Good afternoon Mr. Chair and fellow members,

The Disability Law Center (DLC) appreciates the invitation to share our perspective on the potential impact of the Medicaid per capita cap included in the American Health Care Act (AHCA) on Utahnhs with disabilities. The DLC is designated by the governor as Utah’s Protection and Advocacy agency. Our mission is to enforce and strengthen laws that protect the opportunities, choices, and legal rights of the almost 300,000 Utahns with disabilities.

At least 50,000 seniors and Utahns with disabilities could lose access to affordable and quality care if $834 billion is slashed from Medicaid over the next 10 years. This is precisely the wrong approach. The program is a successful 50+-year partnership between the states and Washington, DC. Cost drivers are also the same in Medicaid and the private market: enrollment growth and the rising cost of care overall. Even so, Medicaid has lower per enrollee cost growth than Medicare or the private market. Effective programs like this deserve to be strengthened and built upon, not decimated and dismantled.

Under the AHCA, a state would receive a set amount annually for each enrollee. The overall cap is based on a state’s 2016 expenditures, plus growth in enrollment and the medical component of the consumer price index (or the CPI-M +1% for enrollees who are aging or have disabilities). While the AHCA contains no mechanism for states to retain any savings, if the total cost of care is greater than the funding provided, a state is on the hook for the difference. For example, if a per capita cap had been in place for the last 10 years, Utah would likely be facing up to a $750 million shortfall compared to current funding levels.

Confronted with a gap like this and another 25% cut off the top, a state may be tempted to provide only the bare minimum to as few individuals as allowed. For instance, nationally mandatory services already account for more than 47% of Medicaid spending. In Utah, these services, such as hospital stays, doctor’s visits, and nursing home care, consume more than half the budget. On the other hand, optional services like prescription drugs, mental health care, and home and community-based supports take up slightly more than a third. Several of these are also often unavailable through Medicare or the private market. Even so, faced with diminishing resources, the state may have no choice but to reduce or eliminate some or all optional services.

Due to Utah’s relatively young population and efficient delivery systems, the Department of Health and Medicaid leadership believes it can live within a capped scenario. However, the resulting relatively low per-enrollee expenditures could comparatively disadvantage the state in terms of baseline funding. Also, although the Utah’s spending is below the national average for all eligibility groups, it is already near the proposed cap (CPI-M) for all eligibility groups except children. Additionally, the situation will likely only become more acute as Utah’s aging and disabled populations develop more costly needs as they grow older and live longer.

Even given CPI-M +1%, this could be problematic. One projection estimates that, over a ten-year span, spending on enrollees with disabilities could decline by $8 billion. Under this scenario, could the program afford the new extremely effective but extremely expensive miracle drug? Will it be able to respond as effectively to a natural disaster or public health emergency as...
it has in the past? Will there be enough to cover the increasing cost of services such as home health care? If not, instead of being active, productive, and contributing members of their communities, Utahns with significant disabilities may be forced to return to an institution.

A cap could also constrain the state’s ability to adopt or expand more efficient and effective services, like the autism or medically complex children waiver, because the resources needed for the upfront investment may be unavailable. Conversely, the growing jail and homeless population in Salt Lake County is a vivid example of the consequences of failing to adequately invest in innovative models, like the intensive community-based mental health and substance use treatment component of the Justice Reinvestment Initiative.

Additionally, a cap could prove difficult for the state because Congress could reduce the amount at any time through a relatively simple budget maneuver. The following example is illustrative: inflation-adjusted funding for 10 of the 13 major housing, health, and social services block grants has fallen by an average of 27% in the last 17 years. Either way, the legislature will be left holding the bag, and ultimately blamed for having to choose between Utah kids, seniors, and persons with disabilities.

Rather than jeopardize a vital lifeline for maintaining and improving the health and safety of vulnerable Utahns, the governor and legislature should weigh in with our congressional delegation in support of ideas designed to improve the quality of care. Our suggestions are consistent with a few of Senator Hatch’s past recommendations, as well as several guidelines recently adopted by Utah’s Medicaid advisory committee:

- encourage prevention, efficiency, and cost savings by promoting the use of allied practitioners (e.g. physician assistant, nurse practitioner, advanced practice registered nurse, etc.), where appropriate, and cost-effective benefits, such as EPSDT and medical homes, while focusing on long-term population health;

- incentivize best practices and model programs through existing tools (e.g. state plan options, waivers, demonstration projects), especially around value-based payments, outcome-based care, and physical and mental/behavioral health integration. Whenever possible, changes should be evidence-based and data-driven; and

- eliminate the institutional bias in Medicaid. Facility-based care is often at least twice as much as community-based support. Allowing money to flow freely between facility-based care and community-based supports could reduce spending and enable more aging individuals and persons with disabilities to exercise control and responsibility over their lives.

Thank you for your time and consideration of our input. If you would like more information or have questions, please do not hesitate to contact us. We look forward to working with you to maintain a strong health care system, which offers robust protections, cost controls, improved quality, and affordable coverage to all Utahns.