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National Association of State Medicaid Directors

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an affiliate of the American Public Human Services Association

5/22/2009

The Honorable Max Baucus  
Chairman  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Charles Grassley  
Ranking Member  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

Dear Senators Baucus & Grassley,

The National Association of State Medicaid Directors (NASMD) respectfully submits this comment letter on the white paper entitled “Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans.” NASMD strongly supports the development of a comprehensive system of care that diminishes wasteful spending, increases value and efficiencies, and reduces the reliance on uncompensated care. We look forward to continuing to work with you, your staff, and your colleagues to ensure that Medicaid’s role in health care reform is appropriately developed, implemented and financed.

Although NASMD supports the efforts of this committee, we do have some questions and concerns regarding some of the proposals within this paper. We look forward to an ongoing dialogue to clarify and resolve these issues, and others as they arise.

#### **SECTION IV: ROLE OF PUBLIC PROGRAMS**

##### *Income Disregards*

The removal of income disregards for all populations greatly restricts state flexibility in programmatic design. Regional variances in cost of living necessitate leaving the ability for states to use income disregards or other methods to increase the income of certain Medicaid beneficiaries. Furthermore, it is unclear how the removal of disregards will interact with other Medicaid-linked programs, such as Supplemental Security Income (SSI). Under SSI, certain types of income are disregarded when individuals go back to work. States also disregard some types of income to ensure that individuals utilizing Long Term Care services are able to meet daily living expenses. NASMD is concerned that the move to modified adjusted gross income would have a negative affect on these individuals. Furthermore, for States that use section 1902(r)(2) of the Social Security Act to disregard some types of income, it is unclear how the removal of income disregards will interact with the requirement to not reduce any income thresholds for existing eligibility groups.

### *Medicaid Program Payments*

NASMD greatly appreciates the willingness of the committee to assist States finance the mandatory expansions of services. However, the phase-in of normal FMAP rates will still create great hardships on the State budgets. Given that the committee, in a separate paper, offers proposals to generate Federal revenue to finance health care reform, NASMD suggests examining options to utilize some of that increased funding to alleviate some of the burden of reform on State budgets. Potential options could be permanent increased FMAP for expanded populations, grants to cover the medical costs of additional eligible individuals, or elimination of the Medicare Part D clawback to free up more State money for expansion.

In addition, the requirement to set Medicaid rates at 80% of Medicare will create great hardship on already strained State budgets. Medicaid programs have historically had a large amount of flexibility regarding provider reimbursement, and many States rely on this flexibility to balance their budgets. Without flexibility to set rates, State programs will likely have to find savings by reducing services. Also, it is important to remember that Medicare and Medicaid are different programs with different services and populations. Many Medicaid programs pay for vastly different services than Medicare using different methodologies. Also, Medicare covers seniors and people with disabilities whereas Medicaid covers a wide variety of low-income individuals, including healthy adults and children. The rate-setting methodologies are very different for these populations. The requirement to base Medicaid rates on Medicare will eliminate existing, cost-effective payment structures across the country.

### *Treatment of Territories*

NASMD strongly supports aligning Territorial Medicaid policy and financing with State Medicaid programs, including calculating FMAP using the standard formula and removing the cap on annual Federal Payments.

### *Children's Health Insurance Program*

NASMD strongly encourages the committee to maintain State flexibility on programmatic design. States are well-positioned to provide most of CHIP care through the Exchange. However, in some cases, the Exchange may not be the best option, depending on the insurance options within the state. Also, the requirement to first provide care through an Exchange plan and then to provide CHIP wrap-around benefits for non-covered services (such as EPSDT), will likely be administratively burdensome and not cost effective. Retaining State abilities to define their programs based upon the unique needs of the state is crucial to effective service delivery. NASMD would also like to reiterate the need to allow income disregards in CHIP as well as Medicaid to account for regional variance in cost of living.

We would also like to request clarification on two items in this section:

- 1) On page 21, the document prohibits states from decreasing eligibility for currently eligible child populations under CHIP. Please clarify whether this prohibition extend to pregnant women or parents who are covered under CHIP.

- 2) On page 21, the document refers to Federal Financial Participation (FFP) continuing under CHIP. NASMD encourages the committee to clarify that the FFP referenced is the enhanced FMAP currently available under the CHIP program.

*Other Improvements to Medicaid: Enrollment and Retention Simplification*

NASMD encourages the committee to retain state flexibility for program oversight. We strongly support creating incentives and tools to increase enrollment in Medicaid and CHIP, but do not believe that mandating these options is the most effective program management. Many of the State options that these proposals remove, such as face-to-face interviews and 6-month redeterminations, are utilized to ensure that only individuals who are truly eligible are enrolled in the program. Retaining these practices, as State options, allows states that rely on these options to continue to manage their programs efficiently.

Additionally, mandated information technology changes, such as enrollment websites, should be funded at the Medicaid Management Information Systems matching rate (90% FFP for development; 75% FFP for maintenance) rather than the normal administrative matching rate (50%).

*Other Improvements to Medicaid: Changes to the FMAP Formula*

Several states have projected new FMAP rates with this proposed formula and there is some concern that the formula, as posted, penalizes some less affluent States. We request that the committee review the proposed formula to determine if there are errors in the mathematics. If this formula is printed correctly, we request a reevaluation to ensure that States are not unfairly punished by the formula calculation.

*Other Improvements to Medicaid: Automatic Countercyclical Stabilizer*

NASMD strongly supports the inclusion of this provision to ensure that Medicaid programs are not overextended during periods of economic downturn.

*Other Improvements to Medicaid: Coordinating Care for Dual Eligibles*

Dual eligible populations are often the most expensive Medicaid beneficiaries, as well as the most difficult to control costs. NASMD encourages the committee to ensure that States are able to effectively manage costs by including these provisions regarding dual eligible care coordination. NASMD especially appreciates the ability to count Federal Medicare Savings towards the cost of 1915(b) and encourages the committee to include this option for 1915(c) waivers.

*Medicare Coverage: Phase out of 24 Month Waiting Period*

NASMD strongly supports the phase-out of the 24 month waiting period for Medicare after a disability determination. These individuals often have significant medical needs and no insurance. State programs are frequently forced to cover their costs as uncompensated care, State-funded general assistance, or Medicaid. Ensuring that these individuals are covered immediately will reduce the degeneration of many conditions and subsequently reduce the reliance on emergency care.

## **Section VI: Options to Improve Access to Preventive Services**

### *Promotion of Prevention and Wellness in Medicaid*

NASMD supports the ability to, at the State option, offer comprehensive wellness and prevention services. States appreciate the proposed FMAP increase to assist with the coverage of these services. NASMD also supports the creation of grants to improve preventive-care services.

## **Section VII: Long-Term Care Services and Supports**

### *Eligibility for HCBS*

NASMD supports the ability to, at the State option, remove institutional level of care criteria from 1915(c) waivers and to allow individuals to be enrolled in more than one waiver at a time. However, NASMD strongly feels that these proposals should be at a state option, not a requirement. We also support the ability to provide “other” Secretary approved services through the 1915(i) in order to craft specific services that meet the unique needs of populations that utilize HCBS care.

NASMD also believes that eligibility for HCBS waivers and the 1915(i) option should be at the state option. In some cases, States may wish to expand eligibility for certain groups above 300% of the SSI standard, such as for workers with significant disabilities who need access to Long-term-care. NASMD encourages the committee to alter financial eligibility to provide states with flexibility to set their own income/resource criteria.

### *Increased Access to HCBS*

NASMD encourages the development of more community-based options for care delivery, however the increased fiscal pressures of raising or removing waiting lists on HCBS waivers, coupled with the additional pressures of funding the other expansions, will likely be unsustainable. Even with the proposed 1% FMAP increase for HCBS, States will not be able to afford these drastic expansions. As an alternative, NASMD suggests that the committee place more emphasis on reducing institutional placements and shifting that money to HCBS.

In general, NASMD supports increasing access to HCBS through both public and private options. Currently, Medicaid is the most significant payer of Long Term Care in the country. NASMD believes that options to increase the utilization of private LTC insurance and funding is crucial to reigning in the growth in public health care spending.

### *Asset Tests*

States already have the flexibility to increase allowable resources by disregarding certain types or amounts of assets under section 1902(r)(2) of the Social Security Act. Providing other options to increase assets may be beneficial, but may also be unnecessary. However, NASMD does not support requirements to increase asset limits; these types of policies should be left as a state option.

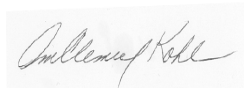
## **Conclusion**

NASMD would like to reiterate support for modernizing the health care coverage and delivery system. However, we remain concerned about the additional financial burden that this will place on State budgets. The financing proposals contained within the accompanying white paper raise money for Federal outlays towards this reform, but do not help States meet their obligations under expanded coverage for Medicaid. Although the proposal includes the Federal government paying for the first 5 years of increased costs associated with expansion, once the gradual phase-in of FMAP occurs, State agencies will have to begin financing a significant portion of increased coverage. At some point, the increased pressure on State budgets will likely lead to difficult choices regarding services and eligibility for some of the most vulnerable populations, such as seniors and individuals with disabilities.

Additionally, although these proposals will significantly reduce the number of uninsured individuals, there will still be instances where practitioners are forced to provide uncompensated care. NASMD encourages the committee to consider ways to ensure that providers are not financially burdened by uncompensated care, beyond the existing DSH methodology payment. NASMD suggests including some kind of reimbursement mechanism in Medicare to account for instances of uncompensated care.

We would like to express our appreciation for the opportunity to comment on these proposals, and our excitement at continuing to partner with the committee to develop comprehensive, effective strategies for Medicaid and CHIP within the health care reform process. Thank you for considering our comments. If you have any questions, please contact me at (202) 682-0100 or [akohler@aphsa.org](mailto:akohler@aphsa.org).

Sincerely,



Ann Clemency Kohler  
Director  
National Association of State Medicaid Directors