

STATEMENT
Of
GAIL CLARKSON
On Behalf Of The
American Health Care Association
&
National Center for Assisted Living
To
House Energy & Commerce Subcommittee on Health Hearing
On
**“Medicare Savings Plan and Low Income Subsidy: Keeping Medicare’s
Promise for Seniors and People with Disabilities”**

May 15, 2007

Thank you Chairman Pallone, Ranking Member Deal, and members of the Committee. I appreciate the opportunity to speak with you on behalf of the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL), which represent nearly 11,000 long term care providers who employ more than 1.5 million compassionate, well-trained caregivers who care for millions of frail, elderly, and disabled Americans.

My name is Gail Clarkson and I am Chief Executive Officer of Medilodge, which is located in Washington, Michigan. All of MediLodge’s 12 facilities participate in Quality First and *Advancing Excellence in America’s Nursing Homes*, which promote continuous quality improvement in long term care. We employ 2,500 individuals who care for more than 2,200 patients and residents. I have worked as a nursing home administrator, director of nursing, and an intensive care nurse. I also have been trained and certified in epidemiology by the Centers for Disease Control & Prevention (CDC) and Yale University and I serve on the Board of Governors of the American Health Care Association.

My experiences have made me acutely aware that providing high quality care for seniors and people with disabilities depends on stable funding. However, we continue to care for patients when payments do not cover the care and services required by these individuals. It is important to note that, nationally, Medicaid under funds care for the average patient by more than \$13.00 per day. The Centers for Medicare & Medicaid Services (CMS) has proposed a rule that would disallow intergovernmental transfers (IGTs)—in effect, further cutting states’ Medicaid funding.

Congress has recognized CMS' shortsighted approach to Medicaid reform; AHCA/NCAL applauds Congress for addressing this issue in including a one-year moratorium on CMS' implementation of the IGT rule.

The vast majority of nursing home patients who rely on Medicaid to pay for their long term care are also eligible for Medicare coverage as well, drawing on Medicare Part B for their outpatient therapy needs and Medicare Part D for their prescription drugs needs. Because these individuals are both poor and elderly and eligible for both Medicare and Medicaid, they are often referred to as "dual eligibles." Nursing homes have worked long and hard to coordinate care for dually eligible patients and residents to ensure that the services provided under both the Medicare and Medicaid programs for these vulnerable Americans is the best care available.

The link between stable funding and quality has been repeatedly acknowledge by the Centers for Medicare & Medicaid Services, most recently by Acting Administrator Leslie Norwalk, who wrote in this month's *Provider* magazine:

Nursing home providers have been on the leading edge of this quality movement. Long before hospitals, doctors, home health providers, pharmacies, dialysis facilities and others came to the table, the nursing home industry was out front with Quality First – a volunteer effort to elevate quality and accountability.

Ms. Norwalk explains that the recently launched *Advancing Excellence in America's Nursing Homes* campaign, builds on the success of Quality First and other initiatives that have helped to improve care quality in long term care facilities since 2002. Moreover, Ms. Norwalk also acknowledges "the essential connection between quality, adequate payment for services and financial stability" and that working together—providers, consumers, government and others—represents "the best path to a high-quality, patient-centered, provider-friendly system that everyone can afford." We wholeheartedly agree.

Providing high-quality long term care and services is a top priority for AHCA/NCAL and our membership. We are especially proud to note that the data is proving our commitment is very real—the Nursing Home Quality Initiative data shows improvement in pain management, reduced use of restraints, decreased number of patients with depression, and improvements in physical conditions such as incidents of pressure ulcers. Last week, My InnerView, Inc. released independent data based on nursing home resident and family member satisfaction surveys that shows that the vast majority—82%—of residents and families would rate care as good or excellent. I am pleased to note that my company, Medilodge, participated in this independent survey of our patients, residents, and family members.

Even so, the long term care system is under considerable pressure—as are we all—to do even more. We strive to deliver the best care possible, yet we face considerable challenges.

We seek your Committee's assistance in meeting some of those challenges. Our profession is working to meet the needs of consumers, which includes being transparent so that our customers can best select the care and services they need and want from long term care providers. We ask that CMS, which reviews our profession, be similarly transparent about the criteria it uses in overseeing such care and services. In addition, we ask that your Committee review CMS' recent

final rule on blood glucose monitoring. CMS' rule now requires a physician order for each finger stick test to monitor patients' blood glucose—an impractical requirement that places an enormous administrative burden on long term care providers while doing nothing to improve patient care. We thank Chairman Dingell and his colleagues who have already called on CMS to redress this rule, which places paperwork over patient care.

As I have noted, improving care quality is a continuous, dynamic, ongoing enterprise. While we are enormously proud and pleased by our care quality successes, we acknowledge there is far more to accomplish. From our profession's standpoint, Mr. Chairman, there has never been a broader recognition of the importance of quality, or a broader commitment to ensure it continues to improve.

AHCA/NCAL worked closely with the Centers for Medicare & Medicaid Services before, during, and since the implementation of Medicare Part D, which began on January 1, 2006. The transition to this new benefit was not easy, but I am proud to say on behalf of my profession that no patient or resident being cared for in a Skilled Nursing facility (SNF) went without his or her medication during the transition to Medicare Part D. I do not know if the same may be said for residents in assisted living facilities and other home- and community-based settings (HCBS) who have prescription needs similar to that of nursing home patients—often requiring up to 9 medications per day—but who may be financially unable to afford the copayments on their Part D prescriptions.

Frequently, dually eligible beneficiaries living in assisted living or residential care (AL/RC) facilities or other home-like settings only have a small personal needs allowance of a few dollars a month, so even a copayment of \$1 - \$3 per prescription can add up when the individual requires multiple prescriptions. That is why we were pleased to see that a bill has been introduced in the Senate entitled, *The Home and Community Services Co-payment Equity Act (S. 1107)*, which would eliminate Part D copayments for more than one million low-income Americans, including dually-eligible residents of AL/RC facilities and other licensed facilities (such as group homes for people with developmental disabilities, psychiatric health facilities, and mental health rehabilitation centers), who receive their services at home under HCBS waivers. This legislation would put dually-eligible home and community based individuals on par with similar beneficiaries in nursing facilities who do not have to make copayments under Part D. We urge members of the Committee to enact and sponsor companion legislation to *S. 1107*.

It is important to recognize the vulnerability and special needs of very low-income people who not only need long term care, but who also need help in getting assistance to pay for the care they need. Federal programs such as the Low Income Subsidy (LIS) and Medicaid are critical parts of the health care safety net in this country, but what I have found in practice is that accessing these programs can be challenging.

Our experience with the auto-enrollment of Medicare dually-eligible SNF residents underscores this point. We spent considerable time and effort working with CMS as well as with our most frail poor and elderly residents—first in identifying into which Part D Plan the resident had been automatically enrolled, and then in determining whether or not that plan met his/her needs. What we learned through that process is that the infrastructure for coordinating Medicare, Medicaid,

Social Security and State Medicaid was not up to par and caused delay, confusion, and ultimately, required all of us to work together to overcome the resultant shortcomings.

AHCA/NCAL understands that retrofitting a new benefit with multiple new processes is difficult. In fact, we have looked at ways we might recommend the program that Americans rely on to pay for care of our most vulnerable citizens—Medicaid—reformed to better meet the needs of a swiftly aging baby boom generation—most of whom will require long term care services at some point in their lives. By 2040, the number of older nursing home residents is estimated to more than double to 2.7 million.

It is important to note that Medicare and Medicaid are inextricably linked to each other and to the quality of care provided. Therefore, we recommend working toward a system that delivers an array of long term care services, administered by knowledgeable, quality-driven providers. We also want to ensure that beneficiaries move seamlessly among services across the long term care spectrum; that they receive the services they need and desire; and that funding is adequate to pay for the necessary care delivered by long term care providers for more than a million Americans on any given day. Additional recommendations can be found in our attached *Medicaid Reform Principles*.

As we try to address the complex problems facing health care in America, we should not be so quick to see any one program as the solution; rather, we should seek to work together—all of whom have a stake in the future of our long term care delivery system. As we look toward an ever-expanding continuum of long term care options, we need to ensure that people understand their options and that they are able to choose the care setting that best meets their individual needs and preferences.

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Principles for Long Term Care Reform Executive Summary

Preamble

Continued Medicaid cost growth and increasing numbers of long term care users are driving states and the federal government to fundamentally reform the Medicaid program. Because long term care costs drive much of Medicaid growth, long term care reform – primarily within Medicaid reform efforts – has become a top policy priority for the federal government and most states.

In order for AHCA/NCAL to best represent member interests, a cross-cutting member work group developed a set of broad long term care reform policy principles – or essential programmatic elements – to guide or serve as a framework for AHCA/NCAL long term care policy development and reaction to federal and state proposals. The long term care reform principles build upon current AHCA long term care and Medicaid policies and will guide future AHCA/NCAL activity. Additionally, the principles also support one or more of AHCA’s long term care and/or Medicaid policy goals previously developed by AHCA’s Finance Subcommittee.

The member work group determined that managed care warrants its own set of principles.

The Principles

Three key principles frame a long term care program(s) that will: (a) support consumer preferences and needs; (b) foster policy efforts aimed at creating a more sustainable array of long term care financing options; and (c) provide a viable operating environment for long term care providers. Each principle includes several key elements.

Principle I. Publicly and privately financed long term care and related supports and services must meet consumers’ and families’ needs and be responsive to their preferences.

- *Recognize that consumers are key stakeholders in long term care policy decision making and government must include them in development, oversight and monitoring.*
- *Provide that every eligible individual who needs long term care services receives them in a timely manner in an appropriate setting, taking into account individual preferences and clinical needs.*

- *Acknowledge the key role that family care givers play and provide family care giver supports.*

Principle II. Long term care policies should promote and integrate a comprehensive array of public and private long term care financing options.

- *Encourage individuals to plan for long term care and provide viable private long term care financing options.*
- *Ensure that individuals have the tools they need to manage their long term care services as beneficiaries assume more personal responsibility for services – publicly and privately financed.*
- *Recognize the impact of reimbursement changes on long term care providers.*
- *Ensure that efficient coordination of benefits reduce administrative burdens on beneficiaries and providers.*
- *Encourage individuals, providers and government payers to engage in a policy debate on balancing public and private financing of long term care.*
- *Encourage the design of tax policies that coordinate with long term care financing strategy alternatives.*

Principle III. Through sufficient federal and state governmental infrastructure, policies should ensure that long term care service delivery systems provide an adequate array of services and administered by knowledgeable and quality driven providers across the long term care spectrum.

- *Include a strategic plan for building needed infrastructure and ensure a sufficient supply of long term care providers that engage in a variety of services to meet the needs of the population.*
- *Ensure that beneficiaries may move seamlessly among services across the long term care spectrum.*
- *Foster and support quality and efficiency in Medicaid services, as well as provide operational flexibility.*
- *Managed care plans should recognize that long term care providers deliver services that are distinct from acute care providers.*

- *Funding is adequate and timely in order to provide stability and predictability to meet the needs of long term care recipients at the appropriate time, in the appropriate place, and at the appropriate cost.*
- *Encourage development and use of a standardized post-acute assessment and benefit package to facilitate determination of patient need and placement.*

Complete AHCA/NCAL Principles for Long Term Care Reform

Introduction

Patients and their families are increasingly interested in sources of care and sites of services that are non-facility based, including home- and community-based settings (HCBS). Local communities, states, and the federal government are responsive, particularly since they believe that HCBS will be less costly and therefore save money. Because of consumer preferences and related federal and state policy changes, the proportion of long term care services delivered in facility-based settings is smaller than in the past. Medicaid reform has become the major vehicle for these and other long term care reform efforts at both the state and federal levels.

To date, many long term care reform proposals focus on delaying or preventing facility-based placement while encouraging use of personal long term care planning and expanding HCBS availability. The culminating outcome likely will be decreasing use of nursing homes and intermediate care facilities for persons with mental retardation (ICFs/MR).

This is not to suggest that the need for facility-based services will disappear. Rather, facility-based services are likely to play a relatively smaller role at least in the next ten to fifteen years. In the longer term, it is less clear how long term care will be delivered. Short term pressures and out-year ambiguity suggest that AHCA – the largest formal long-term care provider group in the country – adopt a forward-looking, leadership-based approach to shape long term care policies and ensure that there is a sustainable array of long term care services – and related privately and publicly financing options – for all Americans.

In late January, AHCA and NCAL members began the process of developing a set of guiding Medicaid reform principles. Principles were developed and assessed against the following dimensions:

- *Will the principles foster policy efforts aimed at creating a more sustainable long term care financing model?*
- *Do the principles support consumer preferences and needs?*
- *Will the principles foster a viable operating environment for long term care service providers?*

The principles were drafted to encapsulate existing AHCA/NCAL policy and provide a more succinct tool for sharing AHCA/NCAL positions as well as to frame proactive policy initiatives. The principles build on past policies by condensing concepts that are highly interrelated, promoting policies that are viable in the current political and budgetary environment, and providing a proactive positive framework for representing AHCA/NCAL interests. The principles also directly relate to AHCA long term care and Medicaid policy goals developed by the AHCA Finance Subcommittee.

The Principles

Three key principles frame a long term care program(s) that will: (a) support consumer preferences and needs; (b) foster policy efforts aimed at creating a more sustainable array of long term care financing options; and (c) provide a viable operating environment for long term care providers. Each principle includes several key elements and also supports one or more of AHCA's long term care and/or Medicaid Policy goals previously developed by AHCA's Finance Subcommittee.

Principle I. Publicly and privately financed long term care supports and services must meet consumers' and families' needs and be responsive to their preferences. Unlike acute and primary health care services, long term care services are not discrete events (i.e., a sore throat, broken leg, etc.) that require specific medical interventions. Instead, receipt of long term care services becomes a lifestyle for both the person receiving services and his or her family. Long term care services are integrated into virtually every aspect of an individual's life and make the experience of long term care highly personal. To that end, long term care policies must:

- *Recognize that consumers are key stakeholders in long term care policy decision making and government must include them in development, oversight and monitoring.* State Medicaid agencies are required to provide public notice and time for comment when changes to the Medicaid program are proposed. They also are required to respond to stakeholder concerns. The federal government should require documentation that these requirements have been met.
- *Provide that every eligible individual who needs long term care services receives them in a timely manner in an appropriate setting, taking into account individual preferences and clinical needs.* Policies must recognize the individual – to the extent possible – as the key decision-maker regarding their supports and care. For privately financed options, policies also must ensure that these options – particularly insurance products – recognize the importance of consumer preference.
- *Acknowledge the key role that family care givers play and provide family care giver supports.* Family care givers are a critical – but often unrecognized – segment of the long term care spectrum. State and federal programs must provide incentives and assistance for family care giving such as income tax deductions, availability of respite and day programming, and family counseling services.

Principle II. Long term care policies must promote and integrate a comprehensive array of public and private long term care financing options. As the proportion of our population age 65 or older increases and the number of younger persons with disabilities increases, the federal government and states must take steps to increase use of private long term care options. Increasing the use of private options will improve the sustainability of a publicly financed long term care program, currently Medicaid. And, reimbursement policies must recognize the potentially interrelated impacts of payment policy changes to ensure a stable long term care provider marketplace. A stable array of long term care providers will be better positioned to meet consumers' needs and preferences. To increase use of the array of long term care financing options, policies must:

- *Encourage individuals to plan for long term care and provide viable private long term care financing options.* The federal government should promote the development of innovative programs, such as incentives for families to purchase long term care insurance, save money for long term care or otherwise plan for private long term care needs. State and federal government also should fund programs to raise awareness of long term care planning needs and help individuals and families make the best long term care financing decisions.
- *Ensure that individuals have the tools they need to manage their long term care service as beneficiaries assume more personal responsibility for services – publicly and privately financed.* Long term care reform proposals include a wide range of elements that give beneficiaries more control over services and service dollars. Examples include HCBS Individualized Budgeting models, Money Follows the Individual and Cash and Counseling programs. In addition to increased control and responsibility, government also should provide adequate supports to beneficiaries on how to direct their own services and wisely allocate service dollars. Government should have safeguards and oversights in place to ensure that these services are appropriate and effective in achieving the care planning goals of the beneficiary.
- *Recognize the impact of reimbursement changes on long term care providers.* Long term care providers receive payments from private sources, Medicaid, and Medicare for post acute care stays. Policy changes that decrease or otherwise affect revenue streams should be evaluated in the broader context of the array of financing sources, e.g., the impact of changes to Medicare payments when providers experience shortfalls under Medicaid.
- *Ensure that efficient coordination of benefits reduce administrative burdens on beneficiaries and providers.* Beneficiaries should be able to move seamlessly among services across the long term care spectrum without limitation due to burdensome administrative requirements that are commonly placed on providers and beneficiaries. Attention to streamlining coordination of benefits will result in better care as needs change.
- *Encourage individuals, providers and government payers to engage in a policy debate on balancing public and private financing of long term care.* The increasing long term care

population and accompanying growing costs results in a need for all stakeholders to be engaged in discussions on how best to finance this expanding population's care. This discussion should examine and weigh both public and private financing options.

- *Encourage the design of tax policies that coordinate with long term care financing strategy alternatives.* Identification of financing strategy alternatives is valuable only to the extent that such alternatives are implemented. Incentives, such as tax policies, will aid implementation efforts.

Principle III. Through sufficient federal and state governmental infrastructure, policies must ensure that long term care service delivery systems provide an adequate array of services and service providers across the long term care spectrum. Long term care reforms are being proposed and implemented at a rapid pace. Changes in service delivery systems, such as significant increases in HCBS use, must be accompanied by adequate increases in state administrative infrastructure including quality assurance and improvement, payment systems, data collection, and consumer and family information and referral services. To ensure market driven long term care system change at an appropriate pace, policies must:

- *Include a strategic plan for building needed infrastructure and ensuring an adequate array of long term care providers.* For publicly financed programs, government should require a reasonable plan for phasing-in changes that require substantial build ups in provider capacity and state infrastructure development. Government also should require that milestones or markers be met before additional changes or expansion. Government should encourage the notion that beneficiaries who need long term care services receive them at the needed intensity level (including facility-based services) as well as an adequate array of care management supports that do not place undue hardship on the individual or family caregivers.
- *Ensure that beneficiaries may move seamlessly among services across the long term care spectrum.* Long term care systems and providers are highly insular. For many beneficiaries, the result is typically a fragmented service system that is confusing and produces questionable outcomes. Government must ensure that long term care providers have the capacity to develop service arrays, partnerships, and business arrangements that foster a seamless service experience.
- *Foster and support quality and efficiency in long term care services, as well as provide operational flexibility.* Long term care providers face significant operational costs including purchasing or upgrading health information technology systems, capital improvements to existing facilities, and financing innovative services that could support specialty populations. Government regulation should not impede long term care service innovations among long term care providers that follow consumer preferences in a cost effective manner.
- *Managed care plans should recognize that long term care providers deliver services that are distinct from acute care providers.* A key long term care reform component is

managed care – particularly for Medicaid-financed long term care. Experiences in states like Arizona show both positive outcomes and concerns for long term care providers. As managed care for Medicaid beneficiaries who are elderly, blind and have disabilities is expanded, federal and state officials should avail themselves of the long term care professionals’ policy, operational, and clinical expertise as these arrangements unfold.

- *Funding is adequate and timely in order to provide stability and predictability to meet the needs of long term care recipients at the appropriate time, in the appropriate place, and at the appropriate cost.* Government should recognize that demand for long term care services and financial pressure on providers – as well as increased risk bearing at the plan, provider and consumer levels – make additional investment in provider capacity, service quality and efficiency a necessity. Government payment rates at all levels of the long term care spectrum should be sufficient to provide quality services and cover the cost of operating, as well as needed capital improvements.
- *Encourage development and use of a standardized post-acute assessment and benefit package to facilitate determination of patient need and placement.* As opportunities to receive services are expanded, the need for uniformity in assessment becomes increasingly important.

Framework for Moving Forward

Since the inception of the Medicaid program, responsibility for long term care financing and delivery gradually has migrated away from the beneficiary and the family to the public sector. Increasing reliance on Medicaid for long term care services raises serious questions about programmatic sustainability. Additionally, demography, care delivery challenges (such as worker shortages), marketplace demands, financing, legal and regulatory, and industry trends, create an unprecedented need for the long term care professionals to help shape its future.

In partnership with consumer groups, long term care providers, including HCBS providers and facility-based, will lead the effort toward development of an integrated, flexible long term care array that responsibly informs and educates Americans about their long term care responsibilities and options, but also delivers Medicaid-financed services in a cost-effective, customized manner. In order to achieve these goals, AHCA/NCAL will partner with other long term care organizations based on its long term care policy principles to address the challenges and opportunities associated with building a sustainable long term care system.

AHCA/NCAL Managed Care Principles

At the AHCA/NCAL long term care reform work group meeting held on January 26, 2006, participants decided that managed care warrants its own set of principles. Staff were assigned the responsibility of drafting such principles for discussion at the March meeting.

Work group participants asked that additional attention be paid to managed care because of growth in:

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1. ***Managed care for Medicaid-only Beneficiaries Who Are Aged, Blind or have Disabilities.*** The effects on long term care systems will be: a) increasing pressure to use less costly services including earlier hospital discharges into sub-acute facilities or temporary placement in nursing homes; b) limited use of nursing home services until all less costly options have been explored; c) increased competition among nursing homes based on managed care organizations' (MCO) focus on best price; d) additional bureaucratic layer, which results in the redirection of a significant portion of available dollars from the bedside into administration; e) increased potential for duplication (among and between MCO's) in both quality assurance and regulatory intervention, which is both costly and cumbersome; and f) increased flexibility and opportunity for innovation.
2. ***Managed Medicare and Medicaid Integration Programs.*** The Medicare Modernization Act of 2003 Special Needs Plan (SNP) authority could lead to increased state interest in managed care arrangements that integrate or better coordinate the Medicare and Medicaid programs. Commercial interest has been considerably greater than expected; to date, 296 SNP products are available.¹ Additionally, the 2007 Medicare Advantage plan application includes an expanded SNP section for Medicare and Medicaid integration options. And, Dr. McClellan has made integration one of his top policy priorities. A significant number of states are exploring managed care arrangements that would capitate both Medicare and Medicaid payments to managed care plans. In turn, providers would be reimbursed with rates based on the Medicare and Medicaid capitation payments to plans. While integrated care may be helpful from a continuity of care perspective, Medicare and Medicaid Integration programs will negatively impact provider reimbursement as it will be considerably lower than traditional Medicare
3. ***Managed Care Delivery of Preventive Care (i.e., disease management (DM), care coordination, and wellness initiatives).*** DM, care coordination and disability management programs hold the promise of reducing disability acuity and the impact of chronic illnesses. In turn, such outcomes also result in lower costs and reduce financial strain on the health care system. Many Section 1115 Medicaid waivers include wellness incentive programs for beneficiaries. States also are heavily leveraging Medicaid managed care plans and/or integrated Medicare/Medicaid managed care plans to deliver such services.

Managed Care Principles

Managed care policies should recognize that long term and post acute care providers deliver services that are distinct from acute care providers. A key long term care reform component is managed care. Experiences in states like Arizona show both positive outcomes and concerns for long term care providers. As managed care for Medicaid-only beneficiaries who are elderly, blind and have disabilities or for dually eligible individuals is expanded, federal and state officials should avail themselves of the long term and post acute care professionals' policy,

¹ Presentation by Jennifer Podulka, MEDPAC staff person using CMS data, at the MEDPAC meeting. January 11, 2006

operational, and clinical expertise as these arrangements unfold. Five key managed care elements should be considered with the managed care principle:

- *Enhanced Flexibility in a More Competitive Operating Environment.* Long term care providers should have the freedom to take on a wide array of roles in the coordination and provision of individuals' long term and post acute care. Policies should allow providers to take on various roles, alone or in partnership, in the delivery of long term and post acute care services including risk contracting, administrative organizations roles, information and referral, care coordination of an individual's clinical needs, as well as care management and disease management.
- *Inclusion in Managed Care Program Development and Operational Decision Making.* Long term care providers should be meaningfully included and engaged in managed care program design. Specific points of engagement should include: (1) ongoing participation in capitation payment methodology and rate development and refinement; (2) agreement on, development and testing of a uniform assessment tool that identifies service needs and will ensure a reasonable and adequate payment by site of service; (3) plan contracting requirements – specifically, plan profit requirements (ensuring that plan profits and overhead costs are not excessive), development of provider rates and processes for reconciliation; (4) ensuring a level playing field, including decisions on “any willing provider” requirements; (5) prompt payment; and (6) coverage, prior authorization and utilization management processes.
- *Special Consideration As Capitation Rates, Risk Adjusters, and Subsequent Provider Rates Are Developed.* Long term and post acute care providers must have the resources to deliver services, meet capital costs associated with facility or unit maintenance, and meet both state and federal licensure and operating requirements. First, MCO contracts and state oversight must ensure that plan capitations payments – including any frailty adjuster – associated with individuals using long term care be fully available for that purpose. Second, in Medicare and Medicaid integration arrangements, states must ensure that rates including or based on Medicare capitation payments to plans and providers also be actuarially sound (currently a Medicaid requirement for managed care capitation payment rates). Third, the long term care provider marketplace faces significant capital costs to maintain aging facilities, upgrade existing facilities, and/or develop new service settings – such as small congregate settings or single occupancy capacity. Payment rates must include a margin that will support critical capital maintenance and development and ensure provider financial viability and sustainability.
- *All long term and post acute care settings should have quality measures tailored to the type of service setting and long term or post acute care populations.* Acute care quality measures and measurement tools are inappropriate for long term care settings and, in some instances, long term care populations. States and plans must work with long term and post care providers to: identify a quality measurement system that is (a) targeted to long term care or post acute care service outcomes; and (b) based on current clinical or social supports best practices. Finally, all willing providers with the capacity to

implement and collect data on the quality measures in a managed care coverage region should have the opportunity to participate in the provider network.

- *Managed care plan coverage determination processes (i.e., medical necessity definitions and related procedural guidance) must reflect the difference between acute care service outcomes and long term care service outcomes.* Because of the unique needs of the long term care population and the nature of long term and/or post acute care settings, coverage determinations on access to care should emphasize maintenance of functioning and specialized healthcare needs. Additionally, coverage determinations should reflect that long term care consumers' physical and psychosocial support needs are ongoing and must be tailored to individual preferences to the degree possible.
- *Development and use of a standardized post-acute assessment and benefit package to facilitate determination of patient need and placement.* As opportunities to receive services are expanded, the need for uniformity in assessment becomes increasingly important.

Conclusion

The long term care system is under considerable pressure driven by payer and consumer preferences to shift from facility-based care to consumer-directed home- and community-based or more home-like services, along with tighter reimbursement, and difficult to manage Medicare and Medicaid operating requirements. Considerable attention must be given to the potential impact of managed care on the stability of the long term care provider marketplace to ensure erosion of capacity is not accelerated. The principles and key elements above should be used by policymakers, providers and others to help craft policies, including a long term care provider bill of rights to address issues arising from the expansion of managed care for long term care populations.