

Summary of Issues Affecting Long Term Care in America's Healthy Future Act of 2009, S. 1796 October 22, 2009

On October 19, 2009, Senate Finance Committee Chairman Max Baucus (D-MT) introduced the *America's Healthy Future Act of 2009* (S. 1796) to reflect the bill reported out of the Committee. S. 1796 is generally reflective of the concepts set forth in the Chairman's Mark, as modified in Committee, which was previously reported on in the October 8, 2009 edition of Capitol Connection. Note that this document highlights only those issues expected specifically to impact skilled nursing facilities (SNFs) and assisted living (AL). This version is an update to the previously issued document dated October 12, 2009.

Medicare

Skilled Nursing Facility (SNF) Market Basket Productivity Adjustment (Section 3401)

Beginning in Fiscal Year (FY) 2012, the Skilled Nursing Facility (SNF) market basket will be reduced by a productivity adjustment equal to the 10 year moving average of changes in annual economy-wide private non-farm business multifactor productivity as projected by the Secretary. The Congressional Budget Office (CBO) estimates the impact in FY 2012 to be \$300 million with ten-year impact of \$14.6 billion.

AHCA believes that the Senate Finance Committee has moved in the right direction. However, we remain concerned about the impact of the cuts. Our view is that the productivity adjustments should be postponed until 2013.

Therapy Caps (Section 3103)

The current exceptions process for Medicare Part B outpatient therapy services is extended through December 31, 2011.

AHCA strongly supports the extension of the exceptions process until a permanent resolution of this problem can be achieved.

National Pilot Program on Payment Bundling (Section 3023)

By January 1, 2013, the Secretary will implement a national, voluntary pilot program to coordinate care for Medicare beneficiaries not covered under Part C during an entire episode of care for eight conditions to be specified by the Secretary. Services to be included in the bundle are: acute care inpatient hospital services; physician services delivered inside and outside of the acute care hospital setting; outpatient hospital services, including emergency department visits; services associated with acute care hospital readmissions; post acute care services including home health, skilled nursing, inpatient rehabilitation, long term care hospital; and other services that the Secretary determines appropriate. The Secretary must take the following into account: whether the specified conditions include both chronic and acute; whether there is a mix of surgical and medical conditions; whether a condition allows providers and suppliers to improve the quality of care while reducing total expenditures; whether there is significant variation in the number of readmissions, the amount of expenditures for post-acute care; whether a condition "has high volume and high post acute care expenditures; and which conditions the Secretary

decides are most “amenable to bundling across the spectrum of care given practice patterns”. The episode of care established in the pilot program would start three days prior to a qualifying admission to the hospital and span the length of the hospital stay and 30 days following the patient discharge, unless the Secretary determines another timeframe is more appropriate for purposes of the pilot. The Secretary must decide which patient assessment tool as well as which quality measures, for both episodes of care and post acute care, are to be used in the pilot. The post-acute care quality measures must be site neutral. The Secretary would develop policies to ensure the traditional fee-for-service program provides payment for post-acute care (PAC) services in the appropriate setting for those patients who require continued PAC services after the 30th day following the discharge. The pilot must be conducted for five years, and if it improves patient outcomes, reduces costs and improves efficiency, then the Secretary would be required to submit a plan to Congress to make the program permanent. In the meantime, the Secretary has the authority to extend the pilot if it is expected that either quality of care will improve without increasing expenditures or that expenditures will decline without reducing quality of patient care. Any Medicare provider, including hospitals, physician groups, or post-acute entities interested in assuming responsibility for the bundled payment would be able to apply to participate in the pilot program. Eligible entities would receive the bundled payment for each patient served, regardless of whether patient receives certain levels of physician or post acute care. If there is overlap between the pilot and the section on readmissions, the condition in question will be exempt from any payment adjustment otherwise required. Quality measures for process, outcome, and structure must be established for: episodes of care; functional status improvement; readmission rates; rate of return to the community; rates of emergency room visits after a qualifying hospitalization; efficiency; patientcenteredness; patient perception of care; underprovision of care; and others as deemed appropriate by the Secretary. An independent evaluation of the pilot must be done considering quality measures, health outcomes; access to care; and financial outcomes.

While AHCA has concerns about post-acute bundling and would prefer to see a demonstration project as opposed to a pilot since a pilot can more easily become permanent, we believe that the requirement in the bill that the Secretary submit a plan to Congress before it becomes permanent is appropriate.

Value-Based Purchasing (Section 3006)

By October 1, 2011, the HHS Secretary is required to submit to Congress a Medicare value-based purchasing implementation plan for Skilled Nursing Facilities. The plan must consider the following: (1) the development, selection, and modification process of measures to the extent feasible and practical of all dimensions of quality and efficiency; (2) the reporting, collection, and validation of quality data; (3) the structure of proposed value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments; (4) methods for publicly disclosing performance information on performance; and (5) any other issues as determined by the Secretary. In developing each plan, the Secretary would be required to consult with relevant stakeholders and take into consideration experiences with demonstrations that are relevant to value-based purchasing in SNFs.

AHCA continues to support value-based purchasing and looks forward to continuing our efforts to work with HHS to develop such a plan.

Independent Medicare Commission (Section 3403)

An independent Medicare Commission would be established, comprised of 15 members appointed by the President and confirmed by the Senate, to develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries. Qualifications for members of the Commission would be similar to the qualifications required for members of the Medicare Payment Advisory Commission (MedPAC). Members would serve six-year, staggered terms and would continue to serve until replaced. The Commission is tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts.

Congress would take up the recommendations under an expedited procedure. Congress would have the option of modifying the recommendations of the Commission but would have to achieve the same level of savings. If Congress fails to act on the recommendations of the Commission, the recommendations would go into effect by an established deadline.

MedPAC would continue to exist in its current form as an advisory body to Congress.

AHCA continues to have reservations about the Medicare Commission. We believe that Congress should continue its role to be involved in the decision-making process about Medicare payment policies as opposed to approving or disapproving an entire package of recommendations. We also believe that both the Medicare Commission and MedPAC must take Medicaid payments into consideration before making any recommendations to Congress, given that in effect Medicare payments subsidize the artificially low Medicaid rates.

National Strategy to Improve Health Care Quality (Section 3011)

The HHS Secretary is directed to create a national quality improvement strategy addressing the following priorities: delivery of health care services, patient health outcomes, and population health. This strategy must be submitted to Congress for review by December 31, 2010. The Secretary is tasked with identifying national priorities and must consider: high-cost chronic diseases; patient safety improvements and medical errors, preventable hospital admissions and readmissions, health care-associated infections; health outcomes, efficiency, patient-centeredness of health care; health care disparities; health care delivery; quality, efficiency and outcomes measures; data aggregation techniques; payment policy quality and efficiency improvements; and other areas as determined appropriate by the Secretary. Stakeholder recommendations must be taken into account, including post-acute providers, through a consensus process. Once the priorities are established, a strategic plan must be created taking into account the following: coordination among agencies to minimize duplication and utilization of common quality measures; agency-specific strategic plans; a regular status reporting process; establishment of annual benchmarks for each participating agency; strategies to align incentives among public and private payors for quality and patient safety efforts; incorporating quality improvement and measures for HIT. A website must be created so that the public may access the details of the strategy.

Quality Measure Development (Section 3013)

As part of the National Strategy to Improve Health Care Quality, the term quality measure is defined as “a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.” At least every three years, the Secretary must do an analysis to identify where there

are no existing quality measures or where existing ones need improvement, updating, or expansion. The results of the analysis must be posted on a publicly available website. Grants will be awarded to improve, update, or expand quality measures with priority given to those assessing health outcomes, functional status, coordination across episodes of care and transitions; meaningful use of HIT; safety, effectiveness, patientcenteredness, appropriateness and timeliness of care; efficiency of care; health disparities; patient satisfaction; and other areas as determined by the Secretary.

Quality Measure Endorsement (Section 3014)

Grants will be awarded to a consensus-based entity to make annual recommendations to the Secretary on the aforementioned national priorities and identify gaps. In the process of making these recommendations in a transparent way, the entity must convene voluntary “multi-stakeholder groups”, which must involve representatives from a broad range of interested parties including; post acute providers, health care professionals, hospitals, quality alliances, health plans, labor, employers and public purchasers, licensing and credentialing organizations; government agencies and consumer representatives. These multi-stakeholder groups will provide guidance on the selection of quality measures and must provide information to the Secretary by February 1 of each year beginning in 2012, such as whether the group has endorsed a particular quality measure. A pre-rulemaking process also will be established for these activities. The Secretary takes the endorsement of such measures under advisement, and may only use a non-endorsed measure in certain circumstances and by following a specific procedure, which includes publication of the rationale in the *Federal Register*. The Secretary must also disseminate these quality measures so that they may be used in workforce programs, training curricula, and payment programs among others.

CMS Innovation Center (Section 3021)

A new Innovation Center would be created within the Centers for Medicaid and Medicare Services (CMS). This new office will examine different payment structures and methodologies to facilitate patient-centered care, increase quality, and reduce the growth rate of Medicare spending. Each evaluation must look at the following elements: (1) coordination of health care services across treatment settings; (2) reduction of preventable hospitalizations; (3) prevention of hospital readmissions; (4) reduction of emergency room visits; (5) improvement in quality and health outcomes; (6) improvement in the efficiency of care; (7) reduction in the cost of health care services covered under this title; and (8) achievement of beneficiary and family-caregiver satisfaction. The center is directed to evaluate a number of topics including the improvement of post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospital, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge. These evaluations are not required to be budget neutral. Outside stakeholders must be consulted.

Independence at Home Pilot (Section 3024)

The bill would create a pilot program to test payment incentive and service delivery models that utilize physicians and nurse practitioners to provide home based primary care to patients with certain specified chronic conditions who are at risk for repeated hospitalizations. The bill would require that the payment system save at least five percent of otherwise projected Medicare spending for these patients, and provides economic incentives for providers who achieve savings beyond the five percent.

Community Based Transition Program (Section 3026)

The bill would require the Secretary to establish a community-based Care Transition Program under which hospitals with high readmission rates would partner with community-based organizations capable of providing transition services. The program would target high-risk Medicare beneficiaries. Hospitals and community-based organizations would submit an application demonstrating their ability to provide interventions to high-risk beneficiaries to reduce readmissions.

Medicaid

Medicaid Bundled Payments Demonstration Project (Section 1673)

A Medicaid bundled payment demonstration project would be established in no more than eight states to begin on October 1, 2011. Services included would encompass acute care hospital, concurrent physician, and post acute care services. Hospitals would receive a single bundled payment from Medicaid for such services.

Changes to the Medicaid and CHIP Payment and Access Commission (MACPAC) (Section 1681)

In FY 2010, MACPAC is to receive \$11 million in funding, \$9 million from Medicaid funds and \$2 million from CHIP. The proposal expands MACPAC's mission to include assessment of adult services in Medicaid, including dual eligibles. Issues to be examined by MACPAC include payments, access to services, quality of care, and interactions with Medicare and Medicaid. The bill also requires MACPAC to consult regularly with MedPAC and other stakeholders such as states.

Medicaid Reimbursement for Health Care Acquired Conditions (Section 1672)

As of July 1, 2011, Medicaid would no longer provide payments to states for services related to health care acquired conditions (HCACs). The HCAC definition under Medicaid would be consistent with the Medicare definition, but will be expanded to include conditions acquired in facilities other than hospitals. Differences between the Medicare and Medicaid programs, and their beneficiaries, would also be considered in the HCACs definition, as would current state practices.

Medicaid Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliations (Section 5102)

Individuals or entities are temporarily excluded from participating in Medicaid if the entity has unpaid overpayments. This exclusion extends to affiliated entities under management, control, or ownership of entities that are excluded from participation.

AHCA/NCAL believes this is already covered by provisions in the current exclusion law, specifically Section 1128 of the Social Security Act. This provision appears to be redundant and unnecessary.

Mandatory State Use of National Correct Coding Initiative (Section 5108)

Medicaid claims filed on or after October 1, 2010 will be subject to compatible methodologies of the National Correct Coding Initiative (NCCI) currently administered by CMS. The current program is designed to promote correct coding methodologies and to control improper coding leading to inappropriate payment in Medicare Part B claims. This new initiative would apply these same principles to Medicaid claims.

Nursing Home Transparency

Required Disclosure of Ownership and Additional Disclosable Parties (Section 4201)

The bill requires SNF/NFs to disclose information on their organizational structures as well as information on officers, directors, trustees, or managing partners, including names, titles, and start date of service. The bill requires disclosure of owners of a whole or part interest in any mortgage, deed or other obligation exceeding 5 percent of a facility's total property/assets.

Additional disclosable parties include entities that provide policies or procedures for any of the operations of the facility, provide financial or cash management services, or provide management or administrative services, management or clinical consulting services, or accounting or financial services to the facility. However, the provision was amended by the Chairman to exclude a requirement for facilities to disclose parties that lend funds or provide financial guarantees of any amount to facilities.

S. 1796 requires a facility to make all disclosable parties' information available to the public upon request and update the information as necessary to reflect changes. Facilities are required to certify to the Secretary and the Inspector General that the information submitted upon request is "accurate and current" and the Secretary must develop a standardized format for the information within two years of date of enactment.

While AHCA appreciates that the bill will not require the disclosure of companies that lend money to facilities, we request that the bill be modified to restrict dramatically the language mandating inclusion of information for so-called "related parties." This change would ensure that nursing homes do not have to report every possible vendor, including landscapers and companies that distribute payroll checks to employees.

AHCA believes that it is appropriate to disclose parties that have operational control over the facility and those who are directly responsible for various aspects of patient care; however, because we are relying on third parties for the accuracy of this data, we believe that facilities should only be required to provide information that is current and complete to the best of their knowledge.

Accountability Requirements for SNFs/NFs (Section 4202)

Compliance Program

The bill requires nursing facility/skilled nursing facility have a compliance and ethics program in operation 36 months after enactment of the concept paper. The compliance/ethics program must be effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care.

The bill also establishes a Quality Assurance and Performance Improvement Program. The Secretary is directed to establish standards relating to quality assurance and performance improvement and provide technical assistance on best practices to meet standards.

With respect to the mandatory compliance and ethics program, AHCA believes that the bill should be amended to require the HHS Secretary to develop specific elements that consider the size of the organization, including allowing organizations with fewer than five facilities to have more streamlined compliance programs. This is consistent with the Office of Inspector General's Supplemental Compliance Program Guidance for Nursing Facilities.

With respect to the Quality Assurance and Performance Improvement Program, AHCA believes that the bill should be amended to clarify that the expanded provisions would not change existing law prohibiting the Secretary or a State from requiring disclosure of QAPI committee records as prohibited under the Social Security Act.

Nursing Home Compare Medicare Website (Section 4203)

The legislation requires Secretary to ensure that information provided for comparison of nursing homes be posted on the Nursing Home Compare website in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable. The website must also include summary information on the number, type, severity and outcome adjudicated instances of criminal violations by a facility or the employees of a facility that were committed inside the facility and the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

The bill would also require that additional information on the Special Focus Facility Program be posted on the Nursing Home Compare website. States must also maintain a consumer oriented website providing info on SNF/NFs in the state including State inspection reports, facilities plan of correction, and any other info that State or Secretary considers useful to the public. The

In reviewing and modifying the website, the Secretary must now consult with State long-term care ombudsman programs, consumer advocacy groups, and provider stakeholder groups.

AHCA believes that the bill should require that all information posted on Nursing Home Compare be updated in a timely fashion. AHCA opposes the requirement that additional information on the Special Focus Facility Program be posted on Nursing Home Compare website. Including Special Focus Facility Program information on Nursing Home Compare would be extremely cumbersome and difficult for a consumer to understand and digest. For consumer advocates, this information is already available in other places on the CMS Web site.

AHCA appreciates the potential to participate in review of the website for modifications.

Reporting of expenditures (Section 4204)

The bill would require SNF/NFs to report expenditures separately for direct care services, indirect care services, capital assets, and administrative costs on cost reports for cost reporting periods beginning on or after two years after date of enactment.

Standardized Complaint Form (Section 4205)

The bill requires the Secretary to develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program.

AHCA urges that any new forms and processes be integrated with current requirements to eliminate duplication that will add administrative cost and more importantly create confusion for those filing complaints.

GAO Study and Report on Five-Star Quality Rating System (Section 4207)

The bill directs the Comptroller General to conduct a study of the CMS 5-Star system. The study will evaluate how the system is being implemented, and problems associated with the system, and how the system may be improved. The Comptroller must issue a report of the study's findings to Congress 2 years after enactment of this bill.

AHCA supports a study of CMS's 5-Star Quality Rating Program and report to Congress and the Secretary on potential improvements to the program.

Civil Money Penalties (CMPs) (Section 4211)

The legislation states that Secretary may reduce civil money penalties (CMPs) in the case where a facility self-reports and promptly corrects a deficiency within 10 days. The maximum percentage of the reduction not specified. Furthermore, reductions would not be made for self-reported deficiencies citing an immediate jeopardy or actual harm violation.

Thirty days after imposition of civil penalty, the bill gives the facility an opportunity to participate in independent formal dispute resolution, but this opportunity does not affect the responsibility of the State survey agency for making final recommendations for penalties.

The Secretary would have the authority to place CMPs in an escrow account following completion of the informal dispute resolution process, or the date that is 90 days after the date of the imposition of the CMP.

The Secretary would be authorized to use a portion of collected CMPs to fund activities that benefit residents. Such funds would also be used for facility improvement initiatives approved by the Secretary, including joint training of facility staff and surveyors as well as technical assistance for facilities implementing quality assurance programs.

AHCA supports the concept of reduced CMPs for self-reporting of deficiencies and believes that that a portion of collected CMPs should fund activities that benefit residents.

National Independent Monitor Pilot Program (Section 4212)

The bill requires HHS Secretary along with the Office of the Inspector General to establish a pilot program to develop, test, and implement use of independent monitoring program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities. Chains would be responsible for a portion of the costs associated with appointment of independent monitors.

In addition to these requirements, the bill also includes new processes and procedures for notification of facility closures, dementia and abuse prevention training, and requirements for a

government study and report on training required for certified nurse aides and supervisory staff. The bill also calls for the Comptroller General to conduct study on financial status, resident care and performance of SNFs and NFs including an examination of ownership and control interests and affiliated parties of facility.

AHCA believes that the bill should be modified to establish the National Independent Monitor Pilot Program as a demonstration project in order to give Congress a chance to assess the program's effectiveness.

Notification of Facility Closure (Section 4213)

The bill imposes sanctions for a facility's failure to comply with the Facility Closure Notification requirements, including CMPs of \$1 million as well as possible exclusion from participating in any federal health care program.

AHCA opposes the penalties for failure to comply with this section.

National Demonstration Project on Cultural Change and Use of Information Technology (Section 4214)

The bill requires the Secretary to conduct two demonstration projects, one for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care. The demonstration projects will be implemented no less than 1 year after the enactment of the bill. The Secretary will award one or more grants to facility-based settings for the development of best practices

AHCA supports the use of information technology in nursing facilities.

Fraud, Waste and Abuse

Provider Screening (Section 5001)

The bill would require that the Secretary screen all providers and suppliers before granting Medicare, Medicaid, and CHIP billing privileges and at time of revalidation. At a minimum all providers and suppliers would be subject to licensure checks. Certain groups of providers and suppliers would be subject to additional screening measures according to risk, as defined by the Secretary. The additional types of screening measures could include: submission of fingerprints, criminal background checks, multistate data base inquiries, and random or unannounced site visits. The screening requirement would begin one year from the date of enactment.

An application fee of \$350 would be imposed on providers and suppliers to cover the costs of screening in 2010; the Secretary is authorized to increase that amount by the Consumer Price Index for subsequent years. Current providers could be subject to a discounted screening fee of \$250 if they pay it within 12 months of enactment.

States failing to create effective screening programs would be subjected to a financial penalty through a reduction in their Federal Medical Assistance Percentage (FMAP). A hardship

exception to the fee would be permitted, as would waiver of the fee for Medicaid providers for whom the state can demonstrate the fee would impede beneficiary access to care.

Nationwide Program for Background Checks (Section 4301)

The bill also includes the entire text of the *Patient Safety and Abuse Prevention Act* (S. 631) which will expand the current pilot background program for those with direct patient access nationwide. A federal match to state funding for this program is provided. This amendment would require the Secretary to establish a nationwide program for national and State background checks on direct patient access employees of certain long-term care (LTC) facilities or providers and provide Federal matching funds to States to conduct these activities. States that enter into an agreement with the Secretary would be responsible for monitoring compliance with the requirements of the nationwide program and have specified compliance procedures in place. The HHS Inspector General would be required to conduct an evaluation of the nationwide program and submit a report to Congress no later than 180 days after completion of the national program in FY 2012.

LTC providers (including assisted living/residential care providers) that participate in either the Medicare or Medicaid programs would be required to obtain state and national criminal history and other background checks on their prospective employees through such means as the Secretary determines appropriate. To conduct these checks, states would utilize a search of state-based abuse and neglect registries and specified state and federal databases and records, including a fingerprint check. There is a 60-day grace period during which newly hired staff may be given provisional employment, pending the completion of the criminal background check.

AHCA/NCAL is concerned that implementation of the program will result in additional fees for providers and thereby increased costs. AHCA believes the bill language should be amended to clarify that long term care facilities and providers will not incur the costs associated with the implementation of this program. Given recent Medicare and Medicaid funding cuts, facilities simply cannot be expected to bear the cost of an unfunded mandate to comply with this new program. In addition, it is unclear at this time whether facilities that are private pay only will have access to the background check program.

Disclosure Requirements (Section 5001)

The bill would also impose new disclosure requirements on providers and suppliers enrolling in Medicare. Applicants would be required to disclose affiliations with any enrolled entity that has uncollected Medicare or Medicaid debt. The Secretary would be authorized to deny enrollment in Medicare if these affiliations pose an undue risk to the program.

Complete One Program Integrity System Integrator “One PI” Integrated Data Repository (Section 5002)

The bill would require CMS to complete development of a centralized data repository, known as “One PI”. The “One PI” would expand existing program integrity data sources and expand data sharing and data matching across Federal health care claims and payment data (including HHS, the Social Security Administration, the Departments of Veterans Affairs (VA), the Department of Defense (DOD), and the Department of Justice (DOJ)). In addition to including all claims and payment data for Medicare and Medicaid, the “One PI” would enable existing and new data sources to be integrated, such as: (1) quality-of-care under fee for service, managed care, and

waivers, (2) Medicaid encounter data, (3) health plan performance, (4) ownership, control, and business relationships, (5) survey and certification; (6) resident/patient neglect or abuse, (7) adverse actions, (8) site visits, (9) penalties and settlements, and (10) data on results from other program monitoring.

The “One PI” would be accompanied by additional authority for the HHS Inspector General (OIG) and DOJ to use these data, including secondary data sources, to identify and investigate potential fraud and abuse. CMS would provide technical assistance to users of the “One PI”. New civil monetary penalties would be imposed for the intentional submission of erroneous data to the “One PI”. Additionally, states that fail to report encounter data could be subject to a reduction in their Federal financial participation (FFP) under Medicaid.

This allows the federal government to look at Medicare and Medicaid data together and it would be greatly beneficial for providers to have this same information.

Expanded Provider Databases (Section 5003)

Under the bill, existing provider databases (HIPDB, NPDB, and LEIE) would be expanded and consolidated with a national patient abuse/neglect registry into a centralized sanctions data system. This data system would include information on providers in Medicare and all state Medicaid programs.

Provider Compliance and Penalties (Section 5002)

In the bill, Medicare and Medicaid providers and suppliers would be required to implement compliance programs as a Condition of Participation. The Secretary of HHS, in consultation with HHS OIG and CMS, would establish core elements for inclusion in a compliance program. Increased authority would be provided allowing for suspensions of payment during creditable investigations of fraud; and new procedures for disclosure and repayment of overpayments. Further, the 60 days providers and suppliers have to repay Medicare overpayments would be modified to either 60 days after the date on which the overpayment was made or the date the corresponding cost report is due. Providers and suppliers would be required to repay any Medicare or Medicaid overpayment identified through an internal compliance audit.

In addition, the existing civil monetary penalty (CMP) law would be amended in several instances to increase penalties and extend use of CMPs.

Program Sanctions (Section 5002)

Intermediate sanctions and program safeguards would be established to provide greater flexibility to CMS and law enforcement to address problems. For example, administrative remedies, as defined by the Secretary to be commensurate with the offense or conspiracy, would be established for knowing participation by a beneficiary in a health care fraud scheme.

Medicare Provider Self-Disclosure Protocol (Section 5009)

The Secretary would be required to establish, within 180 days, a mechanism for providers to disclose voluntarily specific information regarding actual and potential violations of the physician self-referral law. The mechanism would be similar to the Provider Self-Disclosure Protocol operated by the HHS OIG and would apply to any violation of the physician self-referral law and violations of the anti-kickback statute of less than \$50,000. The mechanism would be available

to all health care providers and would not be limited to a particular industry, specialty, or service. The mechanism would also offer an incentive to encourage providers to participate, such as a damage calculation near the lower-end of the statutory spectrum. To ensure successful participation, the Secretary would have the authority to create disclosure requirements similar to those set forth by the HHS OIG in an April 15, 2008 open letter to health care providers. Finally, the mechanism would include an information sharing strategy to apply to the HHS OIG and the DOJ.

The Secretary would not be required to resolve all matters disclosed in this manner. However, the Secretary would be required to work closely with providers that come forward in good faith seeking a resolution. Neither the HHS OIG nor the DOJ would be precluded from opening an investigation into a provider while the disclosure protocol is being implemented. Any resolution entered into by the Secretary and the provider would not be binding on the DOJ or other Federal or state agency.

Waivers From Program Exclusion (Section 5101)

The bill would clarify that hardship waivers of an HHS OIG exclusion can be based on hardship imposed on beneficiaries of any Federal health care program, rather than just beneficiaries of Medicare Part A or B, as it the case in current law.

Recovery Audit Contractors (Section 5011)

Medicare Parts C and D as well as Medicaid would be included in the Recovery Audit Contractors (RACs) Program, which collects and identifies underpayments and overpayments currently for Medicare Parts A and B.

Tort Reform (Section 3701)

The bill would express the Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. In addition, it states that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system.

AHCA strongly supports tort reform and while we support a Sense of the Senate resolution, we urge the Senate to consider stronger tort reforms in the context of this legislation.

Privacy and Security (Section 3601)

The bill would require the Secretary of HHS to ensure all appropriate privacy and security safeguards are followed for activities relating to health disparities data collection, analysis, and sharing.

The bill would establish a timeline for accelerating the development, adoption and implementation of a set of operating rules for each HIPAA transaction for which there is an existing standard. The operating rules would be consensus-based, and reflect the business rules around which health plans and providers would uniformly use the HIPAA standards. The Mark would add the electronic funds transfer (EFT) of health claims payments as a HIPAA transaction and provide for the adoption and enforcement of a standard for EFT.

Additional requirements include adoption of a single set of operating rules for eligibility verification, claims status, claims remittance/payment and EFT. Also the legislation requires the NCVHS to review operating rules for HIPAA standards; directs the Secretary to adopt operating rules for eligibility and health plan claims status transactions no later than July 1, 2011, to be effectively by January 1, 2013. This would include EFT and claims remittance/payment rules no later than July 1, 2012, to be effective on January 1, 2014.

It also provides for a process to update periodically HIPAA standards including operating rules, and defines operating rules as the necessary business rules and guidelines for the electronic exchange of information that are not defined by the electronic standards.

Workforce

Workforce Advisory Committee (Section 3036)

A new Workforce Advisory Committee would be established. Membership will include external stakeholders and representatives of health professionals, schools of higher education for health care professionals, public health experts, health insurers, business, labor, state or local workforce investment boards, and others as the Secretary determines appropriate. The Committee is responsible for developing and presenting a national workforce strategy to the Secretary and the Congress that will set the nation on a path toward recruiting, training and retaining a health workforce that meets the nation's current and future health care needs.

Workforce Demonstration Project (Section 3037)

A new HHS demonstration project would be established for low-income individuals who would like to obtain education and training for those health care occupations that are in high demand or are experiencing shortages. Grants would be made to states, local workforce investment boards, or community based organizations. The demonstration will determine the efficacy of developing core training competencies in the following areas: the role of the personal or home care aide; consumer rights, ethics, and confidentiality; communication, cultural, and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills; personal care skills; health care support; nutritional support; infection control; safety and emergency training; training specific to an individual consumer's needs; and self-care. The project will also evaluate the methods used to implement these competencies including: length of training; appropriate student to trainer ratio; time spent in the classroom compared to on-site; trainer qualifications; content for hands-on training and written certification exam; and continuing education requirements. A personal care aide is defined as one "who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer's disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual."

Graduate Nurse Education Demonstration Program (Section 3039)

The bill would establish a graduate nurse education demonstration program under Medicare in order to increase the supply of highly skilled advanced practice nurses. Participating hospitals would receive reasonable costs reimbursement from Medicare for the educational costs (including faculty salaries, any student stipends, clinical instruction costs, and other direct and indirect costs) of a hospital and affiliated schools attributable to the training of advanced practice

nurses. The demonstration aims to provide these nurses with skills necessary to provide primary and preventive care, transitional care, chronic care management, and other appropriate nursing services through affiliation with one or more accredited nursing schools and in partnership with two or more non-hospital community-based patient care settings where at least half of all clinical training occurs. The Secretary would be able to waive the requirement for affiliation with accredited nursing schools for clinical training of advanced practice registered nurses in rural and medically underserved areas. The term `advanced practice nurse' under this section would include a clinical nurse specialist, nurse practitioner, certified registered nurse anesthetist, and certified nurse midwife.

Other Issues of Specific Interest to Long Term Care, Post Acute Care, and Assisted Living

MedPAC Must Take Medicaid Into Account in Certain Circumstances (Section 1681(b)(3))

The bill includes language offered as an amendment by Senator Ron Wyden (D-OR) that requires MedPAC to report Medicaid data as to trends in spending, utilization, and financial performance for those providers having a significant portion of either revenue or services from Medicaid. The section also expands MACPAC's mission to include assessment of adult services in Medicaid including those for dual eligibles in conjunction with MedPAC.

AHCA strongly supports this language and urges the Senate to maintain this provision in the bill throughout the remainder of the legislative process.

Assisted Living Part D Copay Amendment (Section 3311)

This provision of the bill would eliminate Medicare Part D cost-sharing for institutionally eligible dual eligible beneficiaries receiving services under Sec. 1115 or 1915 waivers or under a 1915(i) state plan amendment, as well as for duals receiving services in a Medicaid managed care organization.

AHCA/NCAL lobbied in support of this provision, which eliminates Part D cost sharing for about 57% of Medicare Part D dual eligibles living in assisted living communities. However, it would not eliminate cost sharing for dual eligibles in assisted living communities receiving long term care services directly under their state Medicaid plan.

Sense of the Senate Amendment on Long Term Services and Supports (Section 1642)

The bill expresses the Sense of the Senate that this Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need and that long term services and supports should be made available in the community in addition to in institutions.

Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-term Care Settings (Section 3312)

The bill would require Medicare Part D prescription drug and Medicare Advantage prescription drug plans to employ utilization management techniques, such as blister packs, when dispensing medications to beneficiaries who reside in long-term care facilities in order to reduce waste associated with 30-day fills.

AHCA membership has expressed varying views from our membership and is currently neutral on this issue.

MedPAC Study of Payment Adequacy for Rural Providers (Section 3127)

The Medicare Payment Advisory Commission (MedPAC) must examine the adequacy of payments for items and services provided under Medicare in rural areas and report to Congress by January 1, 2011 on any recommendations for administrative or legislative action. The study must analyze the following: any payment adjustments; access to items and services; the adequacy of payments to providers and suppliers serving rural areas; and the quality of care furnished.

Long Term Care Services and Supports

A series of amendments discussing long term care services and supports were included in the bill language.

- **Community First Choice Option (Section 1634)** —The bill would establish the Community First Choice Option, which would create a state plan option under section 1915 of the Social Security Act to provide community based attendant supports and services to individuals with disabilities who are Medicaid eligible and who require an institutional level of care. These services and supports include assistance to individuals with disabilities in accomplishing activities of daily living, instrumental activities of daily living, health related tasks and additional supports such as voluntary training on how to select manage, and dismiss attendants. Services and supports may be provided by family members, agencies and others. States would be required to provide these services under a “person-centered” plan and services would be “consumer controlled,” meaning that the individual or his/her representative would have maximum control of HCB attendant services, “regardless of who acts as the employer of record.” States would have to establish Development and Implementation Councils. Under the Community First Choice Option, services must be provided without regard to age, type or severity of disability or form of HCB services required to lead an independent life. States who choose the Community First Choice Option would be eligible for enhanced federal match rate of an additional six percentage points for reimbursable expenses in the program. The option would be available beginning Jan. 1, 2014, and would sunset after five years. The Community First Choice Option also would require data collection to help determine how states are currently providing home and community based services, the cost of those services, and whether states are currently offering individuals with disabilities who otherwise qualify for institutional care under Medicaid the choice to instead receive home and community based services, as required by the U.S. Supreme Court in *Olmstead v. L.C.* (1999).

AHCA/NCAL understands that this provision provides financial incentives for states to expand aid and attendants and similar programs in which community-based Medicaid recipients can exert maximum control over who provides them services and how services are provided to them. While assisted living is not specifically excluded in the definition of entities that might provide the services, we believe it would be very difficult for assisted living providers to participate because of the degree of control over services that beneficiaries would have. In terms of fiscal impact, the increased FMAP would lead

to increased state and federal spending that may divert funds away from AHCA/NCAL members. Additionally, this provision could be expensive as the services and supports are well beyond health related, there is no budget neutrality provision and there is an enhanced FMAP of 6%. The requirement that the state would provide services without regard to severity of disability goes beyond Olmstead in which the Supreme Court clearly stated that a state's responsibility, "once it provides community-based treatment to qualified persons with disabilities, is not boundless." The Supreme Court decision spoke of reasonable modifications and allows the states to resist modifications that fundamentally alter the states services and programs. AHCA applauds the inclusion of language specifying that "services are only reimbursable if the individual chooses to receive such HCB attendant services and supports, "which preserves beneficiary choice; and for including valuable quality assurance provisions.

- **Spousal Impoverishment** – The bill would protect against spousal impoverishment in all Medicaid home and community based services programs by requiring states to apply the same spousal impoverishment rules currently provided to the spouses of nursing home residents in Medicaid. The provision would sunset after five years.

AHCA/NCAL believes that this provision will not have an impact on nursing facility providers. CBO scores this provision at \$1.2 billion over 5 years.

- **Incentives for States To Offer Home and Community-based Services as a Long-Term Care Alternative to Nursing Homes (Section 1636)** This provision would increase the Medicaid FMAP for eligible states with respect to eligible medical expenditures during a "balancing incentive payment period" running from Oct. 1, 2011 to Sept. 30, 2015. Eligible states would be those in which less than 50% of total state long-term care Medicaid spending for FY 2009 goes toward non-institutionally based LTC services and supports. To get the added Medicaid match, states would have to apply to the Secretary and meet conditions including meeting targets for expanding HCB spending as a percentage of paid LTC services. States spending less than 25% on HCB services would have a target of 25% of HCB spending to meet by Oct. 1, 2015 – and these states would get 5 percentage points in additional FMAP. A target of 50% HCB spending would be set for other eligible states – and these states would get 2 percentage points in additional FMAP. (It is not clear exactly what expenditures or population the increased FMAP would be applied to.) Aggregate federal payments under this incentive program would be limited to \$3 billion. States participating in this program would be required to make structural changes to their long term supports and services systems including development of a statewide single entry point system, conflict-free case management services, and development of core standardized assessment instruments for determining HCBS eligibility. Data collection requirements include services data, quality data and outcomes measures.

AHCA/NCAL believes this program provides further impetus for states to redesign Medicaid program to substitute HCB care for institutional care such as that provided in nursing facilities. The definitions do not appear to exclude assisted living communities as sites in which non-institutional services could be provided. While the \$3 billion cap on the program limits its financial impact, it will tend to draw resources away from institutional settings such as nursing homes. Five states would be ineligible for the additional FMAP because they already spend over 50% of Medicaid long term care dollars on HCBS. (Note: In general, a program that increases the FMAP by "percentage points" rather than

by “percent” will tend to advantage higher-income states proportionally more than lower-income states.)

- **Money Follows the Person Rebalancing Demonstration (Section 1637)** This provision would extend the current Money Follows the Person Demonstration grant program for an additional 5 years until 2016. It also would change the requirement that a qualifying individual has been in an institution from no less than 6 months to no less than 90 consecutive days and it also excludes rehab stays.
- **Additional Changes on HCBS Expansion** The bill would clarify the original intent of Congress that the term “medical assistance” as used in various sections of the *Social Security Act* encompasses both payment for services provided and the services themselves. The bill would amend section 1905(a) of the *Social Security Act* by inserting —or the care and services themselves, or both before —(if provided in or after)

For all the HCBS expansions mentioned above, it is important that assisted living be included in the definition of HCBS. In addition, we are concerned about the potential impact that FMAP changes may have. Further, there may be cause for concern about reducing the amount of time required for individuals to qualify for the Money Follows the Person grant program to just 90 days.

State Medicaid Overpayment Amendment (Section 5106)

The bill will extend the time states have to repay the federal share of a fraudulent Medicaid overpayment to one year. If a final judgment has yet to be made within that time period, the state has 30 days to replay after final judgment is made. The offset for this change is modifications to the Recovery Audit Contractor Program provision already included in the Chairman’s Mark: implement Part C, Part D, and Medicaid portions by end of 2010, CMS is to coordinate Medicaid RACs with existing state contracts, and CMS is to submit an annual report to Congress.

Hospital Wage Index Amendments (Section 3131)

The bill includes additional language adopted in committee that will have an impact on nursing homes. Since both are required to be budget neutral, there will not be an overall gain or loss for the industry, but various geographic areas will be impacted positively and others negatively.

Medicaid Quality Bundling (Section 1674)

The bill includes language that would establish a Medicaid Global Payments demonstration project available to in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment system from a fee-for-service structure to a capitated, global payment structure. The CMS Innovation Center would conduct an evaluation of each demonstration project examining any changes in health care quality outcomes and spending. The Chairman’s Mark would exempt the Innovation Center from the budget-neutrality requirements for an initial testing period. The Innovation Center also would be given the authority to terminate or modify the demonstration project during the testing period. The Secretary would be required to conduct and analysis of the demonstration project and report her findings to Congress.

AHCA will work to ensure that SNFs are not impacted by this provision.

Elder Justice Act Amendment (Sections 1911 – 1913)

The legislation includes the entire text of the *Elder Justice Act* (S. 795), which amends the Social Security Act to establish an Elder Justice program under Title XX Block Grants to States for Social Services. It also establishes within the Office of the Secretary of Health and Human Services (HHS) an Elder Justice Coordinating Council (EJCC) as well as an Advisory Board on Elder Abuse, Neglect, and Exploitation. The HHS Secretary is directed to make grants to eligible entities to establish stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation. In addition, the Secretary must provide incentives for individuals to train for, seek, and maintain employment providing direct care in a long term care (LTC) facility. Grants will be made to LTC facilities to: (1) offer continuing training and varying levels of certification to employees who provide direct care to LTC facility residents; and (2) provide bonuses or other benefits to employees who achieve certification. Other grants also will be made to assist LTC facilities in offsetting the costs for standardized clinical health care informatics systems designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors. HHS must not only provide funding to state and local adult protective services offices that investigate reports of elder abuse, neglect, and exploitation; but also collect and disseminate related data in coordination with the Department of Justice. A program of annual adult protective services grants to states must also be created. Moreover, the Secretary must make grants to eligible entities to improve the capacity of state LTC ombudsman programs to respond to and resolve abuse and neglect complaints; and conduct pilot programs with state or local LTC ombudsman offices. Programs must be established to both provide and improve ombudsman training for national organizations and state LTC ombudsman programs. Additionally, each individual owner, operator, employee, manager, agent, or contractor of an LTC facility receiving certain federal support must report to the Secretary and local law enforcement entities any reasonable suspicion of crimes occurring in such facility. Additionally the owner or operator of such an LTC facility must notify the Secretary and the appropriate state regulatory agency of a facility's impending closure, as well as establish a plan for the transfer and adequate relocation of facility residents. The Secretary must also study and report to the EJCC and appropriate congressional committees on establishing a national nurse aide registry.

While AHCA supports the Elder Justice Act overall but has the following concerns about the existing language and suggests the following clarifying changes:

- 1. Definition of Neglect: Revise the definition of "neglect" to add "knowing" as in the case of the definition of "abuse" and add language to make clear that the neglect led to the harm: "the knowing failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder, which failure proximately causes physical or psychological harm;*
- 2. Definition of "Crimes: This definition should be narrowed to "abuse and neglect" since it could be very broadly interpreted.*
- 3. Reporting of Crimes – Determination: AHCA/NCAL believe that the provision should apply only to long-term care facilities that participate in Medicare or a State health care program.*
- 4. Scope of reporting: Because of the definition of "covered individual", "each" could be construed to require multiple individuals at the facility to make the same report, resulting in hundreds of reports to the Secretary and applicable law enforcement.*
- 5. Timing provisions: AHCA believes this provision should be modified in light of the penalty provisions.*

6. *Amount of CMPs: AHCA is very concerned about the amount of penalties to be assessed since facilities are already subject to steep CMPs under federal law.*
7. *Excluded Individual: There are already provisions in the current exclusion law, Section 1128 of the SSA, and the implementing regulations, which prohibit an excluded person from working in a position where their work has anything to do with federal funds. The current financial ramification of hiring an excluded individual means that as a practical matter, these individuals are not employed in facilities; therefore, we believe this provision is redundant and unnecessary.*
8. *Failure to Give Required Notice: Making failure to give the required notice the basis for a program exclusion seems to be extreme, especially for a first offense.*

Additional FMAP Assistance for High-Need States (Section 1601)

The bill would provide additional assistance to high-need states, which are defined as states that: (1) have total Medicaid enrollment that is below the national average for Medicaid enrollment as a percent of state population as of the date of enactment; and (2) had seasonally-adjusted unemployment rates of 12% or higher for August 2009. The additional assistance provided to such states would be full federal funding for the cost of providing medical assistance to newly eligible beneficiaries for the five-year period of 2014 through 2018.

AHCA/NCAL estimates that this provision would likely have an impact in only three states—Michigan, Nevada, and Oregon. These states meet the qualifying criteria outlined in the provision to receive additional FMAP assistance based on Medicaid enrollment and unemployment rates.