

Senate Finance Committee Chairman's Mark, as Amended
America's Healthy Future Act of 2009:
Issues Affecting Long Term Care
October 12, 2009

On September 16, 2009, Senate Finance Committee Chairman Max Baucus (D-MT), released America's Healthy Future Act of 2009. The proposal did not include legislative language, but rather was an outline of concepts. The committee held a lengthy mark up. This document includes changes made by the committee. Some issues will not be clear until actual legislative language is released.

This is an update to the document dated September 17, 2009, and is modified to include amendments adopted by the committee.

Health Care Coverage

Individual Mandate

As of 2013, all U.S. citizens and legal residents must obtain health insurance through one of the following: the individual market, public programs (e.g. Medicare, Medicaid, CHIP, VA, and TRICARE), an employer (as employee or dependent), the small group market, or the large group market. Coverage must meet the requirements of the bronze plan. Some exemptions from this requirement are permitted such as for religious objections, as currently allowed under Medicare. Individuals must attest on their annual Federal income tax return that such coverage has been obtained for themselves and all dependents under age 18. Further, insurers (including employers who self-insure and therefore act as insurers) must also report this information to beneficiaries and the Internal Revenue Service. Employers also must report this information for employees and dependents enrolled in either self-insured plans or public health insurance plans. Penalties would be levied for failing to obtain and/or maintain insurance coverage for individuals and their dependents for more than three months annually. The penalty for not obtaining coverage is \$750 per adult in the household. The penalty would be assessed as additional federal tax liability and would be phased in as follows: 2013 \$0, 2014 \$200, 2015 \$400, 2016 \$600, and 2017 \$750. Noncompliance does not incur either criminal or civil penalties; collection will be limited to withholding of federal payments due. Those who are employed by a company with 200 or more employees, will be automatically enrolled into group plans, but may opt out if they are otherwise covered such as being a dependent spouse/child, Medicare beneficiary, etc. Generally, if an employee is offered employer-provided health insurance coverage, the individual would be ineligible for a low income premium tax credit for health insurance purchased through a state exchange, unless that coverage is deemed to be unaffordable (13% or more of the employee's income).

Employer Contribution

Employers will not be required to offer health insurance coverage. However, as of July 1, 2013, for those employers with more than 50 employees, if coverage is not offered, a fee must be paid for each employee who receives a tax credit for health insurance through a state exchange. The assessment is capped for all employers at an amount equal to \$400 multiplied by the total number of employees at the firm (regardless of how many are receiving the state exchange

credit). The employer would pay the lesser of the flat dollar amount multiplied by the number of full-time employees receiving a tax credit or a fee of \$400 per employee paid on its total number of full-time employees.

For example, Employer A, who does not offer health coverage, has 100 employees, 30 of whom receive a tax credit for enrolling in a state exchange offered plan. If the flat dollar amount set by the Secretary of HHS for that year is \$3,000, Employer A should owe \$90,000. Since the maximum amount an employer must pay per year is limited to \$400 multiplied by the total number of employees (for Employer A, 100), however, Employer A must pay only \$40,000 (the lesser of the \$40,000 maximum and the \$90,000 calculated fee). Fees do not apply to those employees that elect to participate in Medicaid.

If a company chooses to offer coverage and an employee elects to enroll, the employer provided portion of the coverage must be excluded from gross income, whether or not such coverage is provided through a state exchange.

For small employers, states must allow small businesses with a maximum of 100 employees to purchase coverage through the state exchanges. In 2017, businesses with more than 100 employees would also be allowed to purchase coverage through the state exchanges.

Fees assessed for employees receiving premium credits will not be tax-deductible.

Small Business Tax Credit

Small employers with no more than 25 FTEs and whose wages average no more than \$40,000 each taxable year would receive a tax credit to purchase health coverage. The credit would be claimed on the employer's tax return and could only offset tax liability. Not for profit organizations (501(c)(3)) may qualify for this tax credit.

Medicare

Skilled Nursing Facility (SNF) Market Basket Productivity Adjustment

Beginning in 2012, the Skilled Nursing Facility (SNF) market basket will be reduced by an unspecified productivity factor. 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

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 final resolution of this problem can be achieved.

National Pilot Program on Payment Bundling

Beginning in 2013, the Secretary will implement a national, voluntary pilot program to coordinate care for the entire episode of care for eight conditions to be specified by the Secretary. Services to be included in the bundle are: acute care inpatient hospitalizations; 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 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 would develop policies to ensure the traditional fee-for-service program provides payment for PAC services in the appropriate setting for those patients who require continued PAC services after the 30th day following the discharge. If the pilot 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. 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.

While AHCA has concerns about post-acute bundling and would prefer to see a demonstration project as opposed to a pilot, 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

By 2012, the HHS Secretary is required to submit to Congress a Medicare value-based purchasing implementation plan for Skilled Nursing Facilities. Such plan must consider the following: (1) the development, selection, and modification process of measures of all dimensions of quality and efficiency; (2) the reporting, collection, and validation of quality data; (3) a structure of proposed value-based payment adjustments, including recommendations on thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the source of funding for value-based incentive payments; and (4) methods for publicly disclosing performance information on performance. 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 each setting.

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

An independent Medicare Commission comprised of 15 members appointed by the President and confirmed by the Senate that would 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 decisionmaking 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

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. The strategy 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.

CMS Innovation Center

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

Medicaid

Medicaid Bundled Payments Demonstration Project

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.

Funding for the Medicaid and CHIP Payment and Access Commission (MACPAC)

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.

Medicaid Reimbursement for Health Care Acquired Conditions

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.

Nursing Home Transparency

Required disclosure of ownership and additional disclosable

The Senate Finance Chairman's mark 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 Mark 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.

The Mark requires a facility to make all disclosable parties' information available to public upon request and update the information as necessary to reflect changes. Facilities are required to certify to Secretary and IG 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 Chairman's revised mark will not require the disclosure of companies that lend money to facilities, we request that the bill be modified to dramatically restrict 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 quite 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.

Compliance Program

The Chairman's mark 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.

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 5 facilities to have more streamlined compliance programs. This is consistent with the Office of Inspector General's Supplemental Compliance Program Guidance for Nursing Facilities

Nursing Home Compare Medicare Website

The Chairman's Mark requires Secretary to ensure that information provided for comparison of nursing homes is 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 of substantiated complaints. 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.

AHCA believes that the bill should be modified to require the Secretary to include plans of correction on the Website, and require that all information posted on Nursing Home Compare be updated in a timely fashion.

Reporting of expenditures

The Mark would require SNF/NFs to separately report expenditures 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

The Mark 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 confusion for those filing complaints.

Civil Money Penalties (CMPs)

The Senate Finance Chairman's mark states that Secretary may reduce civil money penalties 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 Chairman's mark 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 civil monetary penalties (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; technical assistance for facilities implementing quality assurance programs.

AHCA supports the concept of reduced CMP's for self-reporting of deficiencies and that a portion of collected CMPs to fund activities that benefit residents

National Independent Monitor Pilot Program

The Mark requires Secretary along with OIG 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 Mark 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 Mark 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.

Fraud, Waste and Abuse

The Chairman's Mark would set up new enrollment process for providers and suppliers, including an application fee.

Provider Screening

The Chairman's mark would require that the Secretary screen all providers and suppliers before granting Medicare billing privileges. 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.

An application fee of \$350 would be imposed on providers and suppliers to cover the costs of screening. Current providers could be subject to a discounted screening fee of \$250 if they pay it within 12 months of enactment.

The Mark would also give states authority to impose similar screening procedures in Medicaid, including subjecting providers and suppliers to enhanced oversight and establishing new

disclosure requirements. 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.

Background Checks

The amended Chairman's Mark also adds the text of the Patient Safety and Abuse Prevention Act (S. 631) to the bill, 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

LTC providers 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.

AHCA has concerns that while the Mark states that the Committee intends that the Secretary implement this provision in a fashion that does not result in application fees for potential long term care workers, until we see legislative language, it will remain unclear if the amended language eliminates the cost to providers.

Disclosure Requirements

The Chairman's Mark 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 PI" Integrated Data Repository

The Chairman's Mark would require CMS to complete development of the comprehensive "One PI" Integrated Data Repository (IDR). The "One PI" IDR would expand existing program integrity data sources and expand data sharing and data matching across Federal health care claims and payment data (including HHS, SSA, the Departments of Veterans Affairs (VA), Defense (DOD), and Justice (DOJ)). In addition to including all claims and payment data for Medicare and Medicaid, the "One PI" IDR 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” IDR would be accompanied by additional authority for HHS 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 IDR. New civil penalties would be imposed for the intentional submission of erroneous data to the IDR. Additionally, states that fail to report encounter data could be subject to a reduction in their Federal financial participation (FFP) under Medicaid.

Expanded Provider Databases

Under the Chairman’s Mark, the 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

Under the Chairman’s mark, 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. The mark provides increased authority to suspend payment during creditable investigations of fraud; and new procedures to disclose and repay overpayments

Overpayments: 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.

Deterrence/Civil and Criminal Penalties: The civil monetary penalty (CMP) law would be amended in several instances to increase penalties and extend use of CMPs.

Program Sanctions

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.

Provider Self-Disclosure Protocol

The Secretary would be required to establish, within 180 days, a mechanism for providers to voluntarily disclose 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

The Chairman's Mark 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

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

The Chairman's Mark 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. The Mark would express the Sense of the Senate 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

The Chairman's Mark 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 Chairman's Mark 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 proposal, 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 rues no later than July 1, 2012, to be effective on January 1, 2014.

It also provides for a process to periodically update 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

A new Workforce Advisory Committee would be established. Members should 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

A new HHS demonstration project would be established for economically disadvantaged people who would like to obtain education and training for health care occupations which 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.

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

The language above has been updated from the original September 17, 2009, document to incorporate amendments that have indirect impact on AHCA/NCAL members, but there are some amendments that have direct impact and need to be discussed individually.

Wyden MedPAC Amendment

The committee adopted an amendment offered by Sen. Wyden that requires MedPAC to report Medicaid data as to trends in spending, utilization, and financial performance for those providers with either a significant portion of revenue or services from Medicaid. Expands MACPAC mission to include assessment of adult services in Medicaid including those for dual eligibles in conjunction with MedPAC.

AHCA strongly supports this amendment and urges the Senate to maintain this provision throughout the process.

Assisted Living Part D Copay Fix Amendment

The committee adopted an amendment that includes a provision that eliminates cost sharing under Part D for full-benefit, dual eligible beneficiaries receiving care under a home and community based services under sections 1915, 1932 or 1115 waivers who would otherwise require institutional care. This amendment would be effective no sooner than 2012.

AHCA/NCAL supported this amendment and worked closely with the committee in developing it.

Sense of the Senate Amendment on Long Term Services and Supports

The committee adopted an amendment by Sen. Rockefeller to express 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. The Mark would further express the Sense of the Senate 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

The committee adopted an amendment that requires 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.

There seems to be mixed opinion among the AHCA membership as to whether this is positive or not.

Long Term Care Services and Supports

The committee adopted a series of amendments on long term care services and supports.

- **[Amended Schumer Amendment #C13 included in the Modified Chairman's Mark]** On page 50, at the end of the Long Term Services and Supports section Insert —The Chairman's Mark 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 and health related tasks. 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 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). The Community First Choice Option would also modify the Money Follows the Person Rebalancing Demonstration to reduce the amount of time required for individuals to qualify for that program to 90 days.
- **[Amended Rockefeller Amendment #D11 included in the Modified Chairman's Mark]** On page 50, at the end of the Long Term Services and Supports section Insert, —The Chairman's Mark would express 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. The Mark would further express the Sense of the Senate that long term services and supports should be made available in the community in addition to in institutions.

- **[Amended Kerry Amendment #C16 included in the Modified Chairman's Mark]** On page 50, at the end of the Long Term Services and Supports section Insert —The Chairman's Mark 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.

No impact on nursing facility providers. CBO scores this provision at \$1.2 billion over 5 years.

- **[Amended Cantwell #C1 included in the Modified Chairman's Mark]** On page 50, at the end of the Long Term Services and Supports section Insert —The Chairman's Mark would provide states that undertake structural reforms proven to increase nursing home diversions and access to home and community based services in their Medicaid programs a targeted increase in the federal medical assistance percentage (FMAP). The amount of the FMAP increase would be tied to the percentage of a state's long term services and supports that is offered through HCBS, with lower FMAP increases going to states that will need to make fewer reforms. States would be able to offer HCBS through a waiver or through a state plan amendment (SPA). States that choose a SPA would be able to include individuals with incomes up to 300 percent of the maximum Supplemental Security Income payment. Funding for the nursing home diversion program would be available for five years beginning in 2011.

This provision would likely have an impact in about 18 states, depending on how the legislation will target such states. If states are targeted based on HCBS spending, these 18 states spend less than 15% of Medicaid LTC expenditures on HCBS. For example, states that spend 10% or less of Medicaid LTC expenditures on HCBS include AL, CT, DE, IN, KY, MS, ND, OK, SD, TN, and UT. States that spend between 10% and 15% include FL, IA, MD, NH, PA, RI, and WY. CBO scores this provision at \$3.4 billion over 5 years.

- **[Rockefeller #C31 included in the Modified Chairman's Mark]** On page 51, at the end of Part IV – Medicaid Services Insert —The Chairman's Mark 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 Chairman's Mark 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 expansion amendments, it is important that assisted living be included in the definition of HCBS. In addition, for Schumer C13 and Cantwell C1, there will be significant concern among our state affiliates about changes in FMAP. If the HCBS Medicaid FMAP increases score too high, an alternative to consider might be housing vouchers targeted to the most disabled with assisted living being included as an eligible HCB setting in which to use

them. For Schumer C13, there also is concern from at least one affiliate about reducing the amount of time required for individuals to qualify for the Money Follows the Person grant program to 90 days.

State Medicaid Overpayment Amendment

The committee adopted an amendment by Sen. Carper that extends 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

The committee adopted two amendments 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

The committee adopted an amendment offered by Sen. Kerry 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 would also 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 negatively impacted by this provision.

Empowered at Home Act Amendment

The committee adopted an amendment by Sen. Kerry which includes the following provisions from the *Empowered at Home Act* (S. 434), to expand access to home and community based services under Medicaid:

- allow states to seek approval from the Secretary of HHS to offer additional services under the Medicaid Home and Community Based-Services State Plan Amendment option;
- allow states under the State Plan Amendment option to provide home and community-based services to persons with income above 150% of the federal poverty level, but no greater than 300% of the Supplemental Security Income (SSI) level (placing it on-par with nursing home and home and community-based services waiver eligibility criteria);
- 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 on Medicaid; and

- allow states to exclude up to 6 months of average cost of nursing facility services from assets or resources for purposes of eligibility for home and community-based services.

Elder Justice Act Amendment

The Committee accepted an amendment by Sens. Lincoln and Hatch containing the entire text of the Elder Justice Act (S. 795) into the modified mark. This section 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 Secretary of Health and Human Services 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 will also 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. Further, 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 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.

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 that is the focus of this provision and otherwise could be very broadly interpreted.*
3. *Reporting of Crimes – Determination: The provision should just be applicable to long-term care facilities that participate in Medicare or a State health care program. There are different ways to draft this and I've provided some suggested language. An*

alternative way to draft this would be to state that the facility receives payments under titles XVIII, XIX or XX of the Social Security Act.

- 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. Everyone in a nursing facility with a "reasonable suspicion" would have a duty to report. One option is to delete the "reasonable suspicion" language and revert to the "knows or should know" which is used in the CMP false claims provisions of the Social Security Act. There is already guidance and a body of case law that interprets this language. Using the standard of "reasonable suspicion of a crime (as defined by the law of the applicable political subdivision)" would result in potentially 50 different interpretations of what this means and what has to be report. It is just unworkable and unfair to revert to state law. Another option is to provide by statute that the DOJ come up with a federal definition of both the standard for reporting -- which again we would suggest be a higher standard such as "know or have reason to know" -- and the specific abuse and neglect offenses.*
- 5. Timing provisions: Should be modified especially in light of the penalty provisions. The point should be made that the investigation and remediation should be the immediate goals, along with prompt reporting. I think 2 hours is an unrealistic standard, but we may not be able to move that.*
- 6. Amount of CMPs: With regard to the amount of penalties to be assessed, again, facilities are already subject to steep CMPs under federal law. The CMPs for individuals failing to report should be no higher than those assessed against facilities. Therefore, we recommend \$10,000 per day up to a max of \$50,000, and in the case of severe outcomes, double that amount -- \$20,000 up to a max of \$100,000.*
- 7. Excluded Individual: There are already provisions in the current exclusion law, Section 1128 of the SSA, and the implementing regulations, prohibiting 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. That's why facilities check the OIG's list of excluded individuals so they don't hire them, or if they are excluded, they are terminated. 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.*

FMAP Amendment

The committee adopted an amendment offered by Sen. Wyden that would insert the following into the FMAP section of the chairman's mark: —including those on waiting lists, before —as of the date of enactment in the last line of the paragraph beginning —Under the Chairman's Mark.

To clarify the payment policy in Title I, Subtitle G: Role of Public Programs

On page 44, at the end of the Medicaid Program Payments section

Insert —The Chairman's Mark would provide additional assistance that would be made available 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 estimates that this provision would likely have an impact in only 3 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.