

HCBS Savings, Quality Hard To Measure, AHCA Study Finds

While home- and community-based services (HCBS) account for a rapidly growing share of Medicaid long term care expenditures, the shift hasn't produced widespread savings or meaningful HCBS quality measures, according to a review of research literature on these programs conducted by Washington, D.C.-based Avalere for AHCA.

Spending on home- and community-based care has risen from 4 percent of all Medicaid long term care outlays in 1993, to 25 percent of expenditures in 2005, Avalere reported. Growth is being driven "by state policy goals to slow Medicaid [long term care] rates of spending growth and to meet consumer demand for more [long term care] service options in the community," the study said.

Current and past research consistently shows, however, that the expansion of HCBS has not curbed long term care spending growth, Avalere said. In fact, "most HCBS programs increase total long term care spending and are not cost-effective for state [long term care] budgets," the review found.

While nursing facility costs have slowed in some states, "HCBS has grown significantly in all states," often offsetting savings on the nursing facility side of the ledger, Avalere reported. Overall long term care spending has slowed only in states that combine specific cost-containment strategies: restriction of HCBS eligibility to high-needs individuals at risk of nursing facility placement; use of HCBS expenditure controls such as spending,

service, or enrollment limits; and/or the imposition of a global long term care budget that couples HCBS expansion with an effort to reduce facility-based spending, the report said.

Furthermore, the demand for HCBS is so great that it raises questions of whether these programs can ever meet the need or effectively impact spending, Avalere said. A 2005 study, for example, found that almost 261,000 individuals were on waiting lists for 102 waivers in 30 states, up from 206,000 in 2004—nearly a 30 percent increase in one year.

Weaknesses in HCBS research compound the difficulty of assessing HCBS programs, Avalere said, noting that many studies fail to "compare like populations and/or do not use a control group," while others do a poor job of controlling for "differences among study participants or study settings (e.g., nursing home and HCBS)."

There is also variability in how researchers study risk factors for nursing facility placement. These inconsistencies make it difficult to identify when HCBS serves as a substitute for nursing facility care—a key determinant of cost-effectiveness, Avalere said.

Quality measures of HCBS and comparisons with nursing facilities, meanwhile, remain elusive, with scant data on HCBS quality, the study said. While the Centers for Medicare & Medicaid Services recently developed the HCBS Quality Framework, the new tool "does not allow comparison among HCBS programs or between HCBS and nursing facilities," Avalere said. "Fundamental differences in service delivery models, and consumer bias, make comparisons of HCBS to nursing home service extremely

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Senate Retains User Fee In Spending Bill

Senate appropriators preserved a provision of the fiscal 2008 Labor, Health and Human Services (HHS), and Education spending bill that would impose a revisit user fee on nursing facilities, despite intense opposition from AHCA, which has launched a grassroots effort urging lawmakers to reject the measure.

The fee, which would generate \$35 million, according to estimates from the Office of Management and Budget, is being championed by the Centers for Medicare & Medicaid Services (CMS) and would apply to revisits for deficiencies found during initial certification, recertification, or due to a substantiated complaint.

The House of Representatives Appropriations subcommittee on Labor, HHS, Education struck the revisit fee from its version of the fiscal 2008 appropriations bill, and AHCA's letter-writing campaign had asked key senators to follow the House lead, warning that the fee would "divert mandatory spending funds away from the intended purpose, patient care, to discretionary spending for administrative efforts," and siphon needed investment in the nation's long term care infrastructure.

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A Note From The Chair

Summer is officially here, and it's time for baseball games and fireworks. As we learned from our strategy session with AHCA/NCAL federal political directors in early June, it's also the perfect time to invite your members of Congress to tour your facility.

Right now, AHCA/NCAL staff are pressing House and Senate offices to protect our Medicare market basket update, to exclude revisit user fees, and to continue full, uninterrupted implementation of the 75 percent rule. With Congress needing to find "pay fors" for so many big ticket items—the war in Iraq, the "doc" fix, the state children's health insurance program (SCHIP)—it's tough. We've been fortunate; CMS has recommended a 3.3 percent annual update to our market basket. But nothing is really off the congressional negotiating table. So keeping long term care as a top priority is critical.

All of us remember what summer vacation is like—it's not easy to remember everything you learned during the school year when you're watching baseball or enjoying a Fourth of July celebration. It's no different for Congress. So, when your senators and representatives return home for extended summertime visits in their home districts, you can be sure that the progress we've made all year isn't forgotten. In fact, you can do more than ensure long term care remains top of mind. By simply inviting your representatives to see firsthand the work you do each day, you can demonstrate what their support and votes mean—to you, to your staff, to your hometown.

Not sure you're ready to invite your member of Congress to tour your facility? A simple step-by-step process can be found by going to www.ahca.org/members/p-g-r/grassroots/index.html.

Angelo S. Rotella, Chair, AHCA

HCBS Savings, Quality Hard To Measure *continued from page 1*

challenging," the study said. As states expand HCBS programs through the flexibilities provided by the Deficit Reduction Act of 2005—which allows HCBS to be offered as a state plan option without a Medicaid waiver—new questions, challenges, and complications will

arise in assessing these programs, Avalere predicted. Reviewers also noted that even as HCBS becomes more prevalent, nursing facilities "will remain a critical segment of the long term care spectrum," providing the intensive level of care needed by high-acuity residents.

Senate Retains User Fee *continued from page 1*

"CMS should not solve its budget constraints by assessing a user fee for survey revisits on skilled nursing facilities," said the letter from AHCA members to Sens. Tom Harkin (D-Iowa), chairman of the Appropriations Labor HHS subcommittee, and Arlen Specter (R-Pa.), ranking

member of the panel.

Once the full House Appropriations Committee votes on the measure, differences between the House and Senate bills will be negotiated, and the final version will be voted on by both chambers.

Workforce

Bill Supports Nationwide Criminal Background Checks

A pilot program requiring nursing facility job applicants to undergo criminal background checks—including fingerprinting and screening by the Federal Bureau of Investigation (FBI)—would expand nationwide under legislation introduced by Sen. Herb Kohl (D-Wis.).

The bill, called the Patient Safety and Abuse Prevention Act of 2007 (S 1577), would open a three-year, seven-state pilot program that was launched as part of the Medicare Modernization Act (MMA) of 1993 to all states that want to participate. The bill would provide direct federal reimbursement to providers for the cost of the background checks and offer matching funds to states for streamlining and integrating criminal screens.

"The vast majority of long term care workers are selfless and dedicated," said Sen. Kohl in a floor statement on the legislation. "Yet there are a few with violent criminal histories who pose a clear threat to the defenseless individuals needing long term care services."

Kohl described the current criminal background check process as a "disorganized, patchwork system" in which employers "do not always know which applicants have records of abuse or a history of committing violent crimes."

In Michigan, one of the states in the MMA pilot program, long term care providers use an online system that consolidates several background check registries and databases, said Orlene

Christie, director of the legislative and statutory compliance office at the Michigan Department of Community Health, in May testimony before the Senate Special Committee on Aging. Applicants then go to an independent vendor for a digital scan of their fingerprints and further screening by the FBI.

The state also has a "rap back" system, in which the Michigan State Police notify state health agencies of any employee arrests subsequent to the initial screen. The agency, in turn, notifies the employer.

In the first year of the program, which took effect April 1, 2006, more than 3,200 applicants with records of abuse or other disqualifying criminal convictions were excluded from employment, Christie said.

Kohl's legislative proposal, which has six co-sponsors, including Democratic presidential candidate Hillary Clinton, would require background checks for jobs that put employees in direct contact with residents in a variety of long term care settings, including nursing facilities, home health agencies, hospice care, and assisted living.

Providers would be barred from hiring applicants with convictions for violence, abuse, and other offenses deemed relevant by the state. States could allow a 30-day provisional employment period, while the background check was being

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Bill Supports Background Checks continued from page 2

conducted. AHCA, which has long supported a national background check system for nursing facility applicants and has worked with the National Association of Attorneys General to develop such a system, endorsed the legislation.

“Ensuring that the most capable, honest employees are the ones caring for America’s seniors is the most fundamental criterion for the provision of quality care,” said a statement from Bruce Yarwood, AHCA president and chief executive officer.

Medicaid

New Data Back Full Implementation Of 75 Percent Rule: CMS

A new report from the Centers for Medicare & Medicaid Services (CMS) finds that the number of inpatient rehabilitation facility (IRF) patients with lower-intensity needs has dropped sharply since 2004, when Congress ended a two-year suspension of the 75 percent rule and allowed resumption of restrictions on the type of patients these facilities can treat.

Overall, IRF utilization plummeted 19 percent between 2004 and 2006, with almost the entire decline occurring in five medical and diagnostic areas that CMS says can be more appropriately treated in less costly settings, including skilled nursing facilities (SNFs). These categories—lower extremity joint replacement, cardiac, osteoarthritis, pain syndrome, and miscellaneous—are “associated with conditions that are not generally considered to require the intensive rehabilitation provided by IRFs and can often be more appropriately cared for in other less-intensive settings,” the report said.

SNFs in particular are well-positioned to manage patients with musculoskeletal conditions, with the 2006 introduction of nine new payment categories that “compensate providers more fully for patients with both rehabilitation and medical needs—precisely the patients who may need some level of medical monitoring but do not require the intense level of services provided in an IRF setting,” CMS said.

During the two-year suspension of the 75 percent rule, Medicare IRF admissions for single-joint replacements rose rapidly, while high-intensity admissions deemed appropriate for IRF-level care decreased, the report said. Those trends were reversed once the rule was reinstated on a phased-in basis in mid-2004.

The 75 percent rule is designed to ensure that a high portion of patients cared for by IRFs have high-acuity needs that cannot be met in lower-cost settings. The Medicare payment differential between IRFs and SNFs was about \$500 per patient day in 2004, or \$350 million a year, according to AHCA. To ensure that IRFs provide a commensurate level of care, the 75 percent rule requires that a significant portion of patients be admitted with one of 13 high-acuity diagnoses, such as stroke, spinal cord injury, amputation, brain injury, and neurological disorders. Currently, the rule is being phased in, and the portion of patients that must fall into these categories is 60 percent. Full implementation of the 75 percent threshold is scheduled to take effect in 2008.

The CMS report—brimming with data that shores up the agency’s contention that the rule has had an appropriate and beneficial effect on IRF admissions—comes at time when 187 House members have signed onto legislation that would freeze implementation of the rule at 60 percent. AHCA has joined CMS in opposing the proposal.

“Efforts now under way in Congress to stop or slow this pro-patient, pro-taxpayer statute would turn back the clock on necessary efforts to transform the U.S. health care culture toward one that provides seniors quality care at the lowest, most cost-effective rate,” said Bruce Yarwood, president and chief executive officer of AHCA.

“Attempts to derail full implementation of the Medicare 75 percent rule should be rejected based solely upon what matters most: the facts.”

CMS agrees, stating in its report that *continued on page 4*

Alzheimer’s

Alzheimer’s Treatment Valued In Trillions

Drug therapies that effectively delay the onset of Alzheimer’s disease for up to five years could be worth as much of \$4 trillion in added longevity, productivity, and quality of life, according to a study released by a Washington, D.C.-based coalition, Accelerate Cure/Treatments for Alzheimer’s Disease (ACT-AD).

The study, prepared by researchers at the University of Connecticut and the Center for Medicine in the Public Interest, assigned a dollar value to intangible Alzheimer’s-related losses, using a central component of the United Kingdom’s method of allocating health resources, called the quality-adjusted life year (QALY). The study assumed a QALY value of \$175,000 and concluded that, with 11 million to 16 million Americans predicted to suffer from Alzheimer’s disease by 2050, the benefit of treatments that would delay the disease could be as much as \$1.2 trillion for a one-year delay and \$4 trillion for a five-year delay over the 40-year period 2010 to 2050.

“To add an economic equivalent of improved quality of life to the equation is to approach a fuller and more revealing sense of the value of better treatments for Alzheimer’s disease from the patient’s perspective,” said John Vernon, professor of finance at the University of Connecticut and lead author of the study.

More than 100 Alzheimer’s compounds are in development, and dozens have been submitted to the Food and Drug Administration (FDA) for review, said a statement from ACT-AD. The organization, which is supported by three pharmaceutical firms, wants Alzheimer’s drugs to receive “the same priority review by the FDA as drugs for other life-threatening conditions like cancer and HIV/AIDS,” said Daniel Perry, chair of ACT-AD. “The FDA is working right now to reevaluate their approach to Alzheimer’s drugs, and we believe that the new findings on social value will help to support an argument for rallying the kind of response that the disease demands of all of us,” Perry said in a statement.

OSHA Issues Pandemic Flu Guidance For Health Care Workers

Employers should “plan for rapid vaccination of health care workers” if a vaccine for pandemic influenza becomes available during an outbreak, according to new guidance from the Occupational Safety and Health Administration (OSHA). Providers should also develop a system for documenting the vaccination of workers, as the pandemic virus may require more than one dose for effective protection.

Once the virus emerges, it is expected to take four to six months to develop a matching vaccine. To ensure that workers have the maximum protection, OSHA recommends that employers promote—or even provide—annual seasonal influenza vaccination among staff and volunteers.

Currently, the rate of seasonal vaccination is low among health care workers, OSHA said. In 2003, only 40.1 percent of staff were inoculated, the agency said.

OSHA’s guidance, which reiterates many Department of Health and Human Services recommendations, covers a wide range of issues, including the diagnosis of pandemic flu; compliance with infection control; facility design, engineering, and environmental controls; administrative controls; individual worker protection; facility responsibilities during an alert;

and incorporating pandemic flu into disaster plans.

In the area of personal protective equipment, the agency recommended:

- The use of gloves for “contact with blood and other bodily fluids, including respiratory secretions.” It is not necessary, however, to “double-glove,” OSHA says. Gloves should be discarded after patient care, should never be washed or reused, and “hand hygiene” should be practiced after glove removal.

- The use of gowns when a worker expects that “soiling of clothes or uniform with blood or other bodily fluids, including respiratory secretions, may occur.” Examples of when a gown would be needed include intubation or holding pediatric patients closely.

- The use of goggles or face shields “if sprays or splatters of infectious material are likely.” This includes coming within three feet of a patient who is coughing.

- The use of respiratory protection. OSHA requires that employers provide respirators when they are needed to protect worker health.

The guidance distinguishes between the level of protection offered by surgical masks, which effectively shield against droplet transmission from a sneeze or blood splatter, and respirators, which are needed for protection from airborne particles.

“Surgical masks are not designed to prevent inhalation of airborne contaminants,” the guidance says. OSHA cites studies that show that while multiple layers of surgical masks can reduce the penetration of airborne particles (63 percent reduction of particles for a single mask, 74 percent for two masks, 78 percent for three, and 82 percent for five masks), this is not as effective as a properly fitted N95 respirator, which keeps out 95 percent of infectious particles.

OSHA warned that health care employers and workers can expect a worldwide shortage of respirators if a pandemic occurs and “should not count on obtaining any additional protective equipment not already purchased and stockpiled.”

House Considers Medicare Part D Co-pay For Assisted Living

The National Center for Assisted Living (NCAL) has asked Congress to eliminate Medicare Part D co-pays for dual eligibles—beneficiaries eligible for Medicare and Medicaid—in assisted living and other residential care settings, in a statement submitted to the House Ways and Means subcommittee on health.

Under the Medicare Modernization Act, Congress exempted dual eligibles living in nursing facilities from any co-payments for their Part D prescription drugs. However, dual eligibles in assisted living and residential care facilities must make co-payments for their Part D medications.

Dual eligibles in assisted living are similar to those in nursing facilities. Both have limited incomes and use an average of eight to 10 medications, according to recent studies. Under Part D, co-payments for dual eligibles range from \$1 to \$5.35 per prescription. About 15 percent of the 1 million Americans in assisted living are dual eligibles.

S 1107—the Homes and Community Services Co-payment Equity Act of 2007—would eliminate Part D co-payments for dual eligibles in assisted living, residential care facilities, group homes for people with developmental disabilities, psychiatric health facilities, and mental health rehabilitation centers. Dual-eligible beneficiaries receiving services under home- and community-based waivers in home settings would also be relieved of Part D co-payments under the bill.

New Data Back 75 Percent Rule

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the “ongoing implementation of the 75 percent rule continues to have the desired effect of ensuring that the most appropriate Medicare beneficiaries have access to care in IRFs, while those with lower-acuity cases are increasingly being served in settings that are both less intensive and less costly.”

AHCA Releases Updated Long Term Care Survey Manual

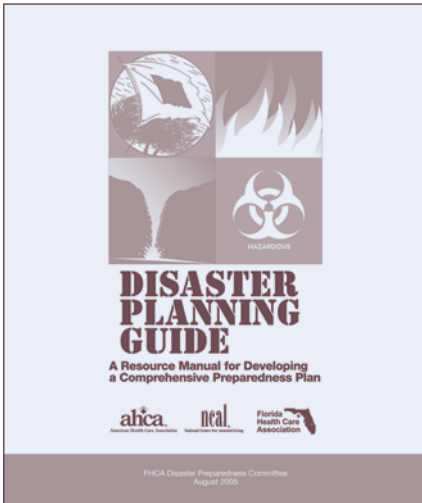
AHCA has updated its Long Term Care Survey manual to include content changes released from CMS through the end of December 2006.

The December 2006 edition includes these changes: F329 Unnecessary Drugs, F334 Influenza and Pneumococcal Immunizations, F425 Pharmacy Services, F428 Drug Regimen, F431 Labeling of Drugs and Biologicals.

The manual is now available in a binder format that includes quarterly updates for a one-year period. The softbound version is also available. Product orders may be placed online at www.AHCApublications.org.

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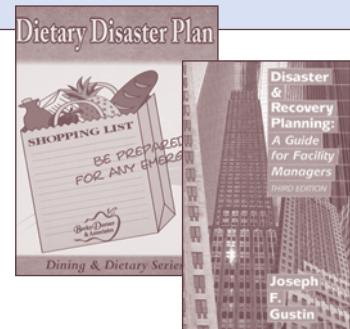
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States Take Different Tacks In Modifying Their Medicaid Programs

■ **States pioneer self-directed care, HCBS as state plan option.** Alabama is the first state to gain approval from the Department of Health and Human Services (HHS) for adding self-directed personal assistance services as a feature of its Medicaid plan. The move relieves the state from “repeated requests for time-limited section 1115 demonstration programs or section 1915(c) waiver programs,” said an HHS statement.

The authority to add self-directed personal care services as a standing benefit derives from the Deficit Reduction Act of 2005, which gave states significant new flexibility to shift benefits that could previously be offered only through waiver programs to permanent status in state Medicaid plans. States must seek approval for the amendment, but once approved, no further permissions are needed.

Alabama’s new benefit will allow Medicaid beneficiaries to direct their own personal care, homemaker,

unskilled respite, and companion services. In addition, participants can hire “legally liable” family members to provide care, HHS said.

Iowa, meanwhile, was the first state to receive federal approval for home- and community-based services (HCBS) as a permanent feature of its Medicaid plan, adding statewide HCBS case management and “habilitation services” at home or in day treatment programs.

■ **Florida scales back Medicaid managed care demonstration.** A statewide Medicaid waiver program that was expected to transform the financing and delivery of long term care in Florida has been significantly diluted in the two years since state lawmakers first approved the initiative. The version of Florida Senior Care, which was recently signed into law by Gov. Charlie Crist, will be limited to a voluntary pilot program in the central part of the state and Miami-Dade area.

Under the original 2005 legislation, enrollment for some of the demonstra-

tion beneficiaries would have been mandatory, and those who did have a choice would have been automatically enrolled unless they opted out, said Tony Marshall, senior director of operations and reimbursement at the Florida Health Care Association. The final program design dropped automatic enrollment. Beneficiaries who want to participate must sign up for the program.

Senior care will still be operated by managed care organizations that negotiate rates for services with providers, but without a mandatory component. Marshall doesn’t expect the program to have a significant presence in the state.

The original legislation required the state to draft and gain HHS approval for the waiver, then return to the legislature for final consideration.

In those intervening two years, the statehouse has changed hands, and the new administration is not as wedded to managed care as a solution to health care problems, Marshall says.

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State Medicaid Spending Growth Slows, Governors Report

Medicaid spending is projected to rise by 5.8 percent next year, according to a report, “The Fiscal Survey of States,” released in June by the National Governors Association and National Association of State Budget Officers.

The anticipated increase for states’ share of expenditures is 7 percent, while the federal share is expected to rise more moderately, by 4.9 percent. Drawn from governors’ fiscal 2008 budget proposals, the projection reflects a slight drop in Medicaid growth from 2007, when spending is expected to increase by 6.6 percent, with state funds rising 8 percent and federal funds growing 6.1 percent, the report said.

Last year, Medicaid growth fell dramatically, to 2.5 percent, due in part to the shift in prescription drug benefits for dual eligibles to the Medicare program. States continue to finance a portion of prescription drug costs by making a pay-

ment to the Medicare trust fund, equivalent to about 5 percent of state Medicaid expenditures.

Despite the slight downturn in projected spending growth, Medicaid accounts for a significant portion—22 percent—of state spending. Overall, health care consumes 32 percent of state budgets, making it the single largest expenditure.

About two-thirds of governors proposed health care coverage expansions as part of their fiscal 2008 budgets. Initiatives ranged from universal coverage to targeted benefits for specific populations. In 22 states, for example, governors directed initiatives to uninsured children. The cost of the expansions, a combined \$18.4 billion, would be funded primarily through the Medicaid and State Children’s Health Insurance programs, supported by various other funding sources, including provider taxes or fees, tobacco taxes, and state general funds, the report said.

Health Reform

Clinton Unveils Three-Part Plan To Lower Health Care Costs

Presidential candidate Sen. Hillary Clinton (D-N.Y.) is rolling out a three-part health reform plan, starting with a proposal to lower health care costs. The other two planks of the proposal, quality and universal coverage, will be unveiled separately at a future date.

“I’ve tangled with this issue before—and I’ve got the scars to show for it,” Clinton said in a recent speech at George Washington University, where she made the announcement with an acknowledgment of her failed effort to advance a massive reform initiative during her husband’s presidency. Clinton said the experience taught her that reform cannot be achieved without the “participation and commitment of health care providers, employers, employees, and other citizens who pay for, depend upon, and actually deliver health care services.”

Since that debacle, health care insurance premiums have almost doubled, rising “four times faster than average wages,” Clinton said. Total health care spending has hit \$2 trillion, or 16 percent of the nation’s gross domestic product (GDP) and is projected to double to \$4 trillion, or 20 percent of GDP, by 2016, she said. To slow the cost spiral, Clinton’s seven-step plan would:

- Launch a national prevention initiative to reduce obesity and chronic illness, such as diabetes. Insurers that participate in federal programs would be required to cover prevention priorities.
- Spur health information technology with a \$3 billion annual investment to help hospitals and physicians adopt technology.
- Improve the management of chronic diseases through care coordination,

drug management, diet and exercise counseling, and other strategies.

- End insurance discrimination against those with costly or pre-existing conditions to spread risk more broadly and reduce administrative costs.
- Create a “best practices” institute to help consumers, providers, and health plans make care choices.
- Constrain excess prescription drug and managed care spending by making it easier for generic competitors to enter the marketplace; allowing Medicare to negotiate lower drug prices; enhancing oversight of drug advertising, marketing “excesses,” and financial relationships with providers; and reducing overpayments to managed care plans.
- Implement “common-sense” medical malpractice reform.

Tort Reform

Bill Would Fund State Tort Reform Demonstrations

Legislation that would provide \$5 million to fund 10 state demonstration projects offering alternatives to the traditional medical tort litigation system has been introduced by Sen. Max Baucus (D-Mont.) and Sen. Mike Enzi (R-Wyo.).

The grants would fund the “development, implementation, and evaluation” of alternatives to dispute resolution involving medical injuries.

Eligible states would be required to allow patient safety and health care quality organizations to collect and analyze dispute-related data that would help reduce medical errors. States would also have to demonstrate how proposed alternatives would enhance the “prompt and fair resolution of disputes;” promote the disclosure of health care errors; improve patient safety by “detecting, analyzing, and reducing medical errors and adverse events;” maintain access to medical liability insurance; and give patients the option of not participating in the alternative program.

The measure is an attempt to shift the debate over tort reform from a long-standing and failed focus on caps for noneconomic damages, Sen. Baucus said in a floor statement on the bill.

Partnership LTC Insurance Won't Yield Significant Savings: GAO Study

State partnership programs, designed to spur the purchase of private long term care insurance, won't produce significant program savings—and may end up adding to Medicaid costs, according to a report from the Government Accountability Office (GAO).

Policies offered through partnership programs relieve policy holders from the usual Medicaid spend-down requirements, allowing them to keep all or part of their personal assets in the event that their private benefits run out and they need to apply for Medicaid eligibility. In addition, the policies are somewhat richer than many offerings in the traditional

marketplace, offering inflation protection and minimum benefits that cover most of the average daily rate in a nursing facility.

GAO examined partnership programs in states that pioneered the plans: California, Connecticut, Indiana, and New York. Launched in the late 1980s, the partnership program ended in 1993 when Congress barred expansion beyond the four founding states.

The Deficit Reduction Act of 2005 lifted the partnership moratorium, and GAO reported that as of February 2007, the Centers for Medicare & Medicaid Services had approved six state plan

amendments for new programs. The revival has raised cost concerns. The Congressional Budget Office projects that new partnerships could boost Medicaid spending by \$86 million between 2006 and 2015.

GAO agreed that the potential exists for heightened costs, as partnership programs give those insured access to Medicaid benefits more quickly.

Furthermore, based on survey data from three of the states and its own financial models, GAO estimated that 80 percent of partnership policy holders would buy other private insurance if the partnership plan was not available.

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