Medicaid is a Lifeline for People with Disabilities and Must Be Preserved

→ Medicaid provides essential services and supports to individuals with disabilities.
→ Turning federal Medicaid funding into a block grant would harm individuals with disabilities.
→ The premise that capping Medicaid would result in savings is false.
→ There is ample flexibility in Medicaid and the ACA for states to innovate.

Medicaid is a lifeline for people with disabilities. It provides essential health care and long term services and supports which enable people to live productive lives in the community. Medicaid must be preserved.

Medicaid Provides Essential Services and Supports to Individuals with Disabilities

The following are a few examples of the critical features of Medicaid that allow it to work effectively for children and adults with disabilities:

- For children with disabilities, access to the cost-effective Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, can often make a major difference in their lives, enabling them to lead healthy and more active lives and participate actively in the community in which they live. EPSDT also enables many children to avoid institutionalization and separation from their families.
- Medicaid is the primary public source of funding for long-term services and supports (LTSS) for people with disabilities of all ages. It is the largest funder of state and local spending on mental health and developmental disabilities services in the country.
- For people with epilepsy, mental illness, HIV, and a variety of other conditions, Medicaid is very often the only source of access to essential prescription drug coverage.
- For people with long-term diseases or conditions like multiple sclerosis who eventually become disabled enough that they lose access to and/or cannot afford private coverage and have spent most of their earnings and savings on management of the disease, Medicaid becomes the only affordable, comprehensive health coverage option—particularly for LTSS.
- For people with a variety of physical disabilities, such as spinal cord injuries and limb loss, Medicaid usually is the only way they have access to durable medical equipment like wheelchairs, prosthetic limbs and orthotic braces, as well as assistive technology.
- For many people with intellectual, cognitive and other disabilities, Medicaid is the main source of funds for them to live and work in the community, avoiding costly, segregated nursing homes or institutions.

Turning Federal Medicaid Funding into a Block Grant Would Harm Individuals with Disabilities

The LTSS Task Force of CCD is strongly opposed to any proposal that would remove the individual entitlement to Medicaid. The following are examples of how proposals to block grant or cap federal funding would harm individuals with disabilities:
• **Remove Individual Protections** – Turning Medicaid into a block grant or global waiver would remove the entitlement to Medicaid for children and adults with disabilities and their families and cap funding, giving states unlimited discretion to limit access to health and long-term services and supports that these individuals need. For many individuals with disabilities in Medicaid, including so-called “optional” beneficiaries, access to Medicaid has life-altering implications. Undermining well-reasoned and time-tested beneficiary protections as though they were responsible for current challenges in financing Medicaid is dangerous for children and adults with disabilities. Federal oversight of state programs is often the only way to ensure fairness and non-discrimination.

• **Increased Cost Sharing** – Medicaid also ensures that coverage is affordable by generally not charging premiums and requiring only modest co-payments; research has found that premiums and cost-sharing tend to disproportionately lead poor households to forgo needed care or remain uninsured. Under a block grant, states could begin charging premiums beyond levels not permitted under current law that discourage enrollment (and leave people uninsured) and require burdensome deductibles and co-payments that reduce access to needed health care.

• **Target Populations For Cuts** – People with disabilities would be at particular risk since they constitute a small percentage of Medicaid beneficiaries but account for a disproportionate share of Medicaid spending as Medicaid is the primary funder of long-term services and supports. Capping federal Medicaid funding would place significant financial pressure on states to scale back coverage on funding for services to low-income people with disabilities in spite of their greater health needs.

• **Higher Costs, Fewer Services** – A block grant could also allow states to shift beneficiaries into private insurance, offering them a voucher to purchase private healthcare coverage on their own. Since Medicaid costs substantially less per beneficiary than private insurance, on average (largely due to its lower provider reimbursement rates and lower administrative costs), shifting beneficiaries into private insurance would raise states’ costs, unless the vouchers purchased considerably less coverage than Medicaid provides. Medicaid works precisely because individuals with disabilities could not obtain private health insurance that provided the comprehensive coverage necessary for vital services. In addition, states facing inadequate block grant funding would also likely have to further scale back provider rates, which would result in decreased access to services and providers withdrawing from Medicaid, undermining the comprehensive service structure for delivering specific health and long-term services. Rural areas would be especially vulnerable to a health and long term services delivery system that is even more limited in providing access to vital services.

The Premise That Capping Medicaid Would Lead To Savings Is False

At first glance, capping or block-granting Medicaid might seem like a cost-saver, but that approach simply would shift costs to states and providers and to individuals least able to afford them, jeopardizing access to needed services for millions of people with disabilities. Such actions could result in many more individuals becoming uninsured, which would compound current problems related to lack of coverage, overflowing emergency rooms, limited access to long term services and increased healthcare costs in an overburdened system.

Capping Medicaid spending would reduce access to home and community-based services and supports, adding to growing waiting lists for community-based services, increasing reliance on more costly institutional care, and leading to greater non-compliance with the U.S Supreme Court’s *Olmstead* decision and the Americans with Disabilities Act. Reducing access to home and community-based services would also produce greater economic burdens for family caregivers and costs to US businesses due to lost productivity and absenteeism.
There Is Ample Flexibility In Medicaid And In The ACA For States To Innovate

The current budget challenges at the state level are not due to a lack of flexibility within the Medicaid program. The current crises are the result of an unprecedented deep recession that produced an increase in enrollment in state Medicaid programs occurring at the same time as a significant decrease in state revenues. Of course, these factors have resulted in exactly what is contemplated in the counter-cyclical and jointly financed approach we now have in the Medicaid program. And, because demand for Medicaid peaks during economic downturns when state revenues fall, the likely impact of a block grant or defined cap is to make Medicaid even less affordable at the time it is most necessary.

The Medicaid program provides enormous flexibility to states. In fact, the Affordable Care Act provided additional flexibility in many areas, such as providing states with new options and incentives to provide more cost-effective Medicaid home and community-based services.

* The Community First Choice Option
  States currently have an option to provide personal care services through their Medicaid plans, and over half of the states currently do that. This option expands on those programs. It allows states to open eligibility to people at higher incomes and to offer additional services. An increased federal matching payment of 6% is a strong incentive for states to take up the option and expand home- and community-based care services in Medicaid. CFC was included in the ACA to help people with disabilities stay in their homes rather than go into most costly nursing homes or other institutions.

* Enhanced 1915(i) State Plan Option
  States can choose to make home and community based services to people before they need nursing home care and to people who make up to 300% of the federal poverty level.

* Balancing Incentive Program
  This program was created by the ACA to help states address the institutional bias in Medicaid. States that spend less than 25% on home and community based services (and 75% or more on institutional services) are eligible for an increased FMAP of 5% on new or expanded home and community based services and states that spend less than 50% on community based services are eligible for a 2% increase in their FMAP. These extra dollars will help states move people out of institutions and into the community.

* Money Follows the Person
  The ACA extended the program through 2016 and made available an additional $2.25 billion in grant dollars. States may apply for 4-year MFP grants to move people out of institutions into the community.

These programs afford states great flexibility in designing services to meet the needs of their populations, reallocating funds to cost efficient service models, and delivering services that people overwhelmingly prefer.

Proposals to cap federal funding or block grant Medicaid would simply exacerbate, not improve, our long-term budget challenges. Policy makers need to take advantage of the significant opportunities to realize efficiencies in Medicaid so that it can continue to be a lifeline for people with disabilities.