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John P. Monahan
President
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August 25, 2005

Hon. Donald Sundquist, Chairman
Hon. Angus S. King, Jr., Vice Chairman
Medicaid Commission
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Chairman Sundquist and Vice Chairman King:

I am writing to request inclusion in the Commission's report an important clarification regarding the recommendation to expand access to the Medicaid Prescription Drug Rebate Program to Medicaid Managed Care Organizations (MCOs) **[adoption of Option #21, "Extension of the Medicaid Drug Rebate program to Medicaid Managed Care"]**. In adopting this proposal, I appreciate the Commission's recognition of MCO success with drug benefit management tools that provide clinically sound and cost effective drug benefits to members. As I mentioned at the Commission meeting last week, however, it is critical to include an emphasis on actuarially sound Medicaid managed care rates for prescription drug and medical benefits.

The successful role of MCOs in managing Medicaid drug benefits requires that MCO rate-setting be consistent, reliable and actuarially sound. Federal law and CMS guidelines require states to actuarially certify Medicaid MCO rates, but some states apply an arbitrary factor outside the actuarial rate-setting process to meet annual budget requirements. Uncertainty and low payment rates lead to market disruption and fewer choices for enrollees. Establishing rates that are not actuarially derived undermine the demonstrated ability of managed care to improve access to quality care for enrollees, and lower program costs for states.

For these reasons, states should not view expanding the Medicaid Drug Rebate Program as another potential "factor" to be used to arbitrarily reduce MCO fees. To assist states in setting MCO rates, the American Academy of Actuaries (AAA) recently developed guidelines for states specific to Medicaid MCOs. I recommend that the Commission reflect these guidelines in its report by stating that, with respect to savings identified in option #21, "Extension of the Medicaid Drug Rebate Program to Medicaid Managed Care", the Medicaid Commission supports this option with the understanding that Medicaid MCO rates should not be adversely impacted and that rate development continue to be subject to the federal regulations requiring actuarially sound rates.

I am honored to participate in the Medicaid Commission. I look forward to the work ahead of us and appreciate the leadership you are providing.

Sincerely,

John P. Monahan

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August 29, 2005

The Hon. Michael O. Leavitt
Secretary, U.S. Department of Health and Human Services
200 Independent Avenue, S.W.
Washington, DC 20201

Re: Medicaid Commission recommendation on Asset Transfers

Dear Secretary Leavitt:

First, I want to thank you again for appointing me to the Medicaid Commission. I am honored to have been selected as a Commissioner and I feel encouraged that the group is energized and capable of tackling the difficult and complicated challenges associated with proposing reforms of the Medicaid system. **At the suggestion of Chairman Sundquist during our recent August 18 meeting, I want to provide some important information and a related request. This is done to provide you with a consensus of the Commission's discussions pertaining to an important aspect of the asset transfer matter contained in the Commission's recent recommendations to you.**

Since the long-term care profession has long advocated for many reforms within the Medicaid program, I especially appreciated the discussion in the Commission's meeting regarding asset transfer issues. My colleagues and I have long believed that there is little incentive for Americans to plan for their long-term care when, with the advice of elder law attorneys, they can structure assets in a way as to become eligible for Medicaid when they would otherwise have been using their own resources. The American Health Care Association and the American Association of Homes and Services for the Aging, on behalf of my organization and others, have advocated for change in this area. It was very encouraging to see the President's support for this matter by addressing it in his recent budget proposal.

The long-term care profession is in agreement with the underlying policy objective of strengthening our nation's laws on asset transfers in order to discourage Americans from practices that have abused the Medicaid system. **We are concerned, however, with the financial hardship that long-term care providers may bear as a result of changing the date when the penalty is incurred.** As I discussed with Dennis Smith during his testimony before the Medicaid Commission, if the penalty date is changed to the date on which an individual is otherwise seeking eligibility for medical assistance, long-term care providers may not receive payment for care being provided to individuals who are already residents in a facility at the time of application. This may have been an unintended consequence but is certainly a real and very damaging potential result for providers. Nursing facility providers may be forced to care for a significant number of beneficiaries without payment. In short, the total cost of care will be shifted from the federal and state government to providers – and not back to the individuals who have transferred their assets (or received these assets) so as to escape responsibility for payment.

Nursing facilities will have no option, due to a combination of law and reality, other than to absorb the cost of care for these residents. The current provisions of Federal law under OBRA 1987 prohibit nursing facilities from requiring a third-party guarantee of payment upon admission; thus, there is no one with resources to turn to for payment. While discharging residents under such circumstances may be permitted by law, it may take as many as six months or more to transfer or discharge a resident for non-payment. Even when a facility can legally transfer or discharge, there is often no place to send the resident. Families will not take them because they require nursing facility care and no other facility or hospital will accept them as they have an inability to pay for their care.

During the Medicaid Commission's August 17th meeting, CMS staff in attendance brought to the Commission's and Dennis Smith's attention that a recipient could file a "hardship exemption." The Commission's discussions that ensued about this matter made it clear that the consensus of the group was that providers should not be harmed by this change in policy. Furthermore, the "hardship exemption" information that was provided by CMS staff was understood to be an effective prevention to any such

potential harm. Subsequent to the meeting, I attempted to gather more information on this practice from CMS staff. As I have now learned, the facility must first give a notice of discharge for non payment to the resident. Then, the resident could file for a hardship exemption. This is a recipient appeal, not a facility appeal, and most likely the facility could not compel the resident to file. Any of these scenarios places the facility in a no-win situation.

Recommendations

While I agree with the underlying policy position, it is critical to ameliorate its negative impact on providers. Options include:

a) Permit facilities to ask for more financial information than is currently allowed during the application process that could help discover if there was an impermissible transfer within the look-back period that could result in the imposition of a penalty. Under current regulations, facilities are severely limited as to the type of information and assurances that can be obtained at that time that would mitigate unfair risk to providers.
b) Permit facilities to require a third-party guarantee of payment for the period arising from the imposition of a transfer penalty.
c) Upon requests of the provider, grant the provider a hardship waiver of ineligibility in cases where individuals are already residents in long-term care facilities at the time of application for medical assistance.
d) Permit facilities to charge this type of uncompensated care to bad debts if the facility obtained a statement prior to admission that the resident had not made a transfer that would result in a penalty and it is later discovered that the statement was inaccurate and the facility has provided care.
e) Permit facilities to deny admission if the resident discloses a transfer that could be deemed improper by the State Medicaid Eligibility Worker.
f) Permit facilities to deny admission if adequate financial information is not available or will not be provided by the prospective resident.
g) Tighten up the time frame for determining medical assistance eligibility and enforce that time frame with counties to minimize the financial exposure to nursing facilities. This particular recommendation is only effective if done in conjunction with one or more of the other recommendations contained herein.

As I have indicated, my organization and others within the long term care profession share a strong conviction that improper transfers of funds to avoid payment for long-term care is inappropriate and damaging to the Medicaid program. However, shifting the financial burden of the care onto the provider does not achieve one purpose of the Social Security Act, which is for the state and the federal government through federal financial participation to pay for care for carious categories of individuals who legitimately cannot help themselves. In addition, such shifting puts into complete jeopardy the principles of both Medicaid law and Section 1115(a) calling for the preservation and enhancement of beneficiary access to quality services.

The long-term care profession agrees that Medicaid was never intended to be this nation's primary system for funding long-term care and the industry is in the forefront of efforts to encourage individuals to plan responsibly for their own long term care needs in advance. Our goal is enactment of national policy that, over time, replaces the current Medicaid long term care financing system with a national public/private, insurance-based program that provides financial support for individuals and their families to take responsibility for financing their own long term care planning needs; that will ensure access to quality services/supports at all points along the long term care spectrum for all individuals; and will provide financing stability in the marketplace and financial recognition for family caregivers.

Again, I greatly appreciate the opportunity to express my position on this issue. Because I feel so strongly about it and because it generated considerable discussion in the Commission meeting I ask that my viewpoint be included in some form in the report. This could be accomplished as my letter serving as an addendum or as a note in the report.

Sincerely,

Douglas A. Struyk
President and CEO