STATEMENT

OF

RESPONSE TO THE SENATE FINANCE COMMITTEE'S POLICY OPTIONS PAPER

ON

EXPANDING HEALTH CARE COVERAGE:

PROPOSALS TO PROVIDE AFFORDABLE COVERAGE TO ALL AMERICANS

MAY 22, 2009

The American Health Care Association and National Center for Assisted Living (AHCA/ NCAL), which represents nearly 11,000 dedicated long term care providers, commend Chairman Max Baucus (D-MT) and Ranking Member Charles Grassley (R-IA) for pursuing a thoughtful, deliberative, inclusive approach in seeking to transform our health care delivery system. AHCA/NCAL shares the Committee's goals of improving patient care and reducing health care costs, and offers these comments and our assistance in achieving much-need health care reform in 2009.

The Senate Finance Committee's *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans* policy options document contains a variety of important initiatives designed to ensure that all Americans can access affordable, quality acute care coverage regardless of age, health status, or medical history.

We applaud the Committee's efforts to ensure that the health insurance market functions effectively; that competition among health insurance plans consider quality of care in addition to cost of care; and that consumers be able to easily understand and compare health insurance coverage best suited to their needs. AHCA/NCAL also commends the Senate for insisting that health insurance be affordable, so that individuals, who have a personal responsibility to have health coverage, can purchase it, and so those who cannot afford coverage will continue to have access to public programs. Shoring up our nation's Medicaid system is especially important as two of every three long term care patients and residents rely on Medicaid for the care and services they need.

Certainly, we agree that reforming acute care is an important, necessary step to achieve the kind of savings that would allow for expansion of health care coverage to the millions of uninsured and

underinsured in the United States. Given that long term care accounts for better than one-third of Medicaid expenditures, we believe that broadening health care reform to include long term care is appropriate. It is especially interesting to note that many of the underlying principles regarding acute care reform that are discussed in the Senate Finance Committee policy options paper echo proposals outlined in AHCA/NCAL's long term care financing reform proposal, which we developed with our colleagues at the Alliance for Quality Nursing Home Care and with the analytical and policy expertise of Avalere Health LLC. Even so, given the considerable attention to Medicaid found in *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans* – not to mention the significance of Medicaid as the largest payor of long term care and services – we are perplexed as to why Medicaid beneficiaries' long term care needs seem to be overlooked in the myriad options under consideration. We would be pleased to share our proposal with the members of this Committee and reiterate the importance of including long term care reform as part of any overall health care reform package.

We are pleased that the Senate Finance Committee is looking at options for expanding Medicaid coverage, which many of the Members of this Committee have championed for years. Eliminating barriers and simplifying Medicaid enrollment and retention are important goals, which we believe should extend to long term and post-acute care. We also support the Committee's efforts to ensure transparency as Medicaid demonstration waivers and State Plan Amendments are developed.

Members of the Senate – and of this Committee in particular – were instrumental in ensuring that states struggling with the current economic downturn received a Federal Medical Assistance Percentage (FMAP) increase as part of the *American Recovery & Reinvestment Act of 2009*. Because FMAP changes have such an immediate impact on low-income beneficiaries, we are pleased that *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans* includes discussion of FMAP, and would encourage the Committee to consider conducting a state impact analysis to understand the potential effects of any changes to the FMAP formula.

AHCA/NCAL is very pleased that *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans* includes a section on "Long Term Care Services and Supports." While we support the expansion of home- and community-based services, we would ask that the Committee be mindful that for many beneficiaries, facility care remains a critically important choice in selecting the most appropriate care setting for an individual's needs.

As with our previous comments regarding the Senate Finance Committee's exhaustive list of policy options, we have focused our comments on those provisions that pertain most to long term care, and include a reference to both the topic and section as outlined in the Committee's policy options paper, *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans.*

Sections I & II   Insurance Market Reforms & Making Coverage Affordable

Although long term care is not a major focus of the Senate Finance Committee's *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans,* AHCA/NCAL shares many of the underlying principles expressed in the policy options document and agree with many of the recommendations offered.

Americans spend more than $250 billion annually on long term and post-acute care. Most exhaust their own resources before receiving any government support, causing many to struggle to bridge the growing gap between need and service—valued at an additional $350 billion each year. These funding inadequacies shift costs to Medicare and put increased strain on the already under-funded Medicaid system. This enormous strain is felt by America's seniors, their families, and taxpayers alike. AHCA/NCAL and the Alliance for Quality Nursing Home Care's reform proposal referenced above would afford consumers greater choice and access to high-quality, streamlined affordable care. We believe that our proposal – which relies on evidence-based care practices, where payment is driven by the individual's care needs, not the care setting – would reduce federal costs. In fact, according to Avalere Health LLC, which provided analytical and policy expertise in developing our proposal, estimates that our proposed changes would result in real savings in federal expenditures and save taxpayers $81 billion over 10 years – offsetting the $46 billion it would cost to launch a new federal long term care program that would address Americans' long term care needs and return an overall 10-year savings of $35 billion.

By reducing federal costs, shifting Medicaid coverage for the elderly to a federal program, and encouraging private savings for long term care, our proposal also would expand benefits available to all elderly Americans. We especially want to call the Committee's attention to the following basic elements that are common to options in the *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans* and our proposed reforms:

- *Insurance market reforms that make purchase of insurance more viable for more Americans –*
  The Committee wisely focuses on options that will make health insurance for acute care more affordable and viable for Americans. Likewise, our long term care reform proposal recommends the creation of federally-endorsed, long term care insurance products that would ensure the reliability and value of long term care insurance.

- *A personal responsibility requirement –*
  We commend the Committee for including "personal responsibility" in *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans.* Personal responsibility for future expenses represents a cornerstone for both the Committee's proposed options and our long term care reform proposal. We agree with the Senate Finance Committee's assessment that while it is incumbent upon government to make affordable, high-quality, and meaningful health care coverage available, it is the individual's responsibility to take advantage of those options in planning for his or her health care needs.

- *Access to long term care services and supports in the home and community based setting* –
  AHCA/NCAL agrees with the Committee that it is important to have greater consumer choice for all Americans regarding where and how they receive long term care and supports. Under our reform proposal, consumers may opt for cash benefits that can pay for community-based care, informal care services, adult day care centers, home health aid and other services, or consumers may choose to receive care in a skilled nursing or assisted living facility.

- *Coordination of Medicare & Medicaid benefits for dual eligible beneficiaries* –
  AHCA/NCAL agrees that coordination for beneficiaries, who are eligible for both Medicare and Medicaid – also known as dual eligible beneficiaries – is important as these individuals often represent our nation's most vulnerable citizens. Establishing an Office of Coordination for Dually Eligible Beneficiaries may prove helpful; however, we also recommend that the Committee consider how creating a unified post-acute and long term care benefit could contribute to more effective Medicare and Medicaid coordination as outlined in our reform proposal.

Because so many of the concepts outlined in *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans* echo those found in AHCA/NCAL's reform proposal, we believe that including post-acute and long term care in the Committee's final recommendations for health care reform policies is both reasonable and feasible.

Section IV Role of Public Programs
Medicaid Coverage

The Senate Finance Committee's *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans* includes a number of thoughtful, innovative options to reform health care and to improve the Medicaid program. AHCA/NCAL is supportive of such efforts; however, we are concerned that very few of the proposed options address elderly Americans' long term care needs. Without expanding the policy options to include much-needed finance and other long term care reforms, which will impact this vulnerable population, we believe that the Committee will fall short of its laudable goal of ensuring health care coverage for the most needy among us.

We, as a nation, spend in excess of $225 billion annually on a long term care system that puts enormous strain on individuals and their families and does not provide consistent, effective, and efficient care. We lack a viable plan for ensuring that seniors and their families can secure and fund appropriate long term care and services. Federal and state budgets – the *de facto* payors for long term care – are not equipped to absorb the runaway healthcare costs associated with aging Baby Boomers. Clearly, the long term care paradigm we have today is fundamentally unsustainable.

As we described earlier, many components of the Committee's proposal to reform acute care are at the very core of reforming post-acute and long term care as well. Again, our post-acute and long term care finance reform proposal – which echoes options under consideration by this Committee – is estimated to reduce federal spending by $35 billion during the program's first ten years between

2012 and 2021. AHCA/NCAL urges the Committee to explore the details in our proposal as it considers expanding policy options to include post-acute and long term care.

Section IV Role of Public Programs

Medicaid Coverage

Medicaid Program Payments

AHCA/NCAL applauds the Committee's consideration of an option that would require Medicaid payments to all providers not fall below a given percentage of Medicare reimbursement rates for the same or similar services. We agree, in concept, with this type of approach as it would help to ensure that providers are paid at adequate levels. Still, we are concerned by the suggestion in *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans* that would set a threshold for Medicaid payments at 80 percent of Medicare rates since such an amount could potentially prove inadequate for appropriate cost coverage. We would welcome the opportunity to learn more about this threshold recommendation and discuss this approach with the Committee in an effort to further develop an approach that pays adequately and achieves appropriate cost coverage.

AHCA/NCAL has given serious consideration as to how policymakers can deal with the perpetual shortfall in Medicaid reimbursement and has developed a proposal, which we would like the Committee to take under consideration. There exist uniform Federal laws and regulations governing nursing facility care for Medicaid recipients, but the scope of state Medicaid nursing facility reimbursement programs varies from state to state without regard to the uniform federal service requirements. Independent studies show that the vast majority of nursing facilities receive Medicaid payments that are significantly less than the costs of providing mandated services. To ensure the scope and quality of services mandated by Congress are available for Medicaid nursing facility residents, Congress should adopt a uniform standard for states to use in setting Medicaid nursing facility payments.

Outline of AHCA/NCAL Proposal

- Each state is required to adopt a funding mechanism based on actual Medicaid cost reports filed not less than two years prior to the year in which such findings are made.
- Medicaid payment rates should be set at a level to ensure that nursing facility payments in the aggregate are at least 95 percent of the aggregate Medicaid costs of all nursing facilities in each respective state.
- Each year thereafter, states adjust such payments at a percentage amount not less than the annual percentage increase in the Medicare Skilled Nursing Facility Market Basket Index (SNF Market Basket Index) – or its successor index – from the SNF Market Basket Index published for the year next proceeding the year of adjustment. States shall be permitted to set payments based on annual cost reports provided the payments are not less than 95 percent of the aggregate Medicaid costs of all nursing facilities in each respective state derived from cost report

filed for the year next preceding the year of adjustment inflated to the rate year by the SNF Market Basket Index. Notwithstanding the foregoing, each state shall adjust its nursing facility Medicaid payment rates not less than every three years using a formula in compliance with this act so that the aggregate adjusted nursing facility Medicaid payment rate is at least 95 percent of the aggregate Medicaid costs of all of that state's Medicaid nursing facilities as derived from nursing facility Medicaid cost reports filed not more than two years prior to the year of adjustment.

- In setting the base rate, and adjusting the rate each subsequent year, Medicaid nursing facility payments shall not be diminished due to state budget constraints, and each state shall maintain the scope of its nursing facility program as it existed in the year prior to the enactment of this legislation, except to comply with new mandates contained in newly enacted federal laws and regulations.

- The failure of a state to follow these requirements shall be subject to a right of action brought by affected nursing facility providers and shall not require an exhaustion of administrative remedies.

- A state found in violation of this act may be subject to loss of Federal Medical Assistance Percentage (FMAP) allocated for its nursing facility Medicaid program.

We would be pleased to work with the Committee to "fine tune" this proposal that seeks to address the seemingly never ending problem associated with Medicaid underfunding.

Section IV Role of Public Programs

Medicaid Coverage

Expanding Coverage Through Medicaid

AHCA/NCAL supports the Senate Finance Committee's efforts to ensure that all Americans have access to health insurance coverage. We believe that the cost of expanding coverage should be carefully distributed across society, and in ways that are as least disruptive as possible. *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans* contains a variety of proposals for expanding Medicaid and coverage through the Children's Health Insurance Program (CHIP). In considering these options, we urge the Committee to take care not to overburden state budgets, which are already struggling with the current economic crisis. Again, we offer this observation as a caution, knowing that many of the members of this Committee were fully behind passage of the enhanced Medicaid funding in the most recent economic stimulus package, which has been so critical to helping states to stabilize existing health care coverage.

Section IV Role of Public Programs

Other Improvements to Medicaid

Enrollment & Retention Simplification

AHCA/NCAL supports the Committee's proposal to eliminate barriers for efficiency in Medicaid eligibility determination and enrollment processes. Long term care providers understand these barriers, which can negatively impact both the nursing facility and the individual applying for Medicaid coverage. As such, we recommend that the Committee extend this proposal to include not only acute care services, but also post-acute and long term care services.

Current federal regulations require state Medicaid agencies to determine eligibility within 90 days for people applying for Medicaid based on a disability, and within 45 days for all other applicants.[1] The time standards in the federal regulations must cover the period from the date of application to the date the agency mails its notice of eligibility to the applicant. State Medicaid agencies must not use the time standards as a waiting period before determining eligibility or as a reason for denying eligibility; however, there are no penalties for states that do not comply with federal time standards.

According to an AHCA survey, most Medicaid eligibility determinations for nursing facility applicants were being made between 90 and 180 days, with some states taking more than 200 days to determine a patient/resident's Medicaid eligibility. Such delays in determining Medicaid eligibility for nursing facility applicants has many negative implications for providers, who must deal with the financial impact that affects cash flow, bad debt, and increased accounts receivable.

From the survey, AHCA has identified several possible solutions or innovative strategies currently employed in some states that could minimize the effect of delayed Medicaid eligibility determinations. We have outlined some of these strategies for the Committee's consideration in evaluating additional options for states. These strategies include:

Automated application submission and review procedures
Many states currently have automated processes for submitting and reviewing Medicaid applications, which may include online or web-based application processing. Automated processes can increase efficiency of submitting and reviewing Medicaid applications. Some automated systems centralize the application screening process, which also can minimize the amount of time it takes to determine eligibility for Medicaid.

Application reviewers located on-site at the facility
Some states may have a Medicaid application screener collocated on-site at the nursing facility. The use of this strategy can vary across states. Some facilities provide office space on-site for a screener, and in some cases, also pay the salary of the screener or share the cost of the screener with the state. Other states do not collocate the screener at a nursing facility, but instead assign a dedicated screener to review Medicaid applications from one nursing facility or a small group of facilities.

[1] See 42 CFR 435.911

Increased staffing & better staff training in application review offices
The survey also revealed high staff turnover in Medicaid offices performing application reviews as a major barrier to timely eligibility determinations. Likewise, poor staff training was cited as an impediment to the application review process. Staff turnover can be a major problem in areas with a high volume of Medicaid applications, such as urban areas. Additionally, recruitment of staff to review Medicaid applications can be difficult in rural areas, where there is a shortage of professionals with the required training and skills.

Centralized application processing
Medicaid eligibility reviews in many states are decentralized and performed in county offices, which can impede timely Medicaid eligibility determinations. Centralized application processing may expedite eligibility determinations. For example, the efficiency of eligibility determinations may be improved in a centralized state agency or through an online or web-based application system.

Presumptive eligibility
Some states maintain presumed eligibility programs for Medicaid applicants seeking home and community-based services (HCBS), which allows these applicants to be presumed eligible for Medicaid payment. There are no states that have a similar program for nursing facility services. AHCA believes presumptive eligibility should also be available to applicants seeking nursing facility services.

Section IV Role of Public Programs

Other Improvements to Medicaid

Transparency in Medicaid & CHIP Section 1115 Waivers
Section 1115 Demonstration Waivers
Medicaid State Plan Amendments (SPA) and Covered Benefits

AHCA/NCAL commends the Committee for including two options that would impose statutory requirements to 1) improve transparency in the development, implementation, and evaluation of certain Medicaid section 1115 demonstration programs, and 2) improve transparency related to the Medicaid State Plan Amendment (SPA) approval process for proposals that limit benefits. When 1115 waivers or SPAs involve far-reaching, complex policy changes that could have a significant impact on beneficiaries, it is imperative that there be opportunities for thorough and transparent reviews by all stakeholders.

The need for such statutory requirements was made clear in 2007 when the Government Accountability Office (GAO) reported that the Centers for Medicare & Medicaid Services (CMS) does not follow its own policies that require a notice and comment period to allow people who may be affected by a demonstration project to learn about the project and to provide input. The GAO has repeatedly recommended that Congress take action to ensure that individuals affected by waivers have an adequate opportunity to review and comment on proposals before they are approved.

The two proposals included in *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans* represent the kind of action needed to ensure meaningful opportunity for public feedback on proposals that impact eligibility, enrollment, benefits, cost-sharing, or financing.

Section IV Role of Public Programs

Other Improvements to Medicaid

Changes to the FMAP Formula

AHCA/NCAL endorses, in concept, the Committee's proposal to change the Federal Medical Assistance Percentage (FMAP) formula to include data on a state's poverty level and to base the per capita income measure on a two-year average rather than a three-year average. Before implementing such a change, we encourage the Committee to consider conducting and releasing a state impact analysis that would allow the public to fully understand the effects such changes to the FMAP formula would have.

Section IV Role of Public Programs

Other Improvements to Medicaid

Automatic Countercyclical Stabilizer

AHCA/NCAL fully endorses the Committee's proposal to create a mechanism that would provide an automatic increase in the Medicaid Federal Medical Assistance Percentage (FMAP) formula during periods of national economic downturn. The current economic downturn demonstrates the importance of such a mechanism in creating stability for states dealing with increased Medicaid enrollment. Equally important, such a mechanism would offer stability to care providers who are struggling to meet the demands of increasing numbers of Medicaid patients and residents. We also ask that the Committee include Maintenance of Effort (MOE) language regarding state share spending and provider payment rates in any final proposal for an automatic countercyclical stabilizer.

The *American Recovery & Reinvestment Act (ARRA)* did not include MOE language on Medicaid funding levels nor provider payment rates. Now, we are finding that many states are shifting state share spending to fill funding gaps in other areas outside the Medicaid program, while reducing or freezing payment rates to nursing facility providers. As a result, nursing facility providers continue to struggle to provide quality care under grossly inadequate Medicaid reimbursement rates. To be sure, the problem of Medicaid's chronic under-funding of nursing facilities existed well before the national economic downturn. A 2008 report by Eljay, LLC, found that the average shortfall in Medicaid reimbursement for nursing facility care to be $12.48 per Medicaid patient day – roughly $13 less per patient per day than the cost of providing care to that patient. The total estimated Medicaid shortfall for skilled nursing care amounts to nearly $4.2 billion annually.

The current national economic downturn has been incredibly challenging for all Americans. AHCA applauds Congress and the Administration for rising to the challenge to create a measure of stability for state Medicaid funding with the *ARRA*. Even so, as illustrated above, more needs to be done to deal with future Medicaid funding crises resulting from economic downturns. Maintenance of effort language on Medicaid funding levels and provider payment rates would greatly enhance the ability of both Medicaid programs and Medicaid providers to deal with the enrollment challenges that are inevitable during such periods of economic downturn.

Section IV Role of Public Programs

Other Improvements to Medicaid

Dual Eligibles

AHCA/NCAL applauds the Senate Finance Committee's emphasis on coordinating care for dual eligibles and its proposal to establish an office to coordinate care for this vulnerable population. We also believe that there are several ways that Congress can act immediately to better coordinate care for this population, including enactment the *Home & Community Services Copayment Equity Act of 2009 (S. 534)*. This legislation would improve the care for dual eligibles who receive both Medicaid in home and community based settings (HCBS) and Medicare Part D drug coverage by providing copayment parity with dual eligibles living in facilities. Current law creates an unlevel playing field because dual eligibles in HCBS must pay Part D copayments while those cared for in institutional settings such as nursing homes do not. Many cannot afford the copayments and may forgo certain needed medications.

Section VII Long Term Care Services & Supports

Long Term Care Services & Supports

Medicaid Home & Community Based Services (HCBS) Waivers & the Medicaid HCBS State Plan Option

AHCA/NCAL congratulates the Senate Finance Committee for including some long term care reforms in its policy options. As an overarching principle, we believe that all Americans should have access to the full range of the long term care services and supports including those provided at home, in assisted living facilities, in nursing homes, and in other settings based upon the individual's needs and choice. While we commend the Committee for its efforts to expand access to home and community based settings (HCBS), we encourage the Committee to ensure that Americans have access to the entire range of services and supports, including facility-based services and supports, as determined by needs and preferences.

Section VII Long Term Care Services & Supports

Long Term Care Services & Supports

Functional Assessment Tool for Post-Acute Long Term Care

AHCA/NCAL supports the development and use of the Continuity Assessment Record and Evaluation (CARE) tool to measure the health and functional status of Medicare acute care patients. The CARE tool is reflective of AHCA/NCAL and the Alliance for Quality Nursing Home Care post-acute and long term care reform proposal call for a post-acute care prospective payment system based on the patient's condition and needs, rather than on the site of service.

Our reform proposal includes a post-acute care site neutral payment system that would use a common data collection tool in order to place individuals in the appropriate care setting. The completeness and consistency of this information would make placement decisions more efficient, more cost-effective, and less confusing to the beneficiary. We again reiterate the importance of having payment systems that are seamless to the beneficiary because they are based on diagnostic-specific conditions rather than the site-specific method currently used.

According to the Centers for Medicare & Medicaid Services' (CMS') current timeline, the ten market sites for the CARE tool are expected to collect data through 2009. Data analysis is planned for 2010, so that CMS may deliver its report on the CARE tool to Congress by mid-2011. AHCA/NCAL is hopeful that CMS can maintain this schedule and are eager to work with the agency in developing a timeline for implement of the assessment tool.

Conclusion

Next year will mark 30 years since the Bipartisan Commission on Comprehensive Health Care (aka the Pepper Commission) released its report calling on Congress to make long term care reform a priority. It is time to make good on that call to action.

We applaud Chairman Baucus, Ranking Member Grassley, and members of this Committee, who have already contributed to a thoughtful discussion about how to reform our very complex health care system. AHCA/NCAL stands ready to work with Congress and the Administration in achieving meaningful reform that ensures all Americans have access to person-centered, cost-effective, quality health care.