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July 11, 2011

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-5507-NC  
P.O. Box 8013  
Baltimore, MD 21244-8013

***Re: File Code CMS-5507-NC; Medicare and Medicaid  
Programs: Opportunities for Alignment Under Medicaid and***

Dear Ms. Bella:

The American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) appreciate the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) entitled, *Medicare and Medicaid Programs; Opportunities for Alignment Under Medicaid and Medicare*. The Medicare-Medicaid Coordination Office's (MMCO) efforts to align benefits and incentives to improve access to care under the Medicare and Medicaid programs is an important endeavor in which we are happy to participate.

AHCA/NCAL is the nation's leading long term care organization. AHCA/NCAL and our membership of nearly 11,000 non-profit and proprietary facilities are dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 1.5 million of our nation's frail, elderly, and disabled citizens who live in nursing facilities, assisted living residences, subacute centers, and homes for persons with mental retardation and developmental disabilities. Because so many of our residents are individuals who are dual eligible, we are especially pleased by the creation of the MMCO and this initiative to align Medicare and Medicaid benefits and incentives.

On behalf of our member long term care facilities, AHCA/NCAL has responded below to the questions and issues raised in the RFI. However, we first wish to acknowledge CMS issuances dated July 8<sup>th</sup> on *Financial Models to Support State Efforts to Integrated Care for Medicare-Medicaid Enrollees*.

We are examining these models and looking closely at the *Demonstration to Improve Care Quality for Nursing Facility Residents*, and *The Initiative to Reduce Preventable Hospitalizations*. We also are examining the following resource programs: *Technical Assistance Resource Center Available to States*, and *Resources Available to All States to Coordinate Care for High-Cost, High-Need Beneficiaries*. We fully understand CMS' focus on assistance to the states, but we

would like to explore a somewhat enlarged pool of participants, or, at a minimum, require that states include representatives of all categories of their care providers in their efforts so that the benefit of technical assistance has an optimum buy-in, and efforts at diminishing rehospitalization has full support.

As indicated above, we are examining these issuances and will communicate with CMS on our perspective and recommendations. In the interim, we offer the comments below in response to the RFI. We note that the problems of Medicare and Medicaid Realignment raised by CMS and responded to by AHCA/NCAL and other providers can be addressed in part by development and implementation of CMS' proposed models, but perhaps in greater part by resolution now before new models are implemented. If that is not done, then the baggage of misalignment may indeed follow us all into the new models.

## **I. Responses to the RFI and Discussion**

### **A. FFS Benefits – Nursing Facility-Hospital Transfers**

AHCA/NCAL is delighted that MMCO identifies nursing facility – hospital transfers as an opportunity for legislative and regulatory alignment. We agree that policy should be revamped so that appropriate Medicare payment could be made to a skilled nursing facility (SNF) in order that dual eligible residents whose medical needs become more acute could continue to be cared for in their SNF rather than transferred to a hospital, which sometimes leads to further deterioration for this fragile population.

As MMCO notes, Medicaid reimburses nursing facilities for custodial care and at a lower rate than Medicare reimbursement,<sup>1</sup> leaving nursing facilities without the resources to continue to care for patients when their condition becomes more acute. According to an annual study on Medicaid funding in nursing facilities, the average daily reimbursement shortfall for 2010 is projected at \$17.33 per Medicaid patient day, i.e., \$17.33 lower than the cost of care. This represents a total of \$5.6 billion in unreimbursed Medicaid nursing home care costs.<sup>2</sup>

The problem is made worse by the strong incentive for these patients to stay in the hospital for three days in order to qualify for Medicare post-acute care upon their return to the SNF.

Clearly, it would greatly benefit these fragile patients if they could receive, when appropriate, their Medicare acute care benefits in their SNF home rather than having to move to a hospital for three days so that their Medicare benefits could take effect. The three-day hospital stay requirement is an artificial barrier to high quality, seamless and cost effective care for this population. By eliminating the three-day stay requirement, care for the individual would be enhanced and costs would be lower.

We realize that a statutory change is required and we urge MMCO to strongly recommend such a change in the Secretary's annual Report to Congress.

### **B. FFS Benefits – Post Acute Care**

It is important to include post acute care in any discussion of coordinating care and transitions. Along with caring for long term, chronic care patients, SNFs also care for short-term, post acute care patients who usually require rehabilitative services following surgery, such as a hip or knee replacement, or comprehensive care to recover from cardiac, pulmonary and neurological

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<sup>1</sup> 76 Fed. Reg. 28205 (May 16, 2011).

<sup>2</sup> *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, December 2010, Eljay, LLC.

conditions before returning home. SNFs are the dominant provider of these types of post-acute services in the Medicare program.

Approximately 3.2 million Americans – both older Americans and people with disabilities – received skilled nursing and rehabilitative care in 2008, including 1.9 million Medicare beneficiaries. More than 50 percent of all Medicare beneficiaries who require post-acute care are discharged from an acute care hospital to one of the nearly 16,000 SNFs nationwide.

SNFs play a critical role and represent a lower cost provider for post-acute care reimbursed by Medicare. For these patients, SNFs successfully manage two transitions: from the hospital to the SNF where the beneficiary receives recuperative and restorative services; and from the SNF back to the community.

### **C. Coordinated Care – Enrollment and Options**

CMS accurately notes that traditionally, there have been few options for Medicare to increase enrollment in coordinated care.<sup>3</sup> AHCA/NCAL believes that encouraging dual eligible individuals to join coordinated care models is best accomplished through the development of appealing new models, such as accountable care organizations and medical homes, and not through a chipping away of freedom of choice requirements for Medicare beneficiaries. We firmly believe that the freedom of choice Medicare requirement should be in effect for all Medicare beneficiaries and that dual eligible beneficiaries should not be singled out and excluded from a Medicare right simply because they are also Medicaid eligible.

AHCA/NCAL agrees that care needs to be better coordinated, which is why we are strong advocates of new models of service and payment delivery. As these new models mature and expand, it is likely that dual eligibles will choose to enroll (or not opt out), thus resolving issues of lack of enrollment in coordinated care.

### **D. Coordinated Care – PACE—For Profit Demonstrations**

Section 4804(a)(2) of the Balanced Budget Act of 1997 authorizes CMS to include in the Programs of All-inclusive Care for the Elderly (PACE) program a maximum of ten for-profit PACE demonstration sites and for CMS to conduct a comparative performance study based on ownership. This demonstration was announced in the *Federal Register* on August 10, 2001. There was very little response and on July 24, 2009, CMS announced a re-solicitation of proposals.

Absent the investment from the private sector, PACE expansion will remain slow. Given PACE's track record in care coordination, CMS should make every effort to encourage for-profit entities to participate in the demonstration so that it can conduct a meaningful evaluation, which hopefully would lead eventually to an increase in PACE sites and more opportunity for dual eligibles to received coordinated care.

### **E. Coordinated Care – MA Cost Sharing Information in Standard Summary of Benefits**

MMCO notes that Medicaid generally pays for Medicare cost-sharing for Qualified Medicare Beneficiaries (QMBs) and full benefit dual eligible beneficiaries in Medicare Advantage (MA) plans.<sup>4</sup> This, however, is not fully accurate. SNF providers have long experienced problems with unpaid cost-sharing and are ultimately forced to bear these unpaid costs. CMS requires that all Medicare Advantage (MA) organizations with dual eligible enrollees specify in their contracts

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<sup>3</sup> 76 Fed. Reg. 28200 (May 16, 2011).

<sup>4</sup> 76 Fed. Reg. 28200 (May 16, 2011).

with providers that such enrollees will not be held liable for Medicare Parts A and B cost-sharing when the state is liable for the cost-sharing. Providers must either accept the MA payment in full or bill the appropriate state source (e.g., Medicaid).

Notwithstanding CMS's intention that dual eligible enrollees are not to be held liable for cost-sharing when the state is liable, the reality for providers is they are, in many cases, absorbing the cost of unpaid cost-sharing for enrollees in MA plans. Moreover, providers are left without any remedies to deal with such a financial loss that can, in some cases, amount to more than \$100 per day per dual eligible enrolled in an MA plan. This adds up to huge losses for many SNF providers and is on top of \$5.6 billion in losses already suffered due to shortfalls in Medicaid reimbursement to nursing facilities.<sup>5</sup>

AHCA agrees that dual eligible enrollees in MA plans should not be held liable for cost-sharing when the state is liable. Neither should the provider be in essence "held liable" by inability to collect cost-sharing amounts from either the state or the MA plan. Indeed, as CMS knows, even when a state is technically liable, an increasing number of states, in effect, do not pay the cost-sharing under various formulas.

There are several ways that CMS could correct this problem. At a minimum, two possibilities present themselves. The first is to treat unpaid cost-sharing for Medicare beneficiaries enrolled in MA plans as Medicare bad debt. Currently, CMS treats bad debt differently in the MA program versus fee-for-service Medicare. CMS should apply the same principle of bad debt reimbursement for unpaid cost-sharing in the MA program as it does in the Medicare program. Upon implementation of the SNF Prospective Payment System, CMS took the step of treating bad debt as a pass-through and continuing to reimburse providers for bad debt. CMS should take the next logical step and apply the principle of bad debt reimbursement for unpaid cost-sharing in the MA program, which *is* a Medicare program.

Another way to address the problem would be to require that MA plans facilitate cost-sharing payments as part of their benefit design or require (or enforce) the payment of cost-sharing by states for those beneficiaries enrolled in MA plans, which could be accomplished by MA plans coordinating with state Medicaid programs so that covered benefits and payments are ensured for dual eligibles enrolled in MA plans.

#### **F. Coordinated Care – Special Need Plans –Current Contracting Issues**

MMCO notes that federal Medicare contracting requirements may conflict with state Medicaid contracting requirements.<sup>6</sup> AHCA/NCAL believes that this is often the case and is a serious problem. It would be helpful if the myriad of state regulations could be brought into line with Medicare requirements thus allowing for uniformity across states as well as more opportunity for coordinated care.

#### **G. Coordinated Care – SNP – Future Contracting Issues**

MMCO correctly notes that dual eligible SNPs are legislatively mandated to have a contract with state Medicaid agencies yet Medicare cannot require states to contract with SNPs.<sup>7</sup> Clearly, this could be a problem. Some states may, without reasonable explanation, choose not to sign contracts with local SNPs and choose instead to focus on a different model for coordinated care.

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<sup>5</sup> *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, December 2010, Eljay, LLC.

<sup>6</sup> 76 Fed. Reg. 28201 (May 16, 2011).

<sup>7</sup> 76 Fed. Reg. 28202 (May 16, 2011).

AHCA/NCAL believes that there is room for a variety of models of coordinated care. Possibly, CMS could establish guidance for states on determining how best to respond to SNPs in their states.

## **H. Enrollment – Asset Test**

Medicaid asset tests for individuals in need of long term care services and supports are cumbersome and time-consuming. AHCA/NCAL believes it is incumbent upon CMS to encourage and assist states in making it easier for vulnerable individuals in need of long term care benefits to enroll in Medicaid. As states move forward, with the assistance of CMS, to automate Medicaid enrollment for newly eligible individuals under the Patient Protection and Affordable Care Act (ACA), attention also should be paid to developing automated enrollment for individuals in need of long term care services.

Automated enrollment for individuals in need of long term care services could potentially be very valuable for improving the enrollment process. Still, automated enrollment should be coupled with better methods to determine Medicaid eligibility. Nursing facility providers have reported lengthy delays in Medicaid offices (county and state) making determinations for Medicaid eligibility of nursing facility applicants. AHCA/NCAL conducted a survey that confirmed that providers in many states were experiencing such problems.

According to the survey results, many long term care providers reported that eligibility for nursing home applicants were being determined between 90 and 180 days, with some determinations taking more than 200 days. Such delays in determining Medicaid eligibility for nursing facility applicants have many negative impacts on providers, including problems with cash flow, bad debt, and increased accounts receivable.

Current federal regulations require states to determine Medicaid eligibility within 90 days for applicants who apply for Medicaid on the basis of disability and within 45 days for all other applicants.<sup>8</sup> The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant. In addition, the agency must not use the time standards as a waiting period before determining eligibility; or as a reason for denying eligibility (because it has not determined eligibility within the time standards). Although federal regulations are clear on the time standards for determining Medicaid eligibility, the regulations do not attach any penalties when states do not comply with federal time standards.

AHCA/NCAL believes such regulations on determining Medicaid eligibility should be enforced so that beneficiaries learn, in a timely manner, whether they will have access to Medicaid benefits and to ease the burden on the providers who serve them.

Additionally, improved methods for determining eligibility should be explored. Such methods could include:

- Presumptive eligibility for all applicants needing long term care services;
- Centralized Medicaid application processing such as at the state level (as opposed to the county level);
- Increased staffing and better staff training in application review offices; and
- Application reviewers located on-site in nursing facilities.

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<sup>8</sup> See 42 CFR 435.911

## **I. Cost-sharing – Crossover Claims**

Medicare beneficiaries in SNF Part A stays are required to pay a Medicare coinsurance payment, referred to as a co-payment, starting on day 21 of a Part A SNF stay. If the patient (or other party responsible for payment on behalf of the patient) fails to pay the co-payment, the SNF provider can receive payment from Medicare. The unpaid co-payment is called an “allowable bad debt.” There is Medicare guidance regarding the steps that providers must go through in order to be reimbursed by Medicare for unpaid co-payments as bad debt. The guidance includes billing the patient and other collection procedures.

Pursuant to the State Medicaid Manual, HCFA-Pub. 45-3 §3490.14, CMS requires that state Medicaid programs pay the Part A co-payment for patients who are dually eligible for both Medicare and Medicaid. Such beneficiaries are referred to as “crossover patients” because after Medicare pays a portion of their health care payment (the PPS payment in the case of SNFs), the coinsurance obligation of the patient crosses over to the state Medicaid program for payment. Some states pay the co-payment. However, an increasing number of states use a formula, permitted by Medicare, which results in no payment by Medicaid to the provider. The formula is based on a comparison of the Medicare per diem in relation to what would have been the state’s Medicaid per diem for the same services.

According to an AHCA/NCAL survey of Medicaid payment rules for Medicare Part A coinsurance, thirteen states<sup>9</sup> have rules that do not normally result in payment of Medicare Part A coinsurance. Another eight states pay the lesser of Medicare and Medicaid.<sup>10</sup> The remaining states utilize rules that normally result in payment of the coinsurance.<sup>11</sup>

AHCA/NCAL believes that the original intent of the current guidance, §§310, 312 and 322 of PRM-I, was, in part, to assure that providers were not billing Medicare for co-payments that could have been collected from the patient. The guidance requirements may be reasonable for private pay patients and instances where Medicaid will pay all or part of the co-payment. It is not a reasonable requirement if the formula used by a state results in a policy of no reimbursement for co-payments. We believe that §§310, 312 and 322 of PRM-I, taken together, make it clear that there is no “must bill” requirement where Medicaid will not pay the co-payment.

Guidance for reimbursement of crossover bad debt by Medicare should require that the provider document the following:

- 1) A valid bad debt exists for a crossover beneficiary;
- 2) The Medicare beneficiary had Medicaid eligibility at the time the Medicare services giving rise to the bad debt were provided;
- 3) The State plan/regulation formula for determining Medicaid payment (if any) for Medicare bad debts;
- 4) Evidence of billing to the state where a partial payment is indicated under the respective formula; and
- 5) Evidence (e.g., a state policy, regulation, formula) that the state co-payment formula will result in no payment due from Medicaid for any crossover beneficiary; in this case, no further documentation should be necessary.

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<sup>9</sup> CA, IN, IA, KY, LA, MD, NJ, NM, NC, OH, SC, VA and WV.

<sup>10</sup> CO, GA, ID, KS, MN, MS, NV and WA.

<sup>11</sup> FL, IL and NE did not provide data. ND pays the coinsurance based on beneficiary’s income.

## **J. Federalize the Dual Eligible Over Sixty-Five Population**

One sure method to enhance coordinated care for the older population dually eligible for Medicare and Medicaid would be to federalize the Medicaid portion of that population. While there are efforts underway to give states authority over Medicare in order to enhance coordination, these efforts are likely to result in a hodgepodge of inconsistent benefit structures around the country. Rather than creating a patchwork quilt of Medicare and Medicaid services and benefits based on state determinations and fiscal challenges, a federalized long term care program for seniors would provide consistency and stability throughout the nation.

Federalizing the older dual eligible population, as opposed to allowing fiscally-challenged states control over Medicare benefits, would ensure that dual eligible individuals are provided their full access to benefits. A single program with a single enrollment process would simplify access to services for these individuals. It would improve care continuity and ensure safe and effective care transitions, as well as eliminate cost-shifting between the Medicare and Medicaid programs.

## **II. Conclusion**

The Medicare and Medicaid programs, created as distinct programs with different purposes and different rules, are difficult to maneuver together to accommodate an increasing number of individuals who are eligible for both programs. As MMCO moves forward in its initiative to determine how Medicare and Medicaid can work more effectively for these dual eligible beneficiaries and the providers who serve them, AHCA/NCAL stands ready to provide proactive input.

We wholeheartedly agree that there are tremendous opportunities to partner together to improve access, quality, and cost of care for dual eligible individuals.

Sincerely,



Janice Zalen  
Sr. Director of Special Programs

cc: Cindy Mann  
Tim Engelhardt  
Laurence Wilson  
Sheila Lambowitz