NAMD
National Association of Medicaid Directors

September 26, 2022

Representative Cathy McMorris Rodgers
House Energy & Commerce Committee
1035 Longworth House Office Building
Washington, DC 20515

Dear Representative McMorris Rodgers,

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is writing in response to the House Energy & Commerce Committee Republicans' request for information: Disability Policies in the 21st Century: Building Opportunities for Work and Inclusion. We appreciate the opportunity to provide comments on federal approaches to drive improvements in care

As the single largest payer for long-term services and supports (LTSS), Medicaid plays an essential role in ensuring that people with disabilities have access to care. States and the federal government have prioritized rebalancing Medicaid's LTSS benefits towards community-based care, which is more cost-effective and generally preferred by members. There is more work to be done, however, to improve our systems of care for older adults and people with disabilities.

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Sincerely,

Allison Taylor

Cynthia Beane, MSW, LSCSW

Allison Taylor
NAMD Board President
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Core Principles

To achieve the ongoing goal of rebalancing LTSS delivery towards home- and community-based services (HCBS), the following principles should be at the forefront of any Congressional action:

- **Moving Towards a Comprehensive Approach to LTSS:** Medicaid is the largest payer of LTSS in the country, but eligibility is tied to income and the individual's level of care needs. Although Medicare provides health coverage for older adults, it plays a relatively limited role in funding LTSS. Congress should consider how the federal government can expand access to LTSS, with the aim of ensuring that access to LTSS is not primarily dependent on meeting Medicaid income eligibility criteria. A range of options could be considered in this area, such as:
    - Federally funded education and options counseling for individuals in need of LTSS so they fully understand available care programs, and requiring such expertise to be embedded within hospital inpatient discharge planning processes.
    - Creating a full-cost buy-in option for Medicaid HCBS for those who do not otherwise meet financial eligibility criteria.
    - Incorporating more robust LTSS benefits into Medicare, which could alleviate ongoing state financial and operational challenges for serving dually eligible Medicare-Medicaid members. This should include covering certain "unskilled" or custodial care to support members staying in the community. Medicare should also provide better counseling about long-term care options for Medicare members who are placed in nursing facilities to support more community-based care.
- **Addressing Workforce Shortages:** Medicaid HCBS is currently an optional benefit, while institutional care in nursing facilities is a mandatory benefit. As Congress seeks to address this "institutional bias," policymakers should be mindful of the drastic workforce shortages that impact the availability of long-term services and supports across both sectors. Without the workforce to staff HCBS programs, it will be difficult to reduce waitlists for services. Congress should implement a comprehensive strategy – including funds for rate increases, training, and pipeline development – to grow the direct service workforce.
- **Flexibility in Program Design and Use of HCBS Dollars**: State Medicaid programs operate in vastly different contexts. States should retain the flexibility to tailor their program designs to match their residents' needs, resource constraints, and other local factors. Congress should also consider granting states additional flexibility to invest HCBS dollars, including allowing Medicaid to pay for room and

board in the community, direct reimbursement for HCBS provider training, and pre-Medicaid eligibility diversion activities that may delay an individual's need for full Medicaid benefits. States must also have the explicit ability to invest a portion of new HCBS dollars in state administrative capacity, data collection, and data analytics infrastructure; these functions are crucial to delivering expanded HCBS.

- **Sustainability of HCBS Investments:** Expanding the availability of HCBS will require significant investments over the long-term. In order to make these investments, state Medicaid leaders must have the confidence that federal fiscal supports will be sustained. Congress should avoid time-limited investments that create a "fiscal cliff" dynamic for states.

Ensuring Access to Long-Term Services and Supports (LTSS)

HCBS Waitlists & Addressing the Institutional Bias

HCBS is an optional benefit in Medicaid, while nursing facility care is a mandatory benefit. This institutional bias has resulted in nursing facility care serving as the default option for LTSS, even if the member would be better served in their home or community. Additionally, Medicaid agencies must go through complex waiver applications and renewals to provide HCBS services, creating an additional administrative burden.

As HCBS services are optional, many Medicaid programs use waitlists to manage service availability constraints – often driven by workforce shortages – and fiscal impacts. In order to reduce HCBS waitlists and support rebalancing away from institutional care, Congress should consider multiple strategies:

- **HCBS as a mandatory benefit:** NAMD supports the principle of correcting the institutional bias in Medicaid by making HCBS a mandatory benefit. However, implementing this option would require significant federal investments, including investments in the state administrative staff needed to implement an expanded program. If Congress makes HCBS a mandatory benefit without providing additional resources, state Medicaid agencies may be forced to tighten eligibility criteria for HCBS or cut other Medicaid benefits to control costs. States would also need long implementation timelines; mandatory services or populations could be phased in over time.
- **Investments in workforce:** Without the availability of a strong direct care workforce, states will not be able to grow the availability of HCBS. Congress should consider investments to support rate increases (and help states ensure that rate increases result in higher pay for direct care workers), develop training programs and pipelines, and help smaller HCBS providers secure health insurance and other benefits for their employees.

- **Allow Medicaid to cover room and board in the community:** Currently, there is a statutory prohibition on Medicaid covering room and board for members living in the community. Medicaid can, however, cover room and board for individuals receiving institutional care, reinforcing the institutional bias. Congress should consider creating new flexibilities for coverage of room and board.
- **Provide robust options counseling:** Individuals' lives are greatly impacted by the decisions they make about the services they want to receive, the providers that they use, and their location of care. Options counseling is essential to ensuring that people make informed choices about their care and have a full understanding of the available options. Community health workers could be leveraged for this type of counseling.
- **Reduce administrative barriers:** Under current regulations, states are often required to secure temporary waivers to provide HCBS. Waiver application and renewal processes can be time consuming and administratively burdensome for states. Congress should consider measures to reduce the administrative burden associated with offering HCBS.

Asset Limitations

Asset limits are a unique aspect of Medicaid LTSS eligibility. Definitions of assets, specific limits set for specific programs, and how asset limits intertwine with other eligibility considerations can create a complex system for individuals in need of LTSS and for states to administer Medicaid-funded LTSS benefits. There can be opportunities to simplify some of these requirements at the federal level, though any steps in this direction would benefit from careful consultation with state Medicaid agencies and agencies with operational responsibility for HCBS waiver programs. Some initial areas for consideration are offered below.

- **Supplemental Security Income:** NAMD supports common-sense changes to Supplemental Security Income (SSI) eligibility criteria, which have not been updated since 1984. Specifically, Congress should consider increasing the asset limit for SSI to $4,000 for married couples to address the "marriage penalty" and increase SSI asset limits with inflation. Congress could also consider excluding life insurance policies from asset tests or considering them non-liquid assets, as states report that accessing life insurance policies is often difficult. Congress could also consider excluding burial funds.
- **Veterans Affairs income:** Congress could consider making US Department of Veterans Affairs (VA) income non-countable income for non-MAGI eligibility categories. Some VA income is currently non-countable, but some is countable. States report challenges obtaining information on benefits from the VA, delaying application processes for veterans.

- **ABLE Accounts:** NAMD supports expanding ABLE accounts to allow those whose disabilities began after age 26 to qualify for their use. Congress could consider revising the age range for use of ABLE accounts to be ages 18 – 64.
- **Equity Limits and Addressing Asset Shielding:** The treatment of equity limits and asset shielding is another area of complex Medicaid policy. The goal of appropriate stewardship of federal and state dollars in the provision of Medicaid-funded LTSS may conflict with goals around increasing the general availability of LTSS and the ease by which Medicaid-funded LTSS are accessed by individuals in need of these supports. Should Congress choose to make current equity limits and approaches to shielding of assets stricter than what is currently in place, consideration should also be given into how LTSS needs that would not be met by Medicaid could be met by other payers, like Medicare or the private insurance market.
    - Congress should consider resetting the 2005 Deficit Reduction Act (DRA) home equity limits to 2022 dollars and incorporate inflation into the equity limit.
        - DRA language could also be refined to more clearly indicate that it provides additional options for states to modify their Medicaid programs in a manner that meets the state's needs in balancing access with fiscal stewardship.
    - Congress could give states additional authority to address asset shielding tactics taken up since the passage of the DRA, most commonly utilized by more affluent individuals capable of retaining sophisticated legal advice. Such tactics include:
        - Promissory notes – if this continues to be an allowable workaround to spenddown resources, then the payments should be considered income and a clause should be added that any proceeds go to the state upon a member passing away
        - Personal needs contracts which are not notarized, are backdated, and are not detailed in services rendered
        - Expense sharing agreements that are applied retroactively for rent, and home health like services
        - Annuities to spenddown resources to qualify for Medicaid
        - The "Name on the Check" rule that allows the owner of an annuity to transfer payments to the community spouse, leaving the state to pay more of the Medicaid expenses

Eligibility Pathways

As explained above, NAMD supports the principle of Medicaid HCBS becoming the default option for Medicaid-funded LTSS. However, making this goal a reality will require significant investment of federal resources to address existing workforce

constraints and state administrative capacity. Further, even if Congress were to reverse the institutional bias in Medicaid and provide states with these tools, state retention of the flexibility to tailor program designs to meet the unique needs of their populations would remain an important principle to overall success.

Should Congress choose to focus on enhancing existing eligibility pathways, a few opportunities suggest themselves. For example, Congress could consider updating the Ticket to Work program to allow those who have not reached their full retirement age to participate, even if they are over 65, and could invest in additional outreach and education about this program to clarify concerns among current service recipients that working would negatively impact their Medicaid eligibility.

Congress could also allow presumptive eligibility for older adults and persons with disabilities to receive HCBS. This would allow states to expedite delivery of HCBS, which can help prevent institutionalization (e.g., in the case of a hospital discharge) or increase transitions out of institutional settings (e.g., by covering home modifications for an individual leaving a nursing facility).

Access to LTSS through Family Caregiving

NAMD supports broader family caregiver and guardian supports, including increased respite services, training resources, care planning resources, housekeeping services, assistive technology, equipment and supplies, and peer supports. States should be given flexibility to support family caregivers who choose to enter a paid employer/employee relationship with a state Medicaid agency and family caregivers who choose to remain unpaid.

Accommodations in Daily Life and the Community

Coverage for Assistive Technologies

NAMD supports Congress authorizing Medicaid to reimburse for the cost of assistive technologies that may have secondary purposes, such as iPads or computers, although state Medicaid programs should retain the flexibility to choose to cover these technologies. There may be times when these technologies facilitate improved outcomes for members but would be unaffordable for the member without Medicaid coverage. Congress could also consider grant programs to support the purchasing of assistive technology that is not covered by Medicaid.

NAMD also supports increasing the allowable age for qualifying for ABLE accounts. This would allow more individuals with disabilities to benefit from having an ABLE account and to save for disability-related expenses.

Accommodations in Healthcare Settings

NAMD supports funding for healthcare settings to make physical or sensory accommodations and training for health care professionals on how to accommodate

people with disabilities. These trainings should include support for direct support professionals and family caregivers, who serve as the backbone of the nation's home- and community-based services system.

NAMD also supports flexibilities around telehealth services and remote monitoring. Although these care modalities are not appropriate for all members, they are preferred by some people with disabilities and can be helpful in addressing workforce shortages. Congress should provide support for technology and broadband internet access to ensure all HCBS members have access to these forms of care.