

**Statement for the Record**  
**To the House of Representatives Committee on Ways & Means Health**  
**Subcommittee Hearing on the President's and Other Bipartisan Proposals to**  
**Reform Medicare Post-Acute Care Payments**

**Introduction**

Golden Living is a family of companies that specialize in recovery care. Its mission is to help people recover health and improve quality of life through a network of healthcare services, including rehab, assisted living, skilled nursing care, pharmacy, and hospice. The Golden Living family of companies include Golden LivingCenters, Aegis Therapies, AseraCare, and 360 Healthcare Staffing. There are more than 300 Golden LivingCenters in 21 states. Golden Living also offers assisted living services at more than 30 locations. In addition, the Golden Living companies provide services to more than 1,000 nursing homes, hospitals and other healthcare organizations in 40 states and the District of Columbia. Collectively, the Golden Living family of companies has more than 42,000 employees who provide quality healthcare to more than 60,000 patients every day.

The comments below address several harmful provisions in the President's FY2014 budget proposal and also offer solutions as requested by Committee members:

1. Freezes or cuts to the annual market basket update;
2. Reductions to payments of bad debt;
3. Section 3310 of Patient Protection and Affordable Care Act (PPACA), to reduce cost and waste of medications for Medicare Part D beneficiaries who use post-acute facilities.

We welcome the opportunity to continue working with the Committee to explore solutions to these very important issues.

**Total margins must be addressed; Medicare Margin Analysis Provides an Incomplete Picture of Overall Health**

The underlying cause of revenue challenges can be correlated to chronically insufficient Medicaid payments. The Medicare Payment Advisory Commission's (MedPAC) own analysis indicated that non-Medicare SNF margins were between -1 and -3 percent, with total margins ranging from 4 to 6 percent in 2011<sup>1</sup>. Medicaid payment "shortfall" has steadily increased every year for the past decade. Nearly

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<sup>1</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*. March 2013.

two thirds of our nursing facility residents are paid for by Medicaid<sup>2</sup>, so underpayments of this magnitude have widespread effects, including the inability to properly invest in health information technology (HIT) and severely limited access to investment capital.

Both the President<sup>3</sup> and the MedPAC<sup>4</sup> have recommended a freeze or a reduction to the annual market basket update to SNFs, representing a cut of millions of dollars to our company. The justification for these proposed cuts is, in large part, analysis<sup>5</sup> from MedPAC which has shown double-digit SNF Medicare margins in recent years. However, looking solely at Medicare margins, while neglecting the performance of the sector's other payer sources, provides an incomplete picture of the industry's overall financial health.

Looking at Medicare margins in a silo is short-sighted and provides only a partial view of the overall financial health of the long term and post-acute care industry. Skilled nursing facilities have consistently been underfunded by its largest payer, Medicaid. Market basket cuts do not encourage a more efficient Medicare system and only threaten facilities' ability to provide critical, long term and post-acute care services.

### **90% of Bad Debt Incurred in Skilled Nursing Facilities is Attributable to Dual Eligible Patients**

The federal government requires that beneficiaries who receive care in a SNF to pay their Medicare co-pay beginning on the 21<sup>st</sup> day of a Medicare-qualified stay. These beneficiaries are either seniors who rely solely on Medicare for cost coverage, or seniors who qualify for both Medicare and Medicaid, also known as dual eligibles. Due to their financial situations, many beneficiaries are unable to cover the Medicare co-pay. In particular, dual eligibles, who are by definition low income, account for more than 90 percent of the bad debt incurred in SNFs. This leaves a gaping hole between the cost of providing care for these vulnerable seniors and the actual payments received for such care in SNFs.

Currently, the Medicare program allows SNFs to turn to the government to recoup some of the cost. With dual eligibles, the federal government allows the state Medicaid programs to provide reimbursement for the unpaid co-payment. However, the statute allows states to pay an amount less than the full co-payment or to elect not to reimburse the co-pay entirely. Because the vast majority of bad debt is directly related to decisions not to cover the cost of the federally mandated copay,

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<sup>2</sup> American Health Care Association 2012 Quality Report, available at: [www.ahcancal.org](http://www.ahcancal.org).

<sup>3</sup> U.S. Department of Health & Human Services, *Fiscal Year 2014 Budget in Brief: Strengthening Health and Opportunities for All Americans*, available at: [www.hhs.gov](http://www.hhs.gov).

<sup>4,3</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*. March 2013.

our company would be required to deliver millions of dollars in uncompensated care.

Recognizing this imbalance, the federal government has traditionally provided a remedy to allow SNFs to make up much of the cost associated with patients' bad debt. Currently, Medicare reimburses SNFs a portion of the copay that the states fail to provide for dual eligibles, and reimburses a portion of the copay that seniors solely on Medicare are unable to pay. This has been a key element in ensuring SNFs can continue providing care to vulnerable Medicare-Medicaid eligibles.

Prior to the passage of the *Middle Class Tax Relief and Job Creation Act of 2012*, SNFs were reimbursed 100 percent of bad debts for dual-eligible beneficiaries. Then starting in FY 2013 (Oct 2012), the legislation gradually reduced Medicare bad debt reimbursement from 70 percent to 65 percent for non-dual eligibles. Medicare bad debt payment reductions for dual eligibles will be implemented in phases:

- 88 percent in FY 2013 (Starting in Oct 1 2012);
- 76 percent in FY 2014 (October 1 2013); and
- 65 percent in FY 2015 (October 1 2014).

In his FY2014 budget, the President proposes reducing bad debt payments from 65 percent generally to 25 percent for all eligible providers over three years beginning in 2014. This proposal would result in millions of dollars in additional cuts to our company, which has already faced a bad debt cut coupled with multiple other reductions.

### **Practices for Dispensing Medications in Post-Acute Settings Must be Improved**

#### *Costs*

The current long-term care pharmacy practice in post-acute settings is to dispense medications utilizing a multi-day, 30 or 14-day, punch card or blister pack model of packaging. This approach results in the provider under Medicare Part A or the Prescription Drug Plan (PDP) under Medicare Part D being billed for the full 30- or 14-day supply of medications upon shipment from the pharmacy to the post-acute setting. This occurs regardless of how long the patient may be in the facility or any changes in the patient's condition that determine how many medications are actually dispensed to the patient.

#### *Waste*

Because of the dispensing practice of using multi-day dosages, there is a significant amount of unused medications that results from changes in patient conditions as well as patients being discharged and no longer needing the medications.

Recognizing both the financial and environmental impact of this medication waste, several states have implemented actions that require LTC facilities and pharmacies to seek ways to reduce drug waste. One of the early methods used in post-acute settings to reduce drug waste was the process known as "return for credit and

reuse.” Over time, however, “return for credit and reuse” has presented significant limitations. This approach does not address:

- Potential savings from the use of lower-cost generics;
- Environmental issues involved with destruction and disposal of unused medications;
- Drug diversion, illegal distribution and use of medications; and
- Drug Enforcement Agency (DEA) requirements with respect to controlled substances.

CMS and the post-acute care community recognize that these are all shortcomings of the current practice and system for dispensing medications in this sector of our healthcare system.

### *Solutions*

As noted, the current system is unnecessarily costly, wasteful, and lends itself to being prone to diversion and error. The optimal solution is to reduce the number of drugs that are actually dispensed and billed by the pharmacy by adopting a single-dosage dispensing system per medication pass by the post-acute clinical staff. That way only the amount of medications actually needed at a given time to meet the patient’s prescribed drug regimen are dispensed and charged. This eliminates the source of a majority of the waste from the accumulation of clinically unneeded medications before it occurs.

This led Congress to include a provision in the *Patient Protection and Affordable Care Act of 2010*, Section 3310, that was intended to address in part these problems with the current system.

The Section required that Medicare Part D sponsors and their contracted pharmacies adopt specific and uniform medication dispensing techniques by January 1, 2012. The Section was designed to reduce cost and waste of medications associated with the traditional 30-day supply model for Medicare Part D beneficiaries who use post-acute facilities.

While CMS issued its final rule and implemented Section 3310 in April 2011, providers have been faced with continuing to have to utilize the 30- and 14-day supply method of dispensing. Until very recently there has not been a scalable alternative methodology available that is both operationally and financially feasible to support smaller or single dosage dispensing at the time of the medication pass to the patient.

### Remote Dispensing Units

Recent technological advancements have enabled the development of automated remote dispensing units (RDU) for medications in post-acute facilities. The RDU functions as an extension of the institutional pharmacy and its professional staff

through a technology platform that is designed to provide immediate access on a single dosage basis to the most commonly prescribed medications in the post-acute setting.

It is believed that that the availability of these RDUs in post-acute facilities will reduce the amount of unused medications and opportunity for drug diversion, thereby lowering costs while improving medication safety. The RDUs automate several manual, time-consuming medication dispensing processes and procedures. These systems can also deliver enhanced analytics of the impact of medications on patients while increasing the accuracy of patient-care records associated with the administration of the medications to the patients. The automation of these patient recording, assessment, and monitoring functions will give nurses more time to spend in the direct care of their patients.

From a cost perspective since the RDU methodology dispenses medication on a single dosage basis per medication pass, only the amount of the medication necessary for that dose is dispensed and charged. There is virtually no waste of medications or unnecessary charges for the unused medications, compared to what can occur under the current 30- or 14-day post-acute dispensing model.

Many healthcare experts believe that the adoption of a robust and comprehensive remote automated pharmacy dispensing solution will not only save the entire healthcare system billions of dollars over the next 10 years, but will also over time enable the healthcare delivery system to significantly improve the quality of patient care.

#### Clinical Pharmacy Service

An enhanced clinical pharmacy service based on the active involvement of a clinical pharmacist with the post-acute facility's clinical team (the physician, pharmacist, nursing staff, dietician, physical therapist, etc.) can provide an insightful review and recommendations on key patient-care metrics.

The approach would be to provide the clinical pharmacist with continuous electronic access to the patient's health information and medication regimen for review, thereby enabling timely consultation with the physician and clinical staff of the provider to optimize medication therapy for the patient. In its design, the clinical pharmacist and the automated RDU are totally integrated to ensure that patients' medications are dispensed appropriately, efficiently, and cost effectively for the patient, provider and payer.

The last four years have seen a few post-acute providers become innovators and aggressive advocates for leveraging the benefits of RDU technology being integrated with an enhanced clinical pharmacy service in a new post-acute pharmacy dispensing system. That has resulted in the formalizing of this new concept into a dispensing system for medications that will more effectively meet the needs of post-acute patients and providers.

**Conclusion**

The post-acute care sector is ripe with new ideas to reform the system. Using the same techniques that have been used in the past as stop-gap measure to curtail spending will only harm the financial viability of the sector and the patients it serves. Congress must look at other avenues to find government savings that do not jeopardize access to critical care.

We are encouraged by the Committee's willingness to consider proposals that do more than simply cut payments to health care providers. The solutions outlined in this statement mean a more efficient system and better quality care for our patients. We look forward to ongoing collaboration with the Committee on these very important issues. For questions or comments, please contact Jack MacDonald, Executive Vice President and Chief Public Affairs Officer, at (202) 347-9928 or [jack.macdonald@goldenliving.com](mailto:jack.macdonald@goldenliving.com)