



STATEMENT
Of
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On Behalf Of The
AMERICAN HEALTH CARE ASSOCIATION
&
NATIONAL CENTER FOR ASSISTED LIVING

Before The
House Energy & Commerce Subcommittee on Health
On
“H.R. 5613, Protecting the Medicaid Safety Net Act of 2008”

April 3, 2008

On behalf of the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL), I thank Chairman Frank Pallone, Ranking Member Nathan Deal, and Members of the Energy and Commerce Health Subcommittee for taking the time to closely examine our nation’s Medicaid policies.

My name is Dr. Stuart H. Shapiro, and I am President and CEO of the Pennsylvania Health Care Association (PHCA) and its companion organization, the Center for Assisted Living Management (CALM). We advocate for compassionate, quality, long term care for Pennsylvania’s elderly and disabled citizens. Our 300-plus members are predominantly long term care providers who operate nursing homes, personal care homes, and assisted living residences and whose top priority is providing quality of care and quality of life for those entrusted to their charge.

Today’s hearing provides an ideal forum to discuss how “so-called policy clarifications” and changes in Medicaid regulations are, unfortunately, a unilateral attempt by the executive branch to cut Medicaid funding without adequate congressional oversight, without a complete understanding about how these changes impact our most vulnerable seniors, and without the public policy transparency clearly needed considering the sweeping nature of the proposed changes.

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Equally important, Mr. Chairman, the Medicaid changes being proposed here in Washington, DC, are completely antithetical and divorced from the budgetary and economic realities that we face in Harrisburg, Pennsylvania and in state capitals from coast to coast.

As the *Wall Street Journal* recently reported, “Slower growth in tax revenues, the result of a weakening economy, are prompting governors from New Jersey to California to consider an array of belt-tightening measures to balance their budgets for this year and next.” According to the National Governors Association (NGA), three-fourths of our states anticipate budget deficits in the year ahead. In my own state, we are facing a \$184 million budget hole in long term care alone should changes to the “Cost Limits for Public Providers” regulation proposed by the Bush Administration take effect.

Beyond just contending with the negative budgetary implications at the state level caused by the economic downturn, seniors and the providers who care for them have struggled with the fact that Medicaid, the largest single payer of nursing home care, fails to cover the cost of care for every Medicaid patient receiving care in a nursing home.

An annual study from BDO Seidman/ Eljay LLC shows that nursing homes receive an average of \$13.15 less than the cost of care for every day of care provided to a Medicaid patient – a shortfall of \$4.4 billion nationwide. Since 1999, the funding gap has grown by 45 percent. In Pennsylvania alone, Medicaid underfunding for the cost of that care in 2007 was estimated at more than \$223.6 million—a shortfall that has occurred, every year for the last five years.

These are more than just abstract numbers. These funding shortfalls have a major impact on the front lines of care and negatively impacts staffing, jeopardizes intra-facility quality improvement efforts, and even costs the jobs of the very staff that make a key difference in the quality of care and quality outcomes.

This crisis is far more than just an inconsequential gap between care costs and reimbursement levels – it is a widening chasm that threatens patients, and undermines providers’ ability to sustain hard-won quality gains on behalf of our patients.

Our profession commends Chairman Henry Waxman (D-CA) and the U.S. House of Representatives’ Committee on Oversight & Government Reform for issuing a report that looks at the state-by-state impact of the seven Medicaid regulations issued by the Centers for Medicare & Medicaid Services (CMS). *The Administration’s Medicaid Regulations: State-by-State Impacts* report reflects concerns that our profession has raised about how these regulations impact the long term care of America’s most vulnerable seniors.

From our perspective, the Committee’s report offers documented proof of the considerable blow these regulations would have on our states, our providers and those we care for, and we share the concerns expressed by the Committee that these seven regulations reduce federal Medicaid funds

not through greater efficiency, but through what the report calls, "...unilateral actions by CMS neither directed nor authorized by Congress."

Especially in the context of the economic downturn and concomitant strain on state budgets, we worry that these regulations will limit seniors' access to key Medicaid programs and resources, and that the loss of federal Medicaid funds will shift costs to the states and disrupt existing systems of care for fragile populations.

We in Pennsylvania are grateful to Chairman Dingell and our own Representative Tim Murphy for pursuing the bipartisan bill being discussed today – *The Protecting the Medicaid Safety Net Act of 2008 (H.R. 5613)* – that would impose one-year moratoria on seven Medicaid regulations issued by CMS. It is simply common sense, and good public policy to pause implementation of these regulations in order to take the necessary time to accurately assess the ultimate impact that these changes would have on the people we serve in the Medicaid program—frail seniors and people with physical and developmental disabilities. I am here on behalf of Pennsylvania providers and nearly 11,000 providers nationwide represented by the American Health Care Association and National Center for Assisted Living, and I am proud to say that we endorse this important legislation that is the subject of today's hearing.

The Bush Administration claims that its Medicaid policy changes would save the federal government \$15 billion over five years, but the House Oversight and Investigations Committee report shows that the impact on states would be more than three times that amount – as much as \$49.7 billion. Certainly, with cost estimates of this magnitude and variation, prudence and further study is in order.

The Dingell-Murphy legislation is the right bill, at the right time, asking the right questions—it is among our profession's highest priorities, and we are working for its passage this year.

While we and a host of other providers are still analyzing the proposed regulatory changes and how they would impact different states in different ways, four of the seven regulations – case management services, cost limits for public providers, provider tax, and rehabilitation services – most directly impact seniors and people with physical and developmental disabilities who need long term care. Specifically:

Case Management Services

The proposed changes to this Medicaid regulation would shorten planning time available for seniors and people with disabilities that need help transitioning from a facility to the community. Also, the administrative complexities in this rule would likely decrease both participation by case managers and beneficiaries' quality of care; meanwhile, states' costs would likely increase. When preparing to leave a nursing home after a lengthy stay, an individual may no longer own a home or have appropriate housing, or even transportation for follow up doctor visits. Reasonable time is needed to help put these services in place and ensure that necessary services are maintained so that the fragile senior or person with physical or developmental disabilities makes

a successful transition from long term care facility to home.

While the regulation does not prevent provision of these services, it appears to constrict funds to pay for them. It would be wrong to constrict services to the point that the person being discharged does not receive the case management necessary to put new services in place or ensure their continuation. Patients should not risk ending up worse off, and requiring re-admission to a long term care facility, which is what we fear could happen if this regulation implements these kinds of constraints.

Cost Limits for Public Providers

The proposed regulation would reduce much-needed Medicaid payments to county nursing homes and other public providers, and also restrict states' use of this legal mechanism to generate funding for states' share of Medicaid costs that would send states scrambling to replace funds previously committed to long term care.

States will be hard-pressed to replace lost federal funds with state dollars. States' use of inter-governmental transfers (IGTs) to enhance the federal funds received from CMS, for example, is a symptom of a greater Medicaid funding crisis. States desperate for more Medicaid funding to meet the needs of seniors and people with disabilities in their states have turned toward programs such as IGTs to access the resources needed to care for a growing patient population who require more complex care.

Data collected by AHCA/NCAL finds thirteen states utilize IGT funds for nursing home costs. CMS documents show that as many as 30 states use funds generated from IGTs to help fund long term care costs. States such as California utilize upwards of \$2.6 billion from IGTs for nursing homes and hospitals, and approximately \$50 million is directed to nursing home care. In Illinois, \$71 million from IGTs goes to nursing home care.

In the Commonwealth of Pennsylvania, we continue to rely on an IGT to help fund long term care. If the Cost Limits for Public Providers regulation takes effect on May 25, Pennsylvania will have a \$184 million hole to fill – that is \$184 million less to fund care of more than 80,000 nursing home residents by the more than 101,000 nursing home employees statewide. If CMS continues to restrict critical funding, then we must find another way to fund long term care. It is not fair to the seniors and people with disabilities who rely on us to care for them to have this funding, in essence, cut by changing a regulation with no apparent regard for how their care will otherwise be funded.

Provider Taxes

The changes to this regulation could alter states' ability to assess a provider tax – sometimes referred to as a quality fee – to raise additional, critical funds for patient care. To assess a provider tax, a state must first pass legislation authorizing the use of a quality fee and then apply for approval of the state's provider tax plan from the Centers for Medicare & Medicaid Services (CMS). More than 30 states currently have obtained CMS approval for a provider tax, including

CMS approval of a complex statistical model that states must build to illustrate that the state has met all of the tests required by the federal statute regarding provider tax.

States struggling with their Medicaid budget have relied increasingly on the use of quality fees. Funds generated help pay for care of seniors and people with disabilities in nursing homes, assisted living residences, intermediate care facilities for the mentally retarded or developmentally disabled (ICFs/MRDD) and other Medicaid-funded long term care settings, including home- and community-based services.

Long term care is often the largest piece of a state's Medicaid pie, and governors and legislatures labor over how to adequately fund it. AHCA/NCAL agrees that the quality fee or provider tax does not represent a long term funding solution. AHCA/NCAL supports major reform of the long term care funding system, focusing on individual responsibility to plan for one's long term care needs. Until we have more comprehensive reform and properly fund the long term care system our nation demands, AHCA/NCAL maintains that the quality fee program should remain to generate important funding to pay for long term care for seniors and people with disabilities.

States with a nursing home provider tax include: Alabama, Arkansas, California, Connecticut, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and the District of Columbia.

In Pennsylvania, we depend on this provider tax. The almost \$400 million dollars this tax generates for the Commonwealth is helping to cushion the "double whammy" of federal cuts to Medicare and Medicaid as well as the cuts being proposed by our own Governor.

Rehabilitative Services

AHCA/NCAL is particularly concerned that this regulation's reduction in expenditures could significantly impact services to individuals with developmental disabilities (DD). Specifically, individuals who may be receiving essential services, such as training to improve physical and mental functioning, under a state plan's rehabilitation option, might lose those longstanding and vital services because the services no longer match the proposed rule's definition of "rehabilitation." Notably, unlike the other provider types and public programs mentioned in the rule, intermediate care facilities for people with mental retardation or developmental disabilities (ICFs/MRDD) and group homes for people with developmental disabilities have no funding source beyond Medicaid, and the services required by DD clients are not included in other government programs.

Further, we are concerned about other impacts of the rehabilitation regulation on the broader population of vulnerable Medicaid beneficiaries. The State of Maine has built a system of private non-medical institutions to care for people who would be considered nursing home eligible anywhere else in the country. This system has reduced state and federal costs as well as the number

of nursing home beds in the state by 3,000—no small feat given Maine providers care for some of the highest acuity patients in the nation. I understand from my colleagues in Maine that providers in the state stand to lose \$100 million in critical funding—a significant loss for such a small state and for Maine’s state plan, which was built on good faith and with CMS’ approval.

Even though the rehabilitation services regulation is expected to have a greater impact on care of Maine’s frail and elderly citizens than the case management services regulation, the state Medicaid agency in Maine has yet to focus on it simply because the agency is still trying to sort through the impact of changes that took effect on March 1 regarding Medicaid case management. The happenstance of this timing that places changes to Medicaid case management ahead of rehabilitation services underscores the need for the moratoria that this Committee is considering today, which would allow states more time to analyze and understand the real impact these regulations will have and to begin planning on behalf of Medicaid beneficiaries.

Mr. Chairman, as we move forward with reforming our nation’s Medicaid program – reform that we acknowledge is not just necessary, but vital – we want to offer several principles that form the basis of AHCA/NCAL’s policy objectives:

- Finding future budget savings should not come at the expense of today’s quality long term care provided for poor and frail elderly;
- Particularly in difficult economic times, states are desperate for supplementary Medicaid funding to meet the needs of their most vulnerable citizens, and must retain the latitude necessary to ensure care quality and access are maintained;
- Instead of focusing on legal mechanisms such as the provider tax, which has been used for nearly two decades, we should focus on why these dollars are needed, and how we can meet the financial challenges ahead.

We appreciate the leadership of Chairman Dingell and Representative Murphy in proposing *H.R. 5613, Protecting the Medicaid Safety Net Act of 2008* and this Committee’s review of the impact these seven regulations would have—an impact that seeks to reduce federal Medicaid funding not through greater efficiency, but through administrative action.

We also look forward to working with this Committee and other leaders in Congress to forge more comprehensive long term care financing reforms for Medicaid as well as our nation’s entire long term care structure.

Important hearings such as this provide a springboard to assess the bigger, broader long term care financing crisis – and how to solve it.

Now, more than ever, we need a bipartisan, serious, open-minded discussion in the 2008 presidential election about financing what amounts to America’s largest unfunded mandate:

paying for nearly 80 million Americans' long term care needs. The impending 'perfect storm' of aging boomers, coupled with advances in healthcare and medical technology, will allow vast numbers of Americans to live longer. That's the good news.

But over the next two decades, nearly 80 million baby boomers – about 10,000 per day – will enter retirement. As the U.S. Department of Health & Human Services (HHS) estimates that nearly 40 percent of all Americans will require the care and services provided in a nursing facility at some point during their lives, the time to invest to protect the future of this critical healthcare infrastructure is now – before the wave of boomers requires these critical services.

Beyond the sheer starkness of these statistics is the disturbing corollary fact that eighty-five percent of Americans believe, mistakenly, their long term care needs will be met by Medicare, Medicaid or their existing health insurance. I am proud to say that our profession is taking an active role in encouraging Senators Obama, Clinton and McCain – and all candidates for federal office in 2008 – to outline proposals to meet this challenge. We are interested in generating ideas and discussion beyond that found in 15-second sound bites and photo opportunities.

Our profession is advancing a plan to help address the long term care financing challenges we face, and our *Long Term and Post-Acute Care Financing Reform Proposal* will not just allow federal and state lawmakers to seize control of eldercare financing issues, but offers welcome help to the nation's Governors by dramatically restructuring the Medicaid program. This is directly applicable to today's hearing.

More broadly, the plan, available at www.ahca.org, would reorganize the Medicaid long term care and Medicare post-acute care systems by centralizing and streamlining government services – and making more private resources available to pay for care that would benefit consumers, providers, and taxpayers alike.

This plan represents but one approach towards solving a looming national crisis, and we hope to see others put a plan on the table for discussion. Now is that time.

Every American's retirement years should be something to look forward to, not to fear. We intend to continue being a positive voice in the long term care reform debate, and to help pass laws and policies that will help ensure every American, from every walk of life, has access to the quality long term care they need and deserve – whenever that may arise, and in the setting most appropriate for them.

Working together with the power of ideas and conviction, we are convinced we can meet this challenge in a manner that makes us proud to be Americans, and proud to be entrusted with the care of our most vulnerable frail, elderly and disabled.

Thank you.