

**WRITTEN TESTIMONY
Of
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**For the U.S. House Energy and Commerce Hearing
*"Medicaid Reform: The National Governors Association's Bipartisan Roadmap"***

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On behalf of the American Health Care Association (AHCA) and National Centers for Assisted Living (NCAL), we thank Energy and Commerce Chairman Barton and Health Subcommittee Chairman Deal for conducting this hearing on the future of our Medicaid program, and how we will go about strengthening the healthcare safety net for our nation's frail, elderly and disabled seniors.

This hearing is important and timely – not just because of the budget and healthcare policy implications, but because the decisions that are ultimately made regarding necessary, comprehensive reform will have far-reaching implications on the lives of nearly every American.

Despite the obvious complexities associated with the topic at hand, the debate centers on five central elements of the health care equation: quality, choice, access, accountability and appropriate investment in care.

Regardless of the inevitable differences in reform plans put forward by the National Governors Association, the Medicaid Commission chaired by HHS Secretary Leavitt and others, we must ultimately determine how best to transform and improve the current fragmentary framework of long term care -- making it more integrated, efficient, affordable and quality-driven throughout the entire care spectrum.

Before outlining specific proposals to strengthen Medicaid for the longer term, we believe it is essential to address the growing importance and utilization of home and community based care services (HCBS) throughout America.

At the state level, expansion of HCBS care is among the most significant developments in the context of budgets as well as overall policy, and no discussion of Medicaid reform is complete without a thorough, unemotional, objective discussion of its benefits and liabilities.

In an attempt to grant more flexibility to states, President Bush has proposed decreasing or eliminating hurdles that states currently face in obtaining approval for their home and community based services (HCBS) waivers. The stated purpose of the waiver is to help curb state spending, while also providing more choices to seniors and people with disabilities. Similarly, the NGA also supports improving access to home and community based care, both for better outcomes and for greater efficiencies.

Obviously, this has enormous appeal for state policy makers of both parties attempting to reign in Medicaid costs while simultaneously improving seniors' and people with disabilities quality of life. Every one of us today can agree we would prefer to reside in our homes for the rest of our lives – and forego a move to a long term care facility.

But we are troubled by the development of a well meaning, yet factually unfounded, mindset among elected officials, seniors' and disability advocacy groups and the media that the simple answer to lower Medicaid costs and higher care

quality will be found by rapidly shifting a significant population of seniors and people with disabilities out of facilities like nursing homes and intermediate care facilities for persons with mental retardation to home and community care settings.

While AHCA/NCAL always has and always will favor individuals being able to receive necessary long term care services in the most appropriate setting, we are concerned that efforts to ostensibly “save” money may not serve that purpose and may drain essential funds away from care to seniors and persons with disabilities who require the services provided in nursing home settings.

Not only is there very little empirical evidence to suggest the budget “savings” from HCBS expansion is a reality, there is very little evidence to suggest that increased HCBS use is offset by decreased nursing home use. In fact, the claims of budgetary savings may mask added costs in other areas of the budget. An important study conducted by Joshua M. Wiener of The Urban Institute entitled, “Can Medicaid Long-term Care Expenditures for the Elderly Be Reduced? (The Gerontologist Vol. 36, No.6 1996) stated the following:

“The most persistent dream in long term care is that the expansion of home care and other nonmedicalized residential long-term care services could reduce overall long-term care expenditures. The fundamental hope has been that lower-cost home care could replace more expensive nursing home care. However, there is substantial, rigorous research to suggest that expanding home care is more likely to increase rather than decrease total long-term care costs (Kane & Kane, 1987; Kemper, Applebaum, & Harrigan, 1987; Weissert, Cready, & Pawelak, 1988; Wiener & Hanley, 1992). Older persons’ aversion to nursing homes explains this increase. Given a choice between nursing home care and no formal services, many elderly people will choose nothing. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset relatively small reductions in nursing home use.”

This same study found that three states that are pioneers in the expansion of home and community based services actually saw increases greater than the national average in their long term care programs during the time they reorganized their long term care delivery system. According to Wiener, “both Oregon and Washington had rates of increase in Medicaid long-term care expenditures that were substantially greater than for the United States as a whole.” Wisconsin, according to Wiener, did have “a much lower rate of increase, but much of its home and community based services are financed outside of the Medicaid program.” The case in Wisconsin demonstrates that the claims of budgetary savings may mask added costs in other areas of the budget. For example, while cost per beneficiary may appear to be lower, costs in other programs may rise to provide additional payments for services already included in nursing home rates -- like housing, meals and social services.

To be clear, AHCA/NCAL supports the expansion of home and community based care. We support an adequately funded, comprehensive, national strategy that ensures that appropriate supports and services are provided in appropriate settings to qualified individuals who are aging and/or have disabilities. We are concerned that a rush to expand these services because they create efficiencies will not provide savings and may siphon funds from those who need 24-hour facility based care.

Moreover, as the fastest growing population of seniors is those eighty and older, now is the time to be *strengthening* our facility-based care infrastructure -- not *divesting* in our capacity to care for patients who will live longer and require higher acuity care. The nursing home of today is treating higher acuity individuals and the infrastructure has not kept up with that demand. Most nursing homes around the country have aging buildings and they need upgrades to their infrastructure to keep up with technology and the needs and choices of today’s patients, such as private rooms. We may need less nursing home beds in the future, but we need more technology and physical plant changes to ensure the safest environment and the highest quality of life for patients and residents. Now is not the time to divert funds from facility care. Rather we should provide incentives to make changes that better serve seniors and people with disabilities who need 24-hour care in a facility.

We are also concerned that the quality, safety and training standards inherent in facility care are not extended to the increasingly diverse array of settings we see in states across the nation. This concern was cited by the General Accounting Office (GAO), which warned in a study entitled, “Long Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should be Strengthened.” Released in July of 2003, the report issues concern in three primary areas:

- Trends in states’ use of Medicaid home and community-based service (HCBS) waivers, particularly for the elderly;
- State quality assurance approaches, including available data on the quality of care provided to elderly individuals through waivers; and
- The adequacy of federal oversight of state waivers.

Comparatively, new federal data from HHS released just six months ago indicates care quality in nursing homes throughout America is improving in important, fundamental ways.

The refrain from HCBS advocates is that “money should follow the person.” Under the proper policy framework, we concur – but we also believe “quality care should follow the person” – and this must be addressed under any broader Medicaid reform plan. Facility-based care and home and community based care are not, as some seem to think, mutually exclusive. They are, in fact, complementary – and the challenge is to apportion funding in a manner that reflects reality.

Providing seniors and people with disabilities with maximum choice and flexibility should always be the mission of government and providers when it comes to delivering quality health care services, in all long term care settings. But as consumers benefit from more diversity, we must also ensure costs are what they claim to be, and that care quality is ensured across all settings.

This is an open question in every state, and we encourage Governors Huckabee, Warner and all of our elected state and federal lawmakers to examine the HCBS Medicaid waiver program far more closely – for the benefit of senior and taxpayer alike.

AHCA/NCAL supports other reforms put forward by the NGA. Proposals such as transfer of asset policy, tax credits and tax deductions for long term care insurance, the continuing the Robert Wood Johnson Partnership Plan and especially encouraging citizens to plan for their long term care needs and, therefore, injecting more private dollars into the nation’s long term care system.

Over the past several months, AHCA/NCAL has also outlined necessary reforms that will help empower individuals to take more control of financing their long term care needs – and this is central to strengthening Medicaid. We have long recognized that our nation has a patch-work system for funding long term care and this will soon become unsustainable as 77 million baby boomers rapidly move toward their retirement years.

AHCA/NCAL is a staunch, longtime advocate of tax incentives for the purchase of long term care insurance, and we are pleased President Bush has put forward several concepts in his budget centered on promoting personal responsibility, and individual planning for one’s long term care needs.

Specifically, we support the NGA’s Medicaid reform policy in these areas:

Medicaid Estate Planning

Medicaid was never intended to become the nation’s primary long term care financing program and is not sustainable if the baby boom generation uses it as such. While we must preserve Medicaid as a safety net program, we must also take steps to encourage people who are able to otherwise fund their own long term care.

Medicaid is a means-tested public assistance program. However, the eligibility rules and the statutory prohibition on asset transfer have not apparently achieved the desired end of care for the truly eligible for at least two major reasons: first, the prohibition itself is not adequate; and, second, the apparent proliferation of Medicaid estate planning techniques that circumvent the prohibition.

The situation results in the inappropriate use of state Medicaid funds for individuals who should not qualify for such public assistance and the concomitant lack of funds for appropriate reimbursement to providers for care of the truly needy. Thus, both the state and Medicaid providers such as nursing facilities are negatively impacted.

The problem for nursing facilities is exacerbated by state rules that delay and then often deny payment to nursing facilities -- due to various reasons including asset transfers that have violated the Medicaid statute, until the state process -- often long and drawn out -- for determining an individual's eligibility has been completed. Some states have sought to change the date on which penalty periods resulting from improper asset transfer begin. In these cases, a nursing home may admit an individual as a private paying resident, will receive private funds for the cost of care until such funds run out and the penalty period begins, and then will continue caring for the individual when there is no source of payment. Such a period could last many months. Nursing homes will have no option due to a combination of law and reality other than to absorb the cost of care of these residents. Federal law prohibits nursing homes from requiring a third-party guarantee of payment upon admission; thus, there is no other party to turn to. Surely, nursing homes were not intended to provide the entire cost of care while this is settled.

AHCA/NCAL supports additional policy and efforts that both help states retain Medicaid funds for the truly needy and help providers to receive reimbursement for care that has been provided.

On the state level, the look back period is one of the weakest links in the asset transfer law and should be lengthened. In addition, a variety of Medicaid estate planning mechanisms -- trusts and annuities, for example -- have been developed to circumvent the legislative asset transfer rules. These permit middle to higher income individuals to make funds disappear through asset transfer and conversion, which could and should be used to support them when they need long term care services.

Thus, AHCA/NCAL supports the following policy positions aimed at assisting states and providers to preserve Medicaid funds for those truly in need:

- Support Section 1115 waiver applications to increase the look back period from 3 to 5 years but leave the starting date of the penalty period as currently provided in law, and close the loopholes in law that enable individuals to use Medicaid estate planning techniques to circumvent asset transfer prohibition and eligibility rules;
- Eliminate the regulatory prohibition on a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility; and
- Change the state policy and process for determining eligibility of individuals for Medicaid so that exposure to inappropriate loss of payment for the facility is eliminated or minimized. The President's FY 2005 budget included a proposal to establish a State Medicaid option allowing presumptive eligibility for institutionally-qualified individuals who are discharged from hospitals into the community.

We argue that presumptive eligibility should apply to all provider categories so that availability of the presumption would not skew an individual's choice of care site, which should be driven by clinical considerations.

However, at a minimum, the facility provider should be held harmless in the event that Medicaid eligibility is denied due to an asset transfer that violates Medicaid law, i.e., there is no recoupment of state payment that had been made to the provider by the state.

The state, in effect, pays the provider and assumes responsibility for recouping the money from the beneficiary; and the state must make an eligibility decision within 30 days of the application of the resident and facilitate discharge and relocation of the individual if reimbursement is denied.

If the state takes longer than 30 days to make a decision, payment is guaranteed to the provider so long as the provider must furnish services to the individual.

State Partnership Long Term Care Insurance Programs

AHCA/NCAL supports the Robert Wood Johnson Long Term Care Partnership program that, beginning in 1991, allowed states (Connecticut, New York, Indiana and California) to provide individuals dollar for dollar or full asset protection against Medicaid spend-down eligibility requirements when buying a qualifying partnership policy.

While critics of this program point to limited success, we believe it is significant in that it delays one's reliance on the Medicaid program. More importantly, utilizing a long term care policy affords the consumer more choice in care settings than Medicaid, which primarily pays for nursing home care.

We understand that results from this program are not overwhelming but it is important to note that less than 100 people have utilized Medicaid during the 11 years of the life of the program, according to the National Association of Health Underwriters. We support repeal of the provision that stopped expansion of this program. We would like to work with this Committee to expand the use of long term care insurance by eliminating the ban on the Long Term Care State Partnership programs.

Tax Incentives to Encourage the Purchase of Long Term Care Insurance

In recent congressional sessions, legislative efforts to expand the utilization of insurance through tax incentives have found growing support. In addition to tax credits, AHCA/NCAL has supported an "above-the-line" deduction to make the deduction available to a maximum number of Americans.

We continue to support such measures today but recognize that the cost to the federal government has been a hurdle for congressional passage of the legislation. Although he has supported it in the past, we were disappointed that the President did not include a similar provision in this year's budget. Such solutions must allow the nation and its citizens' to move beyond today's pay-as-you-go financing system to one that encourages, supports and protects individuals who choose to plan for their own long term care needs through private insurance and other financial means.

Home Equity Conversion and Other Resources

Other proposals being advanced involve home equity conversion, long term care annuities and inclusion of long term care policies in cafeteria plans. While encouraging citizens to utilize long term care insurance alone won't save the Medicaid program from collapse -- these and family caregiver exemptions and credits are all elements that could be combined with the Robert Wood Johnson Long Term Care Partnership into a comprehensive national long term care policy.

Home equity conversions such as reverse mortgages are particularly intriguing. According to the National Council on the Aging, 48% of America's 13.2 million households age 62 and older could utilize \$72,128 on average from reverse mortgages. The value is that these funds are available immediately and could go a long way to pay for help at home

and for retrofitting the home to make it safer and more comfortable. These funds could also be used to purchase long term care insurance, or for assisted living or nursing home care for an ill spouse while the well spouse remained in the family home. We are aware of the limitations in utilizing reverse mortgages to fund long term care expenses. Despite the current limitations, the equity that many seniors possess could help them tremendously with their needs and their desire to remain in their homes. We would like to work with Congress to find creative ways to help seniors tap into this resource.

Medical Liability

Access to quality long term care for our nation’s most vulnerable population is being threatened by a growing long term care medical liability crisis. The frail elderly, who depend on long term care facilities, nursing homes and assisted living facilities alike, are feeling the effects of skyrocketing insurance premiums for nursing facilities.

The difficulty in obtaining insurance and the threat of costly lawsuits has forced some long term care providers to go without coverage and others to close their doors altogether. Long term care medical liability insurance costs have been increasing at an alarming rate over the past several years. Many issues, including civil causes of action based on subjectively defined patient’s rights statutes, unlimited punitive damages, and add-on attorney fees are responsible for this trend. Moreover, efforts to improve quality in long term care facilities are being stifled by the diversion of dollars away from care and toward liability costs.

In their annual actuarial study of long term care general and professional liability, AON Risk Consultants has found General Liability/Professional Liability claim costs have absorbed 21% (\$6.38) of the \$30.69 increase in the countrywide average Medicaid reimbursement rate from 1995 to 2002.

States struggle to provide reimbursement increases to long term care providers and those dollars that are intended for patient care should not have to pay for increased liability premiums.

Medicaid Ripe for Reform

For all of the positions stated above and others, AHCA/NCAL supports reform of the Medicaid long term care system – and we seek to work with you to design a model that allows more choice for seniors and people with disabilities, and that injects more private dollars into the long term care system.

Demographic realities require a change in policy and a transformation in thinking. We must fundamentally shift the role of government – from government simply paying for services to government helping individuals save and plan for their own long term care needs, while still preserving the Medicaid program as a safety net for those who truly need it...

As we work to strengthen every citizens’ future ability to prepare for their retirement, we urge this Committee to further investigate and address the issues we have discussed today.

Thank you, Mr. Chairman, for the opportunity to submit our testimony, and we look forward to working productively and cooperatively with this Committee to help strengthen retirement security for every American.

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