June 15, 2018

The Honorable Frank J. Pallone
United States House of Representatives
Washington, DC 20515

Dear Rep. Pallone:

On behalf of our 5,300 non-profit members, LeadingAge appreciates the opportunity to provide technical assistance on the Medicare Long-Term Care Services and Supports Act of 2018 (MLTCSSA) discussion draft.

LeadingAge is a tax-exempt charitable organization focused on education, advocacy and applied research. The mission of LeadingAge is to be the trusted voice for aging. Our members include the entire field of aging services - nursing homes, home care providers, affordable housing, retirement communities and assisted living.

We commend you for your continued commitment to developing a universal LTSS insurance program that helps individuals with disabilities and their families prepare and pay for catastrophic costs of significant LTSS expenditures. The goals of this legislation share our organization's goals as expressed in our "New Vision" report: facilitate independence, protect families and individuals from high out-of-pocket expenses, alleviate the burden on family caregivers and address unmet needs.

LeadingAge has been deeply involved in the development of a more rational, fair and universal system for financing long-term services and supports (LTSS) since 2006. In addition to advocating for passage of the CLASS Act (and then fighting to prevent its repeal), we co-funded the work done by the Urban Institute on developing financing models. Two members of our senior leadership team served on the Long-Term Care Work Group of the Health Security Act Task Force and one of them worked for the Secretary of Health and Human Services, leading staff in the initial work on CLASS implementation. We offer our continued assistance and support as this process moves forward. You might consider convening a more formal group of stakeholders to provide further guidance, and we would be honored to help form such a group.

These comments are offered as technical assistance, primarily operational. We appreciate that you are bringing stakeholders into the process at this early stage, before the legislation is finalized and during the initial discussion about how to pay for the new benefit. We also recognize that the language will go through many changes before it is a bill, ready to be introduced. As such, these comments identify questions that were raised in our examination of the proposed bill and provide suggestions in response.

Questions you asked us to consider:

1. Creating a new LTSS benefit in the Medicare program.

Embedding the new program in Medicare has pros and cons; on balance, we find the arguments against using Medicare compelling and urge that they be addressed.

- Reasons to make the program part of Medicare include:

    - Many people (wrongly) think Medicare already covers LTSS.
    - Determining eligibility for this program based on eligibility for Part A (basically, most Americans over 65 and persons under 65 who meet certain work and functional criteria) certainly advances the goal of a universal LTC/LTSS program.

- Reasons not to include the new program as part of Medicare include:

    - Adding a "cash" benefit to Medicare could be a slippery slope for the Medicare program and leave it open to future proposals to voucherize or cash out benefits.
    - Perhaps the most structurally challenging issue is that the Medicare program has no experience or operational structure or staff to run a LTSS benefit program. While Medicaid does cover LTSS, each state has its own program. For this program to succeed, it will need to be carefully structured and built out; we should not assume that the Medicare program is "ready to go". We recommend authorizing and evaluating a pilot program to test adding LTSS benefits to Medicare, perhaps through Medicare Advantage, prior to implementing universally.

2. Impact on Medicaid program:

We strongly agree with your intent to ensure that the new benefit supplements but does not supplant Medicaid. We are concerned that the bill text leaves open the possibility that states can reduce their current payment for services to match the respective clawback, and that the clawback is simply treated as a co-pay. We suggest including explicit language mandating maintenance of effort and preventing states from simply paying providers less.

Coordinating benefits: we are interested in how the personal needs allowance (percent of benefits to be retained by the beneficiary) was determined. We particularly did not understand the rationale for the amount of cash that PACE program participants retain compared to other beneficiaries, although we understand that this confusion may be the result of a drafting error. Another question we had was whether the personal needs allowance could be used for anything, or whether it needed to be used for medical and non-medical services and supports? This is not clear from the text.

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3. Cash Deductible:

We understand that the two-year waiting period is a barrier for individuals with significant needs and there is an attractiveness to offering an alternative, a cash buy-in. However, if the financing of the program is actuarially based on it being a catastrophic benefit, we suggest limiting it to a back end benefit, with no exceptions. The immediate buy in also creates unintended economic preferences and leaves the program open to gaming exacerbated by the strong incentive tied to a cash benefit. Assuming a benefit of $100 a day, potential beneficiaries (or consultants wishing to advise them) can simply compute how much it will cost them to receive $36,500. As a practical matter, only relatively well-off beneficiaries will be able to pursue this strategy. We strongly recommend first nailing down the financing for the new benefit then evaluating whether to include a vehicle to accelerate receipt of benefits and how to structure it.

4. Financing:

Paying for the program is the central challenge. The majority of Americans who recognize they may need LTSS help at some point are not willing to pay more than about $15 a month for LTSS insurance; even that is going to be a challenge. The various financing mechanisms that have been put on the table for this type of program include:

- A payroll tax
- "Sin taxes" of various types (cigarettes, sugar, alcohol, gambling, etc.)
- Increased taxes on luxury goods and services
- Medicaid buy in
- Add on to Social Security
- Mandate that employers provide LTSS insurance
- Premium payments

It is worth noting that cash benefits are more expensive than a service-based program. We suggest clarifying in much more detail what the benefit is and how it will be structured, then exploring various financing sources and making adjustments (e.g., cash or no cash, targeting of benefits, targeting of eligible groups, changing the size or duration of the benefit, etc.) to match what seems viable.

5. Additional policies to address LTC needs for persons on Medicaid or in the private market.

We suggest focusing on spelling out the proposed benefit and how it will be financed before exploring additional policies to complement and support it.

Comments by Section:

Eligibility (p. 3):

It is not clear who is considered an "other individual". We understand that the individual must meet the eligibility requirements for SSDI but it is not clear if they are expected to actually meet the disability requirements or the "chronically ill" requirements under Sec. 7702B? Would not these individuals be considered "qualified" as well as "eligible"? In other words, persons under 65 already have to wait 29 months after determination that they are eligible for SSDI to be eligible for Part A; would they then have to wait another 2 years to be "qualified" for Part E?

Also confusing is the definition of functional impairment under Sec. 1860E-1 (p. 4, lines 12-15). These functional limitations are different than those in the Internal Revenue Code ("requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment"). The definition of "functional impairment" should be consistent with current law and consistent throughout the bill.

An individual's abilities or functional impairment would need to be established through some form of assessment, which should be spelled out in the legislation. Provisions for reassessments are on page 5; again, provisions should spell out who is responsible for doing these. At present there is no intake, assessment, and eligibility determination service offered by the federal government, except for the Social Security Disability Determination progress. Based on our experience with CLASS, this is not likely to be a viable option for this new program.

Benefit amount:

The term "home health aide" is not defined. Are you thinking the basis for the hourly rate would be the Medicare home health rate or Medicaid certified nursing assistant rate? These can be significantly different, and each state promulgates its own Medicaid rate.

Inflation provision: if the hourly rate is the on-going rate for a home health aide, then inflation is already built in. Otherwise, the hourly rate plus inflation is actually different than the hourly rate. When would inflation kick in? We suggest choosing one or the other.

Waiting period:

Page 7, lines 12-21: the waiting period begins on the "first day of the first month beginning after the date that the individual is determined to be a qualified individual…" We are concerned that there are no protections embedded in the law regarding length of time it may take to have eligibility determined. There are waiting times of as long as 9 months for Medicaid eligibility determinations and waiting times for Social Security disability applicants. You may want to consider whether an application delay in excess of 3 months, for example, might apply toward satisfying the waiting period.

Eligible individual:

Page 8, lines 12-21: this section, which relates to eligibility to use the "alternative benefit deductible" requires 3 ADLs, not 2 for "a period of at least 90 days due to a loss of functional capacity or who has a severe cognitive impairment". This is confusing, as is the use of the term "eligible individual". We understand this is limited to the ability to use the alternative deductible, but it is confusing.

End-of-life decision-making (pp. 10-11):

We would recommend not including these provisions. They are unnecessary, given the lack of specificity as to what other services this proposal covers.

Benefits:

While we understand consumer preferences for cash benefits rather than service benefits and have long supported that concept, there are challenges to implementing a cash benefit that could be mitigated by including a stronger "management" component. For example, many beneficiaries may want to have a fiscal intermediary (FI) manage their benefit; many will also want or benefit from a more formal, structured management model (closer to "cash and counseling"). The bill places a tremendous burden on the beneficiary to track all expenses and ensure that they are being spent appropriately (see p. 14, ll 18-22); in addition, new infrastructures would have to be set up to manage what is likely to be a vast appeals endeavor and a need to recoup dollars spent in ways that are later determined inappropriate. In this regard, it should be made clear that individuals have the right to appeal adverse determinations, whether under the traditional Medicare appeals process or an appeals process created for this program

The bill should also have stronger consumer protections regarding the FI, case manager, representative payee or other formal advisor/aide. Skipping to pp. 15-16, "advice and benefit management counseling", we would beef this up to authorize the FI. We would note that the bill language regarding available assistance is confusing – e.g. the counselor is appointed after the individual has been qualified but may assist with respect to the determination process and any appeal, which would be before the individual is qualified. Having the assistance available beforehand would be useful, but complicated to implement. In addition, the counselor can assist with the development of a service

and support plan. This is the first time such a plan is mentioned, and while we think it is an excellent idea it would be helpful to have it incorporated more formally into the process.

Also, it is not clear how the cash benefit is calculated for tax purposes. While the bill clearly states that receipt of this benefit does not affect eligibility for other federal income-based programs, it is not clear if it is taxed to the eligible individual or treated as LTC insurance and not taxable. Presumably it is treated as taxable income to whoever is paid out of the account.

Finally, the definition of "medical and non-medical services and supports" is not clear; there are examples of expenditures on page 9, but no actual definition. For example, may the benefit be used for rent, since it can be used for housing? Since the ability to use the benefit is not open-ended it is important to have a clear definition to protect the benefit recipient who has to track and report their expenditures.

Administration:

This program will be very complicated to establish and administer. The Medicare fee-for-service program currently does not address non-health care services (as noted earlier in our comments) so this program would have to be started "from scratch".

Deadlines and starting date for the program:

We assume that the starting date in the bill is a "marker". A starting date cannot realistically be specified until the program's financing mechanism is determined. Sufficient time and resources must be provided for the establishment of a robust administrative apparatus.

Again, we congratulate you on your willingness to take on an issue that challenges virtually every family and which has proven difficult to solve. Your draft proposal is a promising start toward effective solutions and we look forward to working with you, your staff and other stakeholders on legislation to provide and finance long-term services and supports.

Sincerely,

Katie Smith Sloan
President and CEO