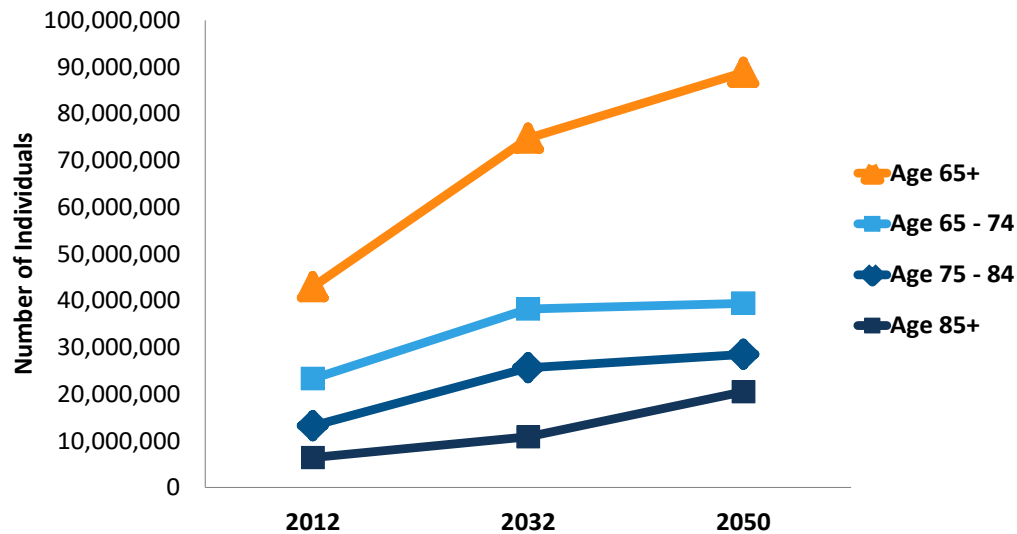


← **Social Services Funding**

Demographics: Demand

Figure 1

The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050



SOURCE: A. Houser, W. Fox-Grage, and K. Ujvari. *Across the States 2013: Profiles of Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, September 2012), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf.



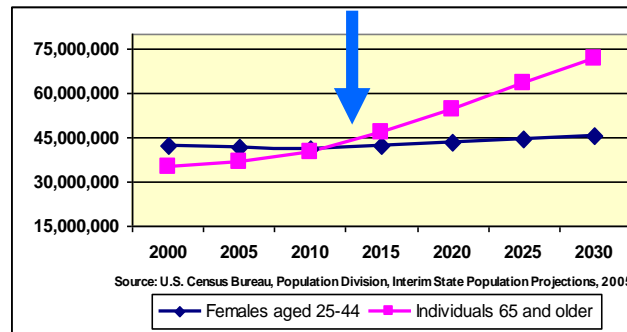
70% of Americans who reach age 65 will need some form of long-term care for an average of three years.



A labor shortage is worsening in one of the nation's fastest-growing occupations — taking care of the elderly and disabled—just as baby boomers head into old age.

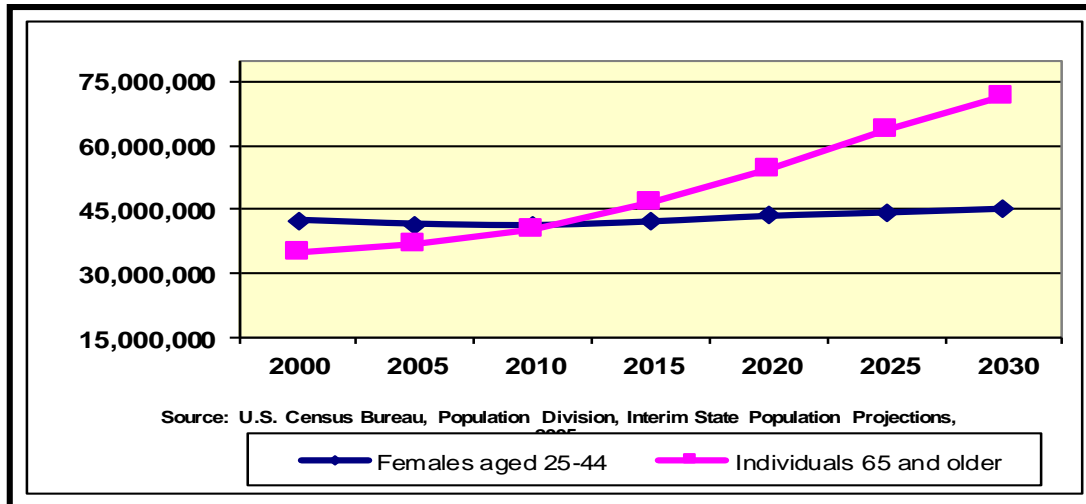
Wall Street Journal
April 15, 2013

Shortage of Caregivers



Larson, Edelstein

Workforce will not keep pace with demand



Efforts to Build a Sustainable Future

- Supporting Families AND
- Developing Innovative Supports – Relationship based
- Expecting Employment outcomes
- Building on Technology
- Focusing on Person Centered Planning –
- Investing in Peer Networks

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So...Repeal Legislation has Stalled (for now)...What Next?

- Congressional fixes for ACA, if they happen, likely to be narrower in scope rather than transformative
 - Never completely rule out a resurrection of repeal
- Absent further legislation to repeal the ACA, policymaking will largely shift to the states
- The Administration's focus is on state flexibility, thus allowing for experimentation with policy, financing, and coverage
 - ACA APTCs/exchanges (see: Alaska and Iowa proposals)
 - State 1115 Medicaid proposals

Current Issues in 1115s

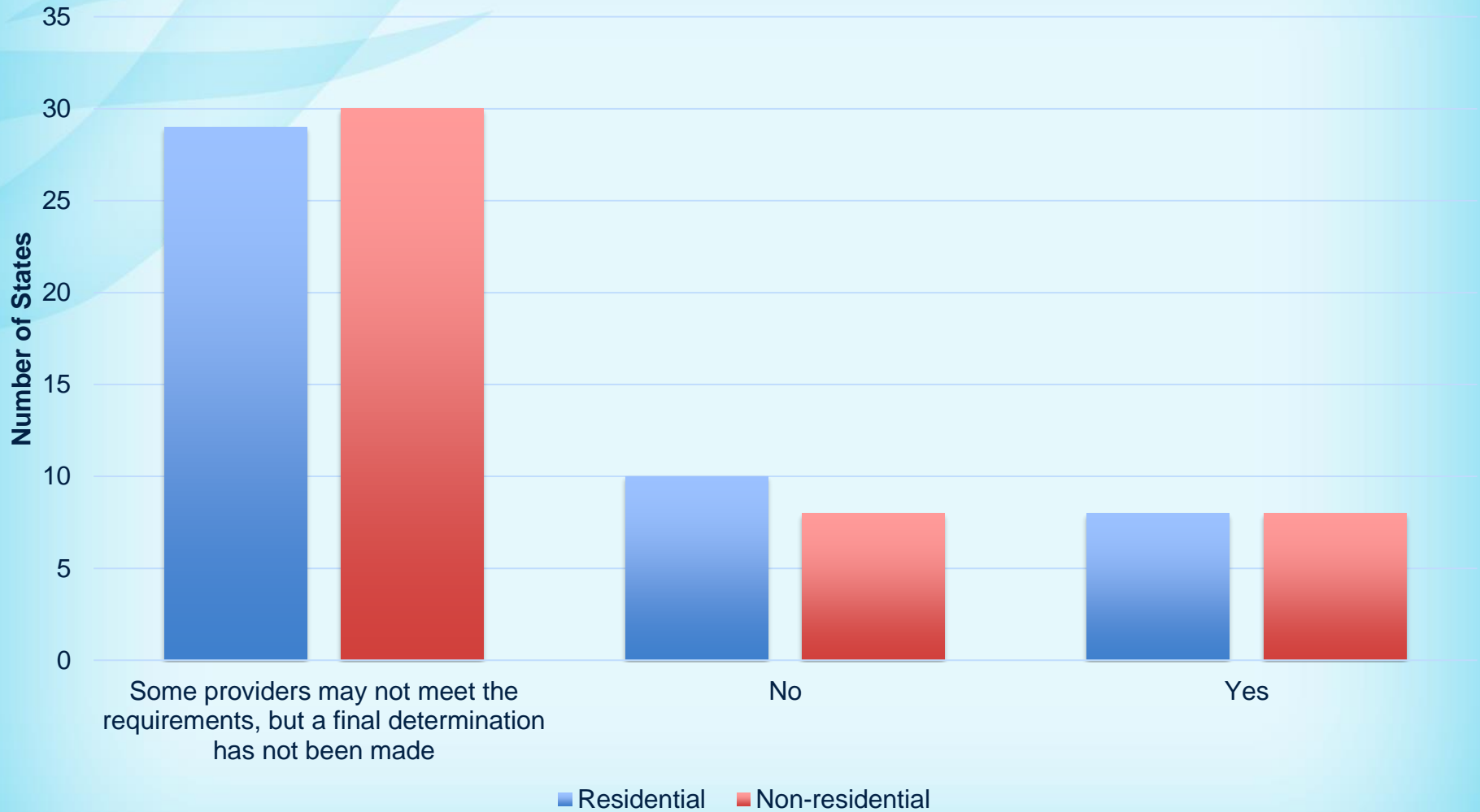
- What is the role of the Medicaid program?
- Where does Medicaid overlap with private insurance? Where does it have different objectives, goals, and desired outcomes?
- Key policy debates & 1115 proposals testing these philosophical propositions:
 - Work requirements & time-limits on enrollment for adults without disabilities
 - Retroactive eligibility waivers
 - Non-emergency Medical Transportation
 - Exchange-based Medicaid delivery
 - Expansion to “Pre-LTSS” populations
 - Caregiver Support
- Important states to watch:
 - Indiana
 - Wisconsin
 - Arizona
 - Arkansas
 - Kentucky
 - Washington
 - Others!

CMS HCBS Regulations and Policy Updates

HCBS Settings Final Rule

- The Medicaid home and community-based services (HCBS) regulation establishes new criteria and requirements for Medicaid-funded HCBS, with an emphasis on ensuring that services are provided in an integrated and community-based setting
- CMS' compliance activities are a process-based approach using transition plans to outline objectives and milestones towards meeting the rule requirements by the 2022 deadline
- States have, for the most part, not made any final determinations regarding the settings that are allowable and those which violate the integration mandate

Has your State Identified Settings which Violate the HCBS Settings Requirements?



Medicaid HCBS Transition Plans

- CMS continues to work with states regarding their HCBS Transition plans;
- Currently, there are four statewide plans with final approval (AR, KY, OK, TN) and 28 with initial approval;
- CMS is focusing on “systemic” and “site-specific” review of settings:
 - Systemic: review of state laws, regulations, licensure requirements, etc., for HCBS settings;
 - Site-specific: process for examining whether the qualities of individual settings comport with the rules.

Current Status and Issues

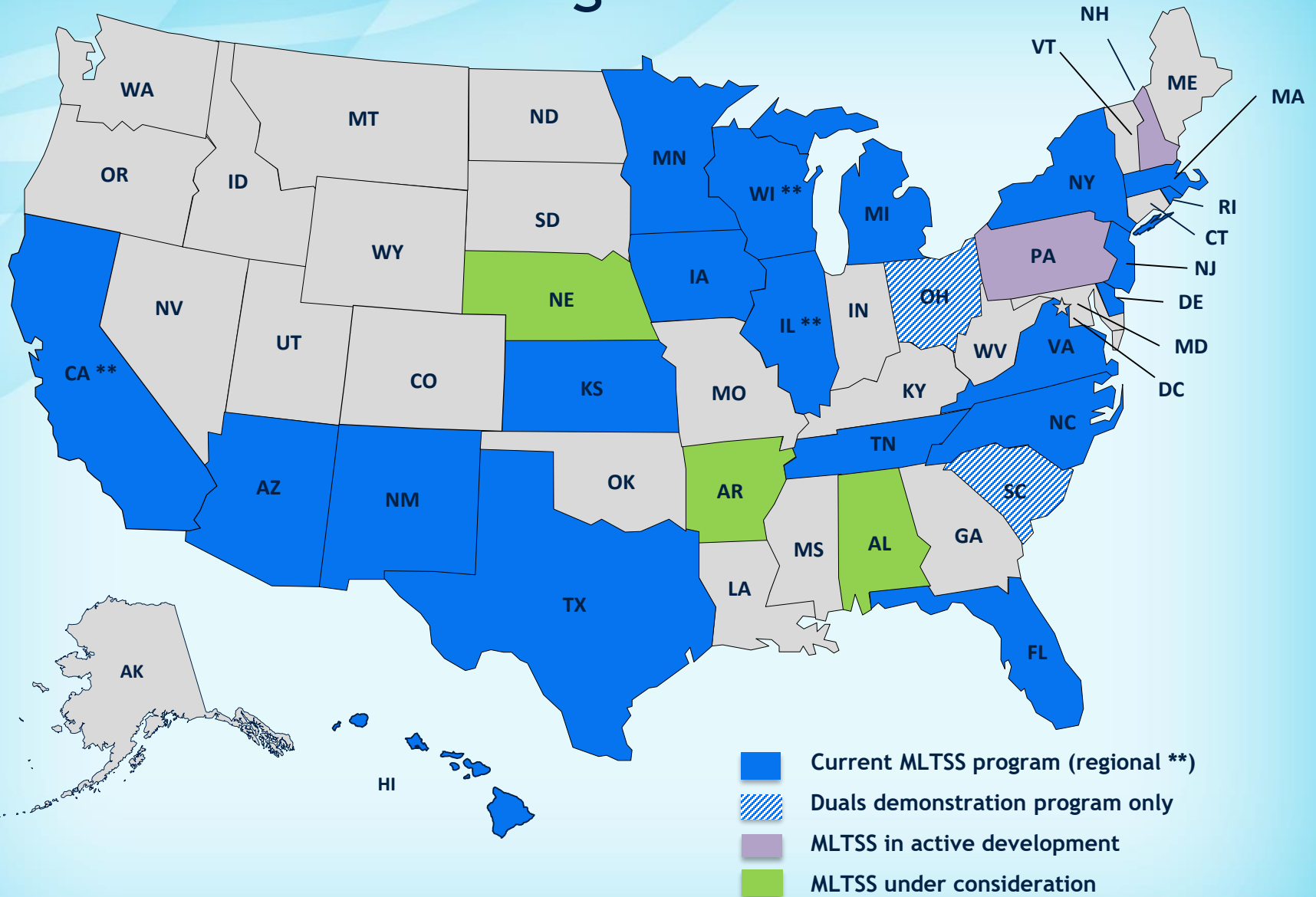
- Timelines – CMS announced a delay in implementation (until March 2022 instead of 2019) given the lengthy process for transition plan approval;
- Heightened Scrutiny:
 - What process will states use to identify settings subject to heightened scrutiny, determine whether they are compliant with the rules, and submit evidence of the determination to CMS?
- Day services – what is compliant for individuals not seeking employment?
- Assisted living, memory care, and other congregate services for older adults – what is allowable?

Other Important HCBS Issues

- OIG investigations in a number of states, especially the northeast, regarding health & welfare as well as critical incident monitoring
 - Connecticut:
<https://oig.hhs.gov/oas/reports/region1/11400002.pdf>
 - Massachusetts:
<https://oig.hhs.gov/oas/reports/region1/11400008.pdf>
- CMS convening workgroups to deal with HCBS issues:
 - Health and Welfare/Quality Assurance
 - 1915(c) Waiver Processing

Medicaid MLTSS

MLTSS Programs - 2017



Source: NASUAD survey; CMS data

Federal Regulations and Requirements

- MLTSS-specific provisions are based on May 2013 published guidance for States implementing Medicaid-only MLTSS and are woven throughout rule in sections dealing with care coordination, stakeholder engagement, and beneficiary supports
- The regulations address these elements:

1. Adequate planning and transition strategies	6. Support for beneficiaries
2. Stakeholder engagement	7. Person-centered processes
3. Enhanced provision of HCBS	8. Qualified providers
4. Alignment of payment structures with MLTSS programmatic goals	9. Participant protections
5. Comprehensive and integrated service package	10. Quality

- States must also develop network adequacy requirements for LTSS

DOL Regulations

- White Collar Exemption and Home Care Rule

White Collar Exemption

- In 2016 DOL released a final rule that would increase the threshold for overtime exemptions to executive, administrative, and professional workers;
- Currently, the threshold is \$455/week (\$23,660/year);
- The final rule sets at 40th percentile of the lowest wage census block (\$47,476/year) and updates every 3 years;
- An estimated 4.2 million individuals will be impacted by the changes;
- Many HCBS provider agencies may be affected by this rule;
- Rule was blocked by a Federal Judge:
 - Federal government provided a response affirming its ability to set a threshold, but indicating that the threshold would be changed
- On July 26, DOL issued a RFI seeking feedback on potential changes to the rule
<https://www.dol.gov/whd/overtime/rfi2016.htm>

Home Care Rule

- DOL released regulations that changed the definition of “companionship” and limited the ability of third-party employers to claim exemption from FLSA;
- Regulations were scheduled to become effective January 1, 2015; however, a Federal Judge placed the major portions of the rule under injunction;
- DOL won appeal of the decision and Supreme Court declined to hear the case;
- Regulations became effective in October 2015 and DOL “discretionary enforcement” ended Dec 31st;
- Administration likely opposed; however, any changes would require a new rulemaking process and could be challenging.

Ombudsman Rule

Long-Term Care Ombudsman Final Rule

- Since its inception in the 1970s, the LTCOPs functions have been outlined in the OAA.
- The LTCO regulation is the first specific regulation focused on the program and aimed to create greater alignment and consistency between state programs.
- The rule also provided clarification and delineation around the functions and responsibility of the LTCO, conflict of interest provisions, exemption from mandatory reporting requirements, among others.
- Rule became effective in 2016; States still working to ensure compliance

LTCO Rule Implementation

- States noted challenges with:
 - Having responsibility for certain LTCO staff but lacking any formal control measures;
 - Provisions related to access to legal counsel for the LTCO program;
 - Ensuring proper firewalls between the ombudsman program and Adult Protective Services (APS); and
 - Updating state laws to reflect LTCO being exempt from mandatory reporting policies.



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www.nasuad.org

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