



Long-Term and Post-Acute Care Financing Reform Proposal

Section 1: Reforming and Rationalizing Medicare Post-Acute Care Benefits

Overview. The proposal will reform and rationalize Medicare post-acute care benefits by creating a new system that is focused on patients' post-acute care needs rather than the care setting. The benefit will require a single patient assessment tool to determine care need, administered by care coordinators. The Secretary of Health and Human Services (the "Secretary") shall be required to establish a single, site-neutral payment system. And post-acute care providers will be required to provide a full course of treatment according to the established care plan. The Secretary will be required to implement the new system by 2012.

Affected Providers. The Secretary shall establish new rules for patients to access long-term acute care hospital provider services, inpatient rehabilitation facility services, skilled nursing facility services, and home health services as defined in the Code of Federal Regulations 409.47. The Secretary may also review other services provided to Medicare beneficiaries to determine whether coverage and payment for those services would appropriately fall into the new post-acute care system.

Rule of Construction. Nothing in this section shall be construed as a change in the current law definition of a home for the purposes of delivering home health or other Medicare services to Medicare beneficiaries residing in assisted living facilities.

Maintenance of Current Level of Post-Acute Care Services. The Secretary shall develop a definition of post-acute services for purposes of coverage and payment. The Secretary's revised definition of post-acute care services shall not reduce current benefit levels (rather, it will create a new system for accessing those services). All post-acute care services will include medically necessary services and items to improve the health and functioning of the beneficiary, and must be provided under supervision of appropriate medical staff. Beneficiaries will have access to a range of services that match their care plan in a setting that most appropriately meets their needs.

Definition of Post-Acute Care Provider. The Secretary shall develop core criteria for low acuity and high acuity health care entities providing post-acute care services. The Secretary shall develop additional criteria specific to provider subgroups within each core acuity level. Criteria shall include whether the provider has the appropriate and

necessary plant capacity as well as appropriate clinical capacity. The Secretary shall ensure that all providers under this title meet a minimum set of facility and patient level criteria. The Secretary may also develop criteria that providers may voluntarily meet in order to admit higher acuity or a specified subset of patients. The Secretary shall specify these criteria to ensure that the overall mix of patients is appropriate for the designated acuity level of the provider. The Secretary may develop new Medicare provider conditions of participation to reflect the minimum and voluntary sets of certification criteria.

Development of a National Patient Assessment Instrument. The Secretary shall develop a common, uniform patient assessment instrument that uses patient information to assess level of care need of the beneficiary for post-acute care services. (Legislative note: this proposal encourages the Secretary to carry out its current program to develop a uniform instrument, within the parameters described below. The Secretary's plans to develop an instrument for demonstration purposes by 2008 may be adjusted to reflect the provisions below.)

Definition of Patient Assessment Instrument. The new patient assessment instrument shall measure patient functioning, predict patient care needs and resource use, and provide information for developing a care plan. Currently, multiple patient assessment instruments are used by providers in treating Medicare beneficiaries, and in developing the uniform assessment instrument the Secretary may include relevant and validated measures from current instruments as well as other measures the Secretary deems appropriate. The instrument shall provide information on the appropriate care plan and predict resource utilization in order to also provide information useful for reimbursement. The instrument shall be Internet-based and will, to the extent feasible, incorporate data from other electronically-based health information relating to the patient, including records related to the acute care episode, pharmaceutical records, and other patient records. The instrument will be designed to replace, over time, the existing site-specific instruments. The Secretary shall be required to update the assessment instrument on a periodic basis, no less than every three years.

Use of National Patient Assessment Instrument for Patient Placement. For coverage of services under this benefit, those services must be designed to improve patient functioning and health as defined by the patient assessment instrument. The patient assessment instrument shall be administered by a care coordinator prior to the initiation of care to determine the appropriate placement of the patient with a post-acute care provider.

Patients seeking admission to a post-acute care setting without prior hospitalization will receive an initial evaluation by a care coordinator employed by the post-acute care provider, using the assessment instrument to determine that the post-acute care placement is appropriate to the patient's level of care needs and to refer the patient to the appropriate setting.

Beneficiaries wishing to receive care at an alternative care setting than that which was determined using the patient assessment instrument may appeal the decision or may pay the difference between the Medicare allowable reimbursement at the assessment instrument-designated setting and the charge at the alternative setting.

Use of Patient Assessment Instrument in Care Plan Development, Continued Stay, and Discharge Decision Making. The Secretary shall develop a schedule for administering the national patient assessment instrument in the post-acute care setting. The administration of the tool in the post-acute care setting will provide the information necessary for care plan development and for continued stay and discharge decision-making.

Use of Patient Assessment Instrument in Development of Quality Indicators. The Secretary shall use the national patient assessment instrument to develop and collect data on post-acute care quality indicators and to measure outcomes.

Use of Patient Assessment Instrument in Payment Calculation. The Secretary shall use the national patient assessment instrument to collect information necessary to determine a patient's clinical classification for the purposes of calculating post-acute care payment rates.

Patient Care Plan. The Secretary shall ensure that each Medicare beneficiary receiving post-acute care services do so under a physician plan of care. The plan of care shall include medically necessary services needed for health and functioning improvement and describe which kinds of providers and/or post-acute care settings shall provide the care. The care plan should also consider the patient's psycho-social and spiritual needs.

Care Coordinator. The care coordinator function shall be performed by the provider with the most direct responsibility for the patient. If the beneficiary is an inpatient at a short-term acute care hospital and is being discharged to a post-acute care provider, the care coordinator function shall be carried out by the acute care hospital for the purposes of identifying post-acute care placement. Upon transfer to a post-acute care setting, the care coordinator function shall transfer to the post-acute care provider. The care coordinator function may include:

- Conducting the initial patient assessment and facilitating placement of the beneficiary with a post-acute care provider, including compiling a list of providers in the discharging hospital's service area,
- Developing and evaluating the plan of care,
- Assuring implementation of the plan of care, and
- Other activities that the Secretary deems appropriate

Integrity of Assessment Process. The Secretary shall create guidelines for the administration of the national assessment tool to ensure the accuracy of data and appropriateness of post-acute care placement. In addition, the Secretary shall periodically assess the implementation of these guidelines and the resulting placement of patients using the assessment tool. The Secretary shall also ensure that the guidelines result in the clinically appropriate placement of post-acute care patients.

Ensuring Quality Care. The Secretary shall create, in consultation with the post-acute care Technical Advisory Group as described below, risk-adjusted quality of care measures to be reported to CMS by all post-acute care providers. The quality of care measures may be derived from the elements of the patient assessment instrument. The Secretary may develop additional incentives to ensure quality of care and reward high performing and improving care providers.

Minimum Stay in Acute Care Facility. Because the uniform patient assessment instrument will determine care need, the three-day prior hospitalization requirement for the Skilled Nursing Facility benefit in Medicare shall be eliminated. Nothing in this provision shall be construed to eliminate the payment for acute hospital discharges subject to the transfer rule.

Payment for Post-Acute Care Services. The Secretary shall develop a post-acute prospective payment system that pays primarily based on the condition, needs and characteristics of the patient regardless of the post-acute care setting in which the patient receives care. The prospective payment system shall adjust for patient acuity, resource use, diagnoses, comorbidities, age and other factors the Secretary deems appropriate. The Secretary shall develop other mechanisms in the payment system, consistent with existing payment systems, including: an annual update for price inflation, adjustments for variation in area wages, annual updates to payment weights for the classification groups for patient acuity.

Study of Payment for Acute Care Services. The Secretary shall study current acute care payments, including payments for hospital inpatient services in light of changes to post-acute payment system changes. In particular, the study shall examine:

- Alternatives to the transfer rule policy
- The appropriate DRG base payment rate for acute episodes in relation to the new unified post-acute care system

Study of Appropriate Payment Methodology for Post-Acute Care Services. The Secretary shall study alternative methodologies for payment for post-acute care services. Such study may examine the appropriateness of payment based on an episode of care and based on a per diem methodology, and may include other payment options.

Beneficiary Cost-Sharing. The Secretary shall specify beneficiary cost-sharing so that beneficiaries will be responsible for the same amount of cost-sharing for which they are

currently responsible for post-acute care services, or the Secretary may determine amounts actuarially equivalent to the amount of cost-sharing beneficiaries would pay under the applicable benefit previous to enactment. For purposes of reducing incentives to seek a particular care setting or service, the Secretary may consider tiered co-insurance schedules for post-acute care services.

Technical Advisory Group. The Secretary shall establish a post-acute care Technical Advisory Group comprised of representatives of the post-acute care industry (as defined in Paragraph 2 of this section), physicians, and beneficiary groups. The Secretary shall routinely consult with the group on a regular basis, no less than quarterly, on the implementation of the requirements of this section.

Refinement of the Medicare Payment Advisory Commission (MedPAC) Activities. Beginning upon enactment, MedPAC shall take into account payment adequacy for post-acute care and LTC providers regardless of payer source in formulating its recommendations to Congress regarding Medicare payments for post-acute care and LTC services. Beginning upon enactment, the Comptroller General of the General Accountability Office shall appoint members to MedPAC to ensure that at least one member is a representative of or has expertise in skilled nursing facilities and one member is a representative of or has expertise in post-acute care.

Conforming Amendments to Medicare Advantage Program

- **Cost Sharing.** Medicare Advantage (MA) plans shall offer an actuarial equivalent post-acute care benefit as specified in Section 1. Plans may alter beneficiary cost-sharing for post-acute care benefits subject to the Secretary's approval that cost-sharing changes do not interfere with a site-neutral payment system as specified in Title I. The Secretary also must certify that cost-sharing changes do not discriminate against any beneficiaries with chronic or other disease conditions.
- **Networks.** The Secretary shall require MA plans to certify that they have an adequate network of post-acute care providers, including post-acute care providers as defined in Paragraph 2 of this Section. Before the implementation of the federal LTC program, MA plans that offer the federal LTC program will be required to certify that they have an adequate network of LTC providers, including assisted living facilities.
- **Quality.** The Secretary shall develop performance standards and quality metrics for the delivery of post-acute care and LTC benefits by MA plans. The Secretary may adjust payment in a budget-neutral manner to reward achieving quality metrics as specified by the Secretary.
- **Prompt Payment and Recertification.** MA plans will be required to provide payment to post-acute care providers within the same timeframe as the Medicare Part A and B programs. MA plans must also establish procedures to re-certify

patient stays promptly using the national patient assessment instrument. The Secretary shall define prompt recertification that would apply for both traditional fee-for-service beneficiaries and MA enrollees. MA plans would be required to comply with uniform standard. Care coordinators, as defined below, would have the responsibility for all re-certifications.

- **Care Coordination.** By plan year 2010, MA plans will be required to certify that they have sufficient number of care coordinators to develop a post-acute care plan for all enrollees with a care need. By 2017, MA plans will be required to have a sufficient number of care coordinators to develop a post-acute care and LTC plan as specified in Section 3 for all enrollees with a care need.
- **Any Willing Provider.** MA plans will be required to contract with any PAC provider specified in this Section or LTC provider specified in Section 3 that agrees to their payment rates and contract terms.
- **Rule of Construction.** Nothing in this section shall be construed as requiring a Medicare beneficiary to enroll in a MA plan to receive post-acute care or LTC benefits as specified in Section 3.

Section 2: Requirement for Individuals to Plan for Future LTC Costs

Overview: Beginning by 2017, the proposal will create new incentives for individuals to plan and save for their future LTC costs (referred to as the “personal responsibility requirement”). In order to participate in a new federal catastrophic long-term care program (described in Section 3), individuals will be required to either purchase a LTC insurance policy or dedicate funds into qualifying LTC savings vehicles dedicated for future LTC costs. The base coverage requirement would be \$100,000 (in 2007 dollars) with higher-income beneficiaries dedicating a greater amount and lower-income beneficiaries exempted from or qualifying for a reduced personal responsibility requirement. In order to create new opportunities for privately financing LTC, the federal government will make improvements to LTC insurance products and develop and improve other financial savings products, as described in Section 4.

Establishment of Personal Responsibility Amount. Upon enrollment in Medicare Part A at age 65, individuals will have their personal responsibility requirement calculated. To enroll in the LTC benefit as described in Section 3, the beneficiary will select an approved LTC financing vehicle through which to fulfill the requirement.

Individuals will have six months from the time of Medicare eligibility to be certified as participating in the federal LTC program. After the initial six month enrollment period but before age 72, individuals will be permitted to enroll but the SSA will assess a greater personal responsibility amount to reflect the actuarially higher costs of delayed enrollment. The Secretary will develop a methodology to calculate the actuarial higher

costs. Individuals who do not enroll before age of 72 will be eligible only for the Limited Benefit described in Section 3.

Recertification of Personal Responsibility Amount on Periodic Basis. Each beneficiary's personal responsibility requirement shall be reviewed on a periodic basis to ensure that any significant upward or downward change in income and assets is reflected in the requirement. The Secretary will specify the conditions under which the required amount may be adjusted downward. The Secretary shall not consider a transfer of assets or income as a qualifying condition for a downward adjustment to the required amount. Beneficiaries shall have the right to request a recertification if their financial circumstances change due to a life-changing event.

Incentives for Early Planning Individuals may contribute to a pre-approved LTC financing vehicle at any age and may have their personal responsibility amount established and their participation in the program certified by the Social Security Administration (SSA) as early as age 55. Early certification shall result in an actuarially determined discount on the personal responsibility requirement upon turning age 65 as determined by the Secretary.

Amount of Personal Responsibility Requirement. The base requirement will be established at \$100,000 for average-income beneficiaries in 2007. The amount will be adjusted on a sliding-scale basis by income and assets as defined below. The requirement will be \$0 for individuals who are determined to be low-income. The maximum requirement will initially be set at \$150,000 for higher-income beneficiaries. The values will be indexed on an annual basis for the annual increase in costs of long-term care services, as determined by the Secretary. The Secretary will be required to establish an adjustment process to lower the personal requirement amount for those who are above age 70 when the new program is implemented.

An average income beneficiary is defined as someone with average earnings over the past ten years equal to the national median income for an individual or couple. Current law assets requirements will apply, except that the value of an individual's home over \$50,000 will be included. The values will be indexed on an annual basis for inflation.

Low-Income Definition. Low-income individuals will be exempt from the personal responsibility requirement and will be immediately eligible for federal LTC benefits upon having a certified LTC need. A low-income beneficiary is defined as an individual with incomes less than 150% of poverty and with countable assets below the SSI thresholds (\$2,000 for an individual, \$3,000 for a couple). The equity value of an individual's home over \$50,000 would be included as a countable asset. Current law assets transfer rules would apply. The values will be indexed on an annual basis for inflation.

Administration of Personal Responsibility Requirement. The SSA will administer the requirement and verify that participating individuals have met their requirement. The SSA will determine the amount of each individual's (or couple's) requirement. It also will establish procedures to re-determine the requirement on a periodic basis (no less than

every three years). It also will establish procedures for individuals to appeal their determinations and to have interim recalculations for life-changing situations (e.g., death of a spouse, divorce, etc.). The IRS will be required to provide all such necessary information to the SSA to implement these requirements.

Use of Funds in Personal Responsibility Account. An enrollee financing LTC services under this benefit must use the certified LTC funding source for payment for those services and must qualify as having a LTC need as defined in Section 3. Individuals having a LTC need must expend all funds from their account before becoming eligible for federal LTC benefits. The Secretary will establish procedures to verify personal responsibility certifications and to track to expenditures made from their accounts. In order to ensure that funds are spent appropriately, the Secretary will establish usual and customary rates of LTC services associated with a LTC level of need, including for when individuals elect to hire family, friends, or neighbors under the community benefit option specified in Section 3. Amounts that individuals pay above these usual and customary rates will not be counted towards meeting the personal responsibility requirement.

Section 3: Creation of New Federal Long-Term Care Benefit

Overview. The proposal will create a new federal long-term care benefit, transferring the responsibility from state Medicaid programs to the federal government. Individuals eligible for Medicare and who exhaust their personal responsibility requirement will be eligible for the federal benefit as will be all aged Medicare low-income beneficiaries who meet income and assets requirements (similar to the eligibility requirements under Medicaid today). Individuals will become eligible for LTC benefits when they have a certified long-term care need. States will be required to maintain their current budget levels of effort, paying the federal government a monthly payment, similar to the state requirement under Medicare Part D. The federal benefit will begin no later than 2017, providing the Secretary sufficient time to establish new LTC financing vehicles, to promote the new personal responsibility requirement, and to give individuals sufficient time to plan for new requirement.

Enrollment. Individuals, upon enrolling in Medicare Part A, shall elect to enroll in the federal LTC benefit through local SSA offices. As described in Section 2, upon becoming eligible for Medicare, individuals will have a six-month window to decide whether to enroll. And as such, the LTC federal benefit will be voluntary. Aged dual eligible beneficiaries will be automatically presumed eligible for the benefit. Beneficiaries will be able to disenroll at any time; beneficiaries also will be disenrolled for failing to comply with the personal responsibility requirement, although such decisions may be appealed for reasons of hardship or other life-changing situations. Individuals may also appeal to re-enroll if they have involuntarily disenrolled, for reasons such as cognitive impairment. As noted in Section 2, Medicare beneficiaries enrolling after the six month window but before age 72 will be eligible to enroll but will be assessed a higher, actuarially-determined personal responsibility requirement amount.

Determination of Eligibility for Services Under the Benefit. Individuals who qualify through the assessment process as having a long-term care need will be eligible for benefits. The Secretary shall define the qualifying levels of disability (physical or mental) and cognitive impairment. Beneficiaries will not be eligible for federal benefits until they have been certified as having a qualifying disability or cognitive impairment.

The Secretary shall periodically review and make changes to these eligibility criteria, no later than every three years. Beneficiaries who have exhausted their personal responsibility requirement and are transferring to the federal benefit will be assigned to the benefit level that most closely matches the benefits they have been receiving unless they have been re-assessed as having a different level of need.

Administration. LTC benefits will be administered by administrative contractors or by Medicare Advantage (MA) plans, similar to how Medicare benefits are administered today. The Secretary shall establish a separate benchmark for MA plans that choose to offer the new LTC benefit but MA plans will not be required to provide the LTC benefit. Administrative contractors and MA plans will be required to establish tracking and reporting requirements for when beneficiaries begin accessing their personal responsibility funds for LTC services and when they have exhausted their funds and become eligible for federal funding. Administrative contractors and MA plans will also work with providers to ensure that care coordinators provide timely assessments of individual's level of need, set benefit levels appropriately and develop care plans. Administrative contractors and MA plans will work with providers to ensure continuity of post-acute and long-term care through the assessment process. The Secretary shall establish processes to track cash accounts and ensure appropriate use of funds.

Level of Benefits and Care Plan Development. The Secretary shall develop a uniform LTC assessment module as part of the National Patient Assessment Instrument described in Section 1. Using the LTC assessment tool, which shall take into account the beneficiary's level of informal support, a care coordinator shall establish the beneficiary's level of need and assign the beneficiary to the most appropriate benefit level as set by the Secretary. The care coordinator shall use the LTC assessment tool to establish a plan of care.

Integrity of Assessment Process. The Secretary shall create guidelines for the administration of the national assessment tool to ensure the accuracy of data and appropriateness of long-term care placement. In addition, the Secretary shall assess the implementation of these guidelines and the resulting placement of patients using the assessment tool. The Secretary shall also ensure that the guidelines result in the clinically appropriate placement of long-term care patients.

Benefits. Beneficiaries, other than those eligible for low-income benefits, may only receive benefits after they have exhausted the personal responsibility requirement of \$100,000 for the average income participant. Beneficiaries may choose to receive their benefit in three ways: 1) cash benefits to pay for community-based benefits such as informal care services, adult day care centers, home health aide services, homemaker

services, and other services determined appropriate by the Secretary; 2) directly from a nursing facility (NF) or assisted living facility (ALF), which will submit claims for delivered services to the administrative contractors; or 3) enrollment in an MA plan that provides the LTC benefit and arranges for services.

The assigned care level will determine benefit level. For beneficiaries choosing the cash payment option, the Secretary shall establish a cash payment amount associated with the daily costs of community-based care for each of the care levels, adjusted for regional variations in the cost of care, and increased on an annual basis to account for annual increases in the costs of care.

The Secretary shall establish separate payment rates for NFs and ALFs. The payment rates for ALFs will pertain only to the long-term care service component and not the housing component. Rates for both NFs and ALFs shall be applied uniformly across the country and shall include a base payment that will be adjusted for the care level of the resident and regional variations in the cost of care. The payment shall be increased on an annual basis to account for annual increases in the costs of care.

Rule of Construction. Nothing in this section shall prevent states from funding the housing component provided in ALFs using state-only funds.

Special Provisions for Cash Benefits. The Secretary shall contract with fiscal agents to administer cash benefits. The fiscal agents will ensure appropriate use of cash funds under guidelines developed by the Secretary. Beneficiaries qualifying for NF or ALF care but choosing community-based care will not receive cash benefits equal to the facility payment rate.

Limited Benefits Those That Do Not Comply With Personal Responsibility Requirement. Beneficiaries who do not participate in the personal responsibility requirement shall be eligible for limited LTC if they have an assessed need for LTC. The Limited Benefit will be a narrowed set of benefit options to be defined by the Secretary. To qualify for limited benefits, individuals must spend-down their income to 100 percent of poverty and their assets down to low-income levels described above. Qualifying expenses are the same as in current Medicaid (paying for medical, LTC expenses). Current law Medicaid asset transfer rules apply, as do set-asides for spouses living in the community. In order to qualify for the Limited Benefit, individuals must convert any home value above \$50,000 into a financial product that would pay for LTC (i.e., reverse mortgage). If a spouse is living in the home, the Secretary may place a lien on the home.

State Maintenance of Effort. States will continue to pay for the costs of LTC services for full beneficiaries. The amount of each state's payment shall approximate the expenditures of its own funds that the state would make if it continued to pay for LTC through Medicaid on behalf of dual eligibles. The payments will be calculated according to the following formula:

A State's monthly payment will be 1/12 the product of multiplying the following two factors: (1) the amount the State spends, per capita, on aged dual eligibles in 2015 for Medicaid LTC services, trended to 2017 based on factors from National Health Expenditures estimates; and (2) the number of dual eligibles enrolled in that State.

Section 4: Creation of New Financial Products to Promote Personal Responsibility in the Funding of Long-Term Care

Overview. To assist individuals to plan for their future LTC costs and to help them meet their personal responsibility requirement, the federal government will foster the development of improved or new financial products for funding LTC. These will include improved reverse mortgages to lower their costs; federally-endorsed LTC insurance products; and new LTC savings and accounts. In addition the Secretary will be required to conduct far-sweeping media campaigns to promote these products in advance of implementation of the new federal benefit.

Creation of Federally-Endorsed LTC Insurance Products. The Secretary shall commission the National Association of Insurance Commissioners (NAIC) to develop model regulations for LTC insurance products. The regulations shall address the following areas for improvement: a) promoting consumer choice of products; b) free look period; c) guaranteed issue and renewability; d) prohibiting exclusion of coverage disease or chronic condition; e) premium stability; f) permitting policy holders to upgrade or downgrade their policy; g) inflation protection; h) nonforfeiture of benefits; i.) portability, j.) grandfathering of existing policies. The NAIC shall also develop model requirements for the training of licensed agents in selling these products. LTC policies that comply with the model regulations and other requirements deemed appropriate by the Secretary shall be considered federally-endorsed. LTC plans must also provide coverage that is actuarially equivalent to an individual's (or couple's) personal responsibility requirement.

Improving Reverse Mortgages. The Secretary, in coordination with the Secretary of Housing and Urban Development, shall recommend ways to make reverse mortgages more attractive and more affordable to individuals. For individuals that use a reverse mortgage to fulfill their personal responsibility requirement, the Secretary shall ensure that reverse mortgage funds are only expended for qualified LTC services. The recommendations may include capping administrative expenses and creating a federally-chartered agency to package reverse mortgages into tradable securities (similar to FannieMae). The Secretary shall provide legislative recommendations to Congress three years before implementation of the new federal benefit for any necessary improvements to reverse mortgages.

Establishing LTC Savings Accounts. The IRS shall issue regulations by 2010 to establish LTC savings accounts in which individuals and couples can deposit funds for future LTC costs. Deposits shall receive the same tax treatment as deposits to IRA accounts. Individuals can purchase a LTC saving account at any time, and if they have a sufficient balance may apply the balance towards meeting their personal responsibility

requirement. Funds may only be expended for long term care expenses if an individual is certified to have a LTC need. The IRS shall establish a penalty structure if funds are expended for any other purpose. Funds expended for other purposes may disqualify individuals from the federal LTC benefit if they do not have an alternative source of funding for their personal responsibility requirement.

Public Outreach Campaign. For each of the three years prior, the Secretary will be required to conduct a public outreach campaign to promote the new and improved LTC financing products and to enable individuals (and couples) sufficient time to plan for the personal responsibility requirement and enrollment in the federal LTC benefit. The campaign shall include print, radio, television, and internet media. The Secretary shall conduct the activities in coordination with the SSA, state Medicaid programs, aging agencies, and state health insurance programs. The Secretary shall ensure that appropriate notices are included in Social Security statements, federal tax forms, and the annual “Medicare and You” handbook. Funds equaling \$300 million shall be appropriated for this outreach campaign.

The Secretary shall establish performance measures for states in promoting the federal program. The Secretary may reduce, by an amount to be determined by the Secretary, individual state maintenance of effort requirements for states achieving measurable success.

In conjunction with the IRS, the Secretary shall develop recommendations to Congress for a tax incentive to encourage employers to promote and educate employees about the federal program and the long-term care financing options.