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January 30, 2017

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight
and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Oversight
and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Murphy and Ranking Member DeGette:

Thank you for holding this hearing on Medicaid Oversight: Existing Problems and Ways to Strengthen the Program. AARP appreciates the opportunity to share this letter on Medicaid with the subcommittee. AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

As Congress considers changes to Medicaid -- a joint federal and state funded program -- it is important to look at the impact of Medicaid on the people it serves. Medicaid is a vital safety net and intergenerational lifeline for millions of individuals, including 17.4 million low-income seniors and children and adults with disabilities who rely on the program for critical health care and long-term services and supports (LTSS, i.e., assistance with daily activities such as eating, bathing, dressing, managing medications, and transportation).

Of these 17.4 million individuals: 6.9 million are ages 65 and older (which equals more than 1 in every 7 elderly Medicare beneficiaries)¹; 10.5 million are children and adults living with disabilities; and about 10.8 million are so poor or have a disability that they

¹ Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Medicaid at 50", May 2015, 13. Available at: <http://files.kff.org/attachment/report-medicaid-at-50>

qualify for both Medicare and Medicaid (dual eligibles).² Dual eligibles account for almost 40 percent of Medicaid spending.³ While they comprise a relatively small percentage of enrollees, they account for a disproportionate share of total Medicare and Medicaid spending. While some use fewer services, many have intensive care needs associated with exceedingly high costs. As a group, they tend to be sicker, poorer, and more expensive to care for than other individuals covered by either the Medicare or Medicaid programs.

Medicaid beneficiaries with disabilities include younger individuals with physical conditions such as multiple sclerosis or epilepsy; HIV/AIDS; spinal cord and traumatic brain injuries; disabling mental health conditions such as depression and schizophrenia; intellectual and developmental disabilities such as Down syndrome and autism; and other functional limitations, as well as older adults in nursing homes or receiving home and community-based care.⁴ Disabling conditions that affect older adults include Alzheimer's disease, stroke, and chronic and disabling heart conditions. Individuals may have low incomes, high costs, or already spent through their resources paying out-of-pocket for LTSS, and need these critical services. For these individuals, Medicaid is a program of last resort.

Individuals with disabilities and older adults rely on critical Medicaid services, including home and community based services (HCBS) for assistance with daily activities such as eating, bathing, dressing, and home modifications; nursing home care; assistance with Medicare premiums and cost-sharing; and other benefits such as hearing aids and eyeglasses.⁵ People with disabilities of all ages rely on Medicaid for access to comprehensive acute health care services. Medicaid also helps some people with disabilities stay in the workforce and lead productive lives. Children with significant disabilities are able to stay with their families and receive the help they need at home or in their community because of Medicaid.⁶

As Congress considers possible changes to Medicaid, it is important to understand how any proposed changes will affect real people. AARP opposes Medicaid block grants and per capita caps because we are concerned that such proposals will endanger the

² Medicaid and CHIP Payment and Access Commission, "MACStats: Medicaid and CHIP Data Book", Exhibit 14. Available at: <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-14.-Medicaid-Enrollment-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2013.pdf>

³ Rudowitz, Robin, Kaiser Family Foundation, "Medicaid Financing: The Basics", December 22, 2016. Available at: <http://kff.org/report-section/medicaid-financing-the-basics-issue-brief/>

⁴ Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015", 1. Available at: <http://files.kff.org/attachment/report-medicare-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015>

⁵ Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Medicaid at 50", May 2015, 13. Available at: <http://files.kff.org/attachment/report-medicare-at-50>. Not all 17.4 million people receive LTSS.

⁶ Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Medicaid at 50", May 2015, 10, 11, 13. Available at: <http://files.kff.org/attachment/report-medicare-at-50>

health, safety, and care of millions of individuals who depend on the essential services provided through Medicaid.

A block grant would end the guaranteed access to care for millions of Americans who are eligible and instead provide a fixed amount of federal funding to each state for its Medicaid program, which may not take into account increases in actual cost or need. We oppose the end of the guarantee and are concerned that fixed federal funding to states will result in cuts to program eligibility, services, or both – ultimately harming some of our nation’s most vulnerable citizens.

In addition, moving from the current Medicaid financing structure to fixed federal Medicaid block grant funding would shift costs to states and state taxpayers. With aging demographics, the rising needs of the chronically ill, and individuals with some form of dementia, states cannot meet these increased Medicaid costs. The National Governors Association has also recently stressed the importance of protecting states from unforeseen financial risks and not shifting costs to states.

Per capita cap proposals would provide a fixed amount of federal funding per person, while allowing for enrollment growth. This approach to financing would also likely result in overwhelming cost shifts to state governments and families unable to shoulder the costs of care without sufficient federal support. It is unclear how Congress would determine the baseline amount of the caps in ways that would accurately reflect the cost of care for individuals in each state, let alone determine growth rates that would accurately reflect the cost of care for individuals in each state.

We are especially concerned with how caps would be set for children and adults with disabilities, as well as for seniors. There is great variation among people of all ages living with disabilities in terms of the severity of their condition. Such variation makes it very challenging to establish realistic baseline cap amounts that would be sufficient to meet the very costly needs of those living with the most severe disabling conditions. Establishing unrealistic baseline spending for this population would make it impossible to meet the needs of those who have very high levels of need.

In terms of poor seniors, we have serious concerns about setting caps at a time when per-beneficiary spending for poor seniors is likely to increase in future years. By 2026, when boomers start to turn age 80 and older, they will likely need much higher levels of service—including HCBS and nursing home—moving them into the highest cost group of all seniors. As this group continues to age, their level of need will increase as well as their overall costs. We have not seen any per capita cap proposals that take this into account.

If Congress is interested in changes to improve Medicaid, there could be an opportunity to address Medicaid’s longstanding institutional bias. When Medicaid was created in 1965, nursing homes were the only option for a person who needed LTSS. States receive the funding they need to provide nursing home care for those who are eligible, but they can only provide home and community-based services (HCBS) to a more

limited extent in practice. The funding is now treated differently for nursing homes and services in homes and communities. It is time to update the law to reflect where and how people want to receive services today. In addition, governors have called for additional flexibility in the administration of the Medicaid program. We suggest that states should be given the flexibility to use Medicaid dollars for HCBS – without having to request permission from the federal government. About 90 percent of older adults want to remain in their own homes and communities for as long as possible.⁷ They want to maintain their independence and have control over their own decisions.

On average, in Medicaid, the cost of HCBS per person is one-third the cost of institutional care.⁸ HCBS are more cost effective and help people live in their homes and communities where they want to be – this makes fiscal sense and commonsense. States should be able to access funding for HCBS in the same way they can access nursing home funding. Eliminating the institutional bias in Medicaid aligns public policy with consumer preference. In addition, such efforts can yield significant returns on investments both to governments looking for more cost-effective solutions and taxpayers.

AARP appreciates the opportunity to provide written input and looks forward to working with you to keep Medicaid's vital safety net in place and help people live in their homes and communities for as long as is reasonably possible. If you have further questions, please feel free to contact me or have your staff contact Rhonda Richards on our Government Affairs staff at richards@aarp.org or 202-434-3770.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs

⁷ Nicholas Farber and Jana Lynott. Aging in Place: A State Survey of Liability Policies and Practices (Washington, DC, AARP Public Policy Institute and the National Conference of State Legislatures, December, 2011)

⁸ Terence Ng, Charlene Harrington, MaryBeth Musumeci, and Erica L. Reaves, "Medicaid Home and Community-Based Services Programs: 2011 Data Update" (HCBS) and 2013 Medicare and Medicaid Statistical Supplement (Nursing Homes). Available at: <http://dataexplorer.aarp.org/indicator/31/medicaid-ltss-spending-per-user#/bar?primarygrp=dist18&secondgrp=loc&dist18=102,103,104,105,106,107,108&loc=1&tf=12&fmt=132?>