Center for
Medicare Advocacy

Advancing Access to Medicare and Health Care

December 27, 2019

Secretary Alex M. Azar, II
United States Department of Health and Human Services
Washington, DC

VIA ELECTRONIC SUBMISSION

RE: TennCare II Demonstration Amendment 42

Dear Secretary Azar:

The Center for Medicare Advocacy (Center) is pleased to provide comments regarding the proposed Waiver Amendment 42 for Teneessee's Medicaid, known as the TennCare II Demonstration Amendment 42. The Center is unequivocally opposed to this proposal that would radically change Tennessee's Medicaid partnership with the federal government by converting federal funding for TennCare into a "block grant." This proposal would cause immense harm and jeopardize coverage for vulnerable Tennesseans. We urge you to reject this proposed amendment.

The Center for Medicare Advocacy, founded in 1986, is a national, non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality healthcare. At the Center, we educate older people and people with disabilities to help secure fair access to necessary health care services. We draw upon our direct experience with thousands of individuals to educate policy makers about how their decisions affect the lives of real people. At the Center, we focus on matters regarding access to health care for lower-income people, including the rights of those dually eligible for Medicare and Medicaid. Additionally, we provide legal representation to ensure that people receive the health care benefits to which they are legally entitled, and to the quality health care they need.

We urge HHS to reject this proposal because of the harms it would cause to Tennesseans who rely on Medicaid to access health care and long-term services and supports, including older adults and people with disabilities who are dually eligible for Medicare and Medicaid. The proposed amendment would jeopardize coverage for vulnerable Tennesseans and set a harmful precedent for other states and the Medicaid program as a whole. The Center strongly opposes

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capped funding of any sort as it would fundamentally alter the Medicaid program, threatening TennCare and the integrity of the Medicaid program nationwide.

The Proposal Is Impermissible under Federal Law

We incorporate here by reference the reasons the Tennessee proposal is not approvable under federal law submitted in our joint comments with Justice in Aging, Medicare Rights Center and National Academy of Elder Law Attorneys.

Block Grant Would Harm Nursing Home Residents

The Center has advocated on behalf of nursing home residents for decades, and released an Issue Brief in 2017, "Nursing Home Residents in Jeopardy if Medicaid Becomes a Block Grant," outlining the catastrophic consequences of a Medicaid block grant like the one in the Tennessee proposal for residents and their families (Issue Brief is attached to these comments). The limited Medicare benefit for nursing home care means that many current Medicare beneficiaries rely primarily on the Medicaid program to help pay for their nursing home care. The proposed block grant for Medicaid in Tennessee would eliminate the financial and quality of care protections that residents have relied on for decades.

Medicare covers skilled nursing facility care for a limited category of people – those needing skilled nursing (not custodial) care – and only for a limited period of time (no more than 100 days in a benefit period).[i] Private insurance does not generally cover nursing home care at all. As a result, people who need nursing home care, but who are not covered by Medicaid, must pay the facility's charges out-of-pocket. With limited state exceptions, nursing homes can charge private-paying residents whatever they choose.

Medicare pays for only limited nursing home care. Nearly a million and a half people live in nursing facilities and most rely on Medicare or Medicaid or both. However, while the Medicare program pays for many residents at the beginning of their stay,[ii] it covers only short-term nursing home care. On average, in 2014, Medicare paid for only 27.6 days of care in a benefit period.[iii] Nationwide, Medicare was the primary payer for only 14.18% of all nursing home residents.[iv] The number of residents relying on Medicare actually declined 1.4% between 2013 and 2014, "paralleling the decline in inpatient hospital use,"[v] as hospitals increase their use of observation status and call hospitalized patients "outpatients" rather than "inpatients."[vi]

Most residents remain in a nursing home far longer than the few weeks covered by Medicare. As a result, for most residents, Medicaid quickly becomes the primary payer for long-term care. The Kaiser Family Foundation reports that in 2014, Medicaid was the primary payer for 63% of nursing home residents.[vii] In five states (Alaska, Georgia, Louisiana, Mississippi, and West Virginia) and the District of Columbia, more than 70% of residents relied on Medicaid.[viii] Nursing home residents using Medicaid already pay for a considerable portion of the nursing home charges for their care. Nursing home residents are already required to contribute virtually all of their income

toward the cost of their nursing home care, usually retaining only a small monthly personal needs allowance.[ix] In addition, states can recapture the cost of a Medicaid resident's nursing home care by placing a lien on the resident's property and by collecting from the resident's estate after the resident's death.[x] Only long-term care Medicaid beneficiaries are required to repay the Medicaid program in this way for Medicaid benefits they received.

Nursing home residents could lose Medicaid coverage of their nursing home care. Under a Medicaid block grant program, many people who are currently entitled to comprehensive nursing home care could lose coverage entirely. States could change the income, resource, and medical need eligibility rules, making some current residents completely ineligible for any further coverage.

More likely, under block grants, states would continue Medicaid coverage of nursing home care to some extent. However, there could be substantial changes in who would be covered, what type of care and services residents would receive, and how long coverage would continue. Under a block grant, states could limit coverage to only the poorest and sickest people and even then, for only limited periods of time.

Even if states choose to pay for nursing home care under a block grant program, Medicaid's current financial rules and protections for residents and their families would disappear, since Medicaid block grants will not require states to continue current federal protections for Medicaid coverage of nursing home care. Four of the most significant current financial protections enacted over the 50+-year history of the Medicaid program could be lost under a block grant. They are:

- Relative Responsibility. Since 1965, the Medicaid program has prohibited nursing facilities from requesting or requiring contributions from residents' families.[xi] Adult children have never been legally responsible for their parents' nursing home care under the Medicaid program. That provision disappears if Medicaid is repealed. States could require residents' families to contribute to the cost of their relatives' care, even as they address their own health care needs, plan for their own retirement, or seek to help a child attend college.
- Supplementation. Currently, the Medicaid program requires that nursing homes accept the Medicaid rate as payment in full for covered services.[xii] This provision means that nursing homes are not allowed to ask residents or their families to pay any amount above the Medicaid rate for services that are covered by Medicaid – to "supplement" the Medicaid rate. Loss of this protection means that residents receiving Medicaid coverage could be asked to pay an additional amount to the facility, over and above the Medicaid payment, using their (or their families') personal funds. If a resident or prospective resident failed to pay these additional charges, the facility could deny admission (or discharge a resident who did not pay).
- Liens and Estate Recovery. Under current law, states cannot place a lien on a home where a Medicaid beneficiary's spouse, dependent or disabled children, or certain siblings

live. States cannot foreclose on a lien on a beneficiary's home if adult children live there who cared for the Medicaid beneficiary before the beneficiary received Medicaid. Similarly, states cannot recover from a deceased beneficiary's estate while a spouse or dependent child is living. These protections are lost if Medicaid becomes a block grant program. States could place liens on residents' homes and force foreclosure, or recover from a deceased resident's estate, depriving the resident's spouse and dependent or disabled children of their home or other assets on which they may depend.

- Spousal Impoverishment. Since 1987, the Medicaid program has recognized that the spouse of a nursing home resident needs to retain some of the couple's income and assets in order to be able to continue living in the community.[xiii] The loss of this statutory protection could return the country to the time when all of a couple's money was required to be used for nursing home care and the spouse in the community was left with, literally, no income at all.
- Prescription drug cost-sharing. Under current federal law, residents with Medicaid have no cost-sharing obligation for their prescription drugs. If Medicaid is block-granted, residents could be required to pay for prescription drug coverage under Medicare Part D.

Block Grant Reduces Consumer Protections and Federal Oversight

If approved, the proposal would allow TennCare to limit the "amount, duration, and scope" of core benefits that TennCare is required to provide, and to limit or eliminate optional benefits, without requesting approval from the federal government or providing an opportunity for public comment. The proposal seeks to exempt Tennessee from all federal regulations for managed care plans.

Without federal oversight, Tennessee would have the ability to restrict or end essential services like physical therapy, occupational therapy, hospice, and transplant coverage, or to arbitrarily limit who gets those services and the duration. All of this could be done without public notice and comment. Additionally, under this proposal the state could limit access to health services like hospital care and emergency services.

Exempting Tennessee from federal standards and oversight of its Medicaid managed care plans would give the state substantial ability to cut costs by limiting access to care for the 93 percent of TennCare beneficiaries covered through such plans.[xiv] For example, Tennessee could let plans ration care or provide such limited networks that beneficiaries would have trouble accessing services. The Center strongly believes that federal oversight provides guardrails that protect beneficiaries, and must not be waived.

The Center is also concerned that the state's request for authority to waive comparability or to forego CMS approval for adding optional benefits or adjusting the amount, duration, or scope of existing benefits could lead to discriminatory benefit design with little or no federal oversight. The statute's comparability requirement is partly intended to prevent such discrimination.

Block Grant Limits Access to Essential Prescription Drugs

The proposal would also give Tennessee unprecedented authority to limit access to FDA-approved prescription drugs, without any defined criteria for which drugs would be covered or an appeals process for individuals with a medical need for an excluded drug. This would likely lead the state to exclude or restrict access to high-cost drugs, preventing some people with serious health conditions from accessing needed medications.

While TennCare enrollees who are dually eligible for Medicare get their prescription drug coverage through Part D, we are deeply concerned that older adults who are on TennCare before they become eligible for Medicare would not have access to the full range of prescription drugs they may need.

The state would only be required to cover one drug per therapeutic drug class. However, in many cases, people cannot tolerate or do not benefit from one drug in a therapeutic class, and therefore need an alternative that may be restricted under this new policy. People with chronic and serious health conditions disproportionately rely on Medicaid and often need access to more than medication per drug class. While the state proposes to allow alternatives through an exceptions process, studies have shown that such work-arounds are often poorly understood and difficult to access. Under Tennessee's proposal, these individuals would be forced to navigate a cumbersome exceptions process despite the devastating, even life-threatening, consequences any delay in access might cause. The proposal does not specify an appeals process for beneficiaries with a medical need for drugs that are not covered.

The proposal references Medicare Part D as the model for this closed formulary, however there are several reasons this comparison is concerning. First of all, individuals enrolling in commercial plans or Medicare Part D have the ability to review several plan options and choose a specific plan that provides the medications they need. But on Medicaid, individuals have only one plan option. Additionally, Medicare beneficiaries with low incomes and modest assets are eligible for Special Election Periods (SEP) once per calendar quarter during the first nine months of the year (January through September) and separate SEPs can be used in additional circumstances.

Also, at the Center we know from our experience with Part D that limited formularies and exceptions processes do not work well and can delay access to medication. In fact, we have long called for reforms to the Part D appeals process. The multi-level, protracted Part D exceptions and appeals process is onerous and time-consuming for Medicare beneficiaries, pharmacists, and prescribing physicians and often significantly delays access to necessary medications. Many Part D enrollees are unaware of both their right to appeal and how to go about initiating the appeals process. Further, Part D enrollees are not provided individually-tailored information when refused a medication at the pharmacy counter, and such refusal does not trigger an appeal. This set up results in considerable time and effort on the part of the beneficiary and his/her physician

trying to obtain enough information to affirmatively file an appeal, while many individuals who are denied at the pharmacy counter simply give up. The Center has called for allowing the pharmacy counter refusal to serve as the coverage determination by the Part D (or Medicare Advantage-Prescription Drug) plan and for the establishment of a cost-sharing exception and appeal process for drugs included on the specialty tier, both as a matter of fairness and to promote affordable access to high-cost medications, among other Part D appeals reforms. We are concerned that the Tennessee proposal's limited formulary and lack of a robust appeals process would have devastating consequences.

Conclusion

The Center appreciates the opportunity to submit these comments. Overall, the Tennessee proposal establishes a dangerous precedent and undermines Medicaid's program integrity by limiting federal oversight. This amendment is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. We respectfully urge you to reject this harmful proposal. We request that the full text of each of the sources cited, along with the full text of the attached Issue Brief, and the full text of our comments be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

For additional information, please contact Kata Kertesz, Policy Attorney, kkertesz@MedicareAdvocacy.org, at 202-293-5760.

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[i] 42 U.S.C. §1395d(a)(2)(A).
[ii] The National Nursing Home Survey reported in November 2010, that in 2004, 543,100 of 1,492,200 residents used Medicare at the time of admission. At the time of their interview, however, only 189,400 were using Medicare. Many residents had shifted to Medicaid. 518,700 residents used Medicaid at admission, but by the time of their interview, 890,200 relied on Medicaid. Table 8, "Number of nursing home residents by selected resident characteristics according to all sources of payment at time of admission and at time of interview: United States, 2004," http://www.cdc.gov/nchs/nnhs/nnhs_products.htm (click on Series 13, No. 167).

[iii] Medicare Payment Advisory Commission (MedPAC), *A Data Book: Health Care Spending and the Medicare Program*, 112, Chart 8-4 (June 2016), http://medpac.gov/docs/default-source/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf?sfvrsn=0.
[iv] *Id.* 8.
[v] Medicare Payment Advisory Commission (MedPAC), *Health Care Spending and the Medicare Program (A Data Book)* 112, Chart 8-4 (June 2016), http://medpac.gov/docs/default-source/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf?sfvrsn=0.
[vi] HHS Inspector General, *Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy*, OEI-02-15-00020 (Dec. 2016), https://oig.hhs.gov/oei/reports/oei-02-15-00020.pdf.
[vii] Charlene Harrington, Helen Carrillo, University of California, San Francisco, and Rachel Garfield, Kaiser Family Foundation, *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2009-2014* (Aug. 2015) 7, Figure 6, https://kaiserfamilyfoundation.files.wordpress.com/2015/08/8761-nursing-facilities-staffing-residents-and-facility-deficiencies.pdf.
[viii] *Id.*
[ix] Nursing home residents receiving Medicaid and those receiving Medicaid-financed home and community based services are the only Medicaid beneficiaries who have a second financial determination made *after* they are found eligible for Medicaid. In the "post-eligibility" financial determination, the state determines how much of his or her income the Medicaid beneficiary must contribute to the cost of nursing home or community based care. All income must be contributed, with limited deductions for health insurance premiums, costs of maintaining the home while a spouse or dependent child lives there, and a monthly personal needs allowance of $30 (which some states supplement). 42 C.F.R. §§435.832, 436.832 ("Post-eligibility treatment of income of institutionalized individuals; Application of patient income to the cost of care").
[x] 42 U.S.C. §1396p.
[xi] 42 U.S.C. §1307a(a)(17)(D).
[xii] 42 C.F.R. §447.15
[xiii] 42 U.S.C. §1396r-5.
[xiv] Center on Budget and Policy Priorities, "Tennessee Block Grant Proposal Threatens Care for Medicaid Beneficiaries" (Sept. 25, 2019) available at https://www.cbpp.org/research/health/tennessee-block-grant-proposal-threatens-care-for-medicaid-beneficiaries#_ftn4

— Issue Brief —

Nursing Home Residents in Jeopardy if Medicaid Becomes a Block Grant

If Medicaid becomes a block grant program, nearly one million nursing home residents who rely on Medicaid could immediately lose coverage for their nursing home care. In addition, all of the federal standards that govern nursing home care today could be in jeopardy.

The United States does not have a comprehensive program to pay for long-term care services. Medicare covers skilled nursing facility care for a limited category of people – those needing skilled nursing (not custodial) care – and only for a limited period of time (no more than 100 days in a benefit period).[1] Private insurance does not generally cover nursing home care at all. As a result, people who need nursing home care, but who are not covered by Medicaid, must pay the facility's charges out-of-pocket. With limited state exceptions, nursing homes can charge private-paying residents whatever they choose.

Nursing home care is expensive. A study of the costs of nursing home care, released July 30, 2013 by John Hancock Financial, reports, "the average annual cost of care in the U.S. is $94,170 for a private room in a nursing home; $82,855 for a semi-private room in a nursing home."[2] These charges are far beyond the means of most people age 65 and over, whose average income in 2012 was $31,742.[3]

Medicare pays for limited nursing home care. Nearly a million and a half people live in nursing facilities and most rely on Medicare or Medicaid or both. However, while the Medicare program pays for many residents at the beginning of their stay,[4] it covers only short-term nursing home care. On average, in 2014, Medicare paid for only 27.6 days of care in a benefit period.[5] Nationwide, Medicare was the primary payer for only 14.18% of all nursing home residents.[6] The number of residents relying on Medicare actually declined 1.4% between 2013 and 2014, "paralleling the decline in inpatient hospital use,"[7] as hospitals increase their use of observation status and call hospitalized patients "outpatients" rather than "inpatients."[8]

Nursing home residents rely on Medicaid. Most residents remain in a nursing home far longer than the few weeks covered by Medicare. As a result, for most residents, Medicaid quickly becomes the primary payer for long-term care. The Kaiser Family Foundation reports that **in 2014, Medicaid was the primary payer for 63% of nursing home residents.**[9] In five states (Alaska, Georgia, Louisiana, Mississippi, and West Virginia) and the District of Columbia, more than 70% of residents relied on Medicaid.[10] **Nursing home residents using Medicaid already pay for a considerable portion of the nursing home charges for their care.** Nursing home residents are already required to contribute virtually all of their income toward the cost of their nursing home care, usually retaining only a small monthly personal needs allowance.[11] In addition, states can recapture the cost of a Medicaid resident's nursing home care by placing a lien on the resident's property and by collecting from the resident's estate after the resident's death.[12] Only long-term care Medicaid beneficiaries are required to repay the Medicaid program in this way for Medicaid benefits they received.

Medicaid Funding Under Block Grants Would Not Be Medicaid Funding As It Is Known Today

Nursing home residents could lose Medicaid coverage of their nursing home care. Under a Medicaid block grant program, many people who are currently entitled to comprehensive nursing home care could lose coverage entirely. States could change the income, resource, and medical need eligibility rules, making some current residents completely ineligible for any further coverage.

More likely, under block grants, states would continue Medicaid coverage of nursing home care to some extent. However, **there could be substantial changes in who would be covered, what type of care and services residents would receive, and how long coverage would continue.** Under a block grant, states could limit coverage to only the poorest and sickest people and even then, for only limited periods of time.

Even if states choose to pay for nursing home care under a block grant program, Medicaid's current financial rules and protections for residents and their families would disappear, since Medicaid block grants will not require states to continue current federal protections for Medicaid coverage of nursing home care. Four of the most significant **current financial protections** enacted over the 50+-year history of the Medicaid program could be lost under a block grant. They are:

- **Relative Responsibility. Since 1965, the Medicaid program has prohibited nursing facilities from requesting or requiring contributions from residents' families.**[13] Adult children have never been legally responsible for their parents' nursing home care under the Medicaid program. That provision disappears if Medicaid is repealed. States could require residents' families to contribute to the cost of their relatives' care, even as they address their own health care needs, plan for their own retirement, or seek to help a child attend college.
- **Supplementation. Currently, the Medicaid program requires that nursing homes accept the Medicaid rate as payment in full for covered services.**[14] This provision means that nursing homes are not allowed to ask residents or their families to pay any amount above the Medicaid rate for services that are covered by Medicaid – to "supplement" the Medicaid rate. Loss of this protection means that residents receiving Medicaid coverage could be asked to pay an additional amount to the facility, over and above the Medicaid payment, using their (or their families') personal funds. If a resident or prospective resident failed to pay these additional charges, the facility could deny admission (or discharge a resident who did not pay).
- **Liens and Estate Recovery. Under current law, states cannot place a lien on a home where a Medicaid beneficiary's spouse, dependent or disabled children, or certain siblings live.** States cannot foreclose on a lien on a beneficiary's home if adult children live there who cared for the Medicaid beneficiary before the beneficiary received Medicaid. Similarly, states cannot recover from a deceased beneficiary's estate while a spouse or dependent child is living. These protections are lost if Medicaid becomes a block grant program. States could place liens on residents' homes and force foreclosure, or recover from a deceased resident's estate, depriving the resident's spouse and dependent or disabled children of their home or other assets on which they may depend.
- **Spousal Impoverishment. Since 1987, the Medicaid program has recognized that the spouse of a nursing home resident needs to retain some of the couple's income and assets in order to be able to continue living in the community.**[15] The loss of this statutory protection could return the country to the time when all of a couple's money was required to be used for nursing home care and the spouse in the community was left with, literally, no income at all.
- **Prescription drug cost-sharing. Under current federal law, residents with Medicaid have no cost-sharing obligation for their prescription drugs.** If Medicaid is block-granted, residents could be required to pay for prescription drug coverage under Medicare Part D.

At Present, Medicare and Medicaid Establish the Standard of Care in Nursing Facilities

The Medicare and Medicaid programs do more than provide funding for nursing facility residents' care. The Nursing Home Reform Law,[16] enacted during the Reagan Administration as part of the 1987 budget reconciliation law, amended the Medicare and Medicaid statutes to set out a comprehensive framework for quality nursing home care. The law established the standards of care that facilities must meet and a regulatory structure to ensure the standards are met. If both Medicare and Medicaid are repealed, the Nursing Home Reform Law will be gone, with all of its provisions governing the care of residents and enforcement of those standards.[17] Even if the Medicare provisions remain, questions could be raised about the applicability of Medicare standards to Medicaid-covered residents.

Standards of care that will be lost if Medicare and Medicaid are repealed include requirements that:

- Facilities' multi-disciplinary teams comprehensively assess each resident and develop an individualized plan of care to meet each resident's medical, nursing, therapy, activities, and social services needs;
- Facilities actually provide each resident with care and services to attain or maintain each resident's "highest practicable physical, mental, and psychosocial wellbeing;"
- Facilities respect residents' rights, including rights to privacy, access and visitation rights, protection from discrimination, protection of resident funds, and transfer and discharge rights;
- Nurse aides be trained and demonstrate competency before providing care to residents;
- Facilities not require residents to waive their rights to coverage by Medicare or Medicaid and not require residents to pay out-of-pocket for designated periods of time before being allowed to use Medicaid.

The Nursing Home Reform Law also requires annual unannounced surveys and investigations of complaints and sets out a system of remedies that may be imposed against facilities that fail to provide residents with the quality of care and quality of life they need and are entitled to receive.

Conclusion

The limited Medicare benefit for nursing home care means that many current Medicare beneficiaries rely primarily on the Medicaid program to help pay for their nursing home care. Proposed block grants for Medicaid would eliminate the financial and quality of care protections that residents have relied on for decades. Further analysis must await actual legislative language. Regrettably, the implications for nursing home residents and their families could be worse than the predictions discussed here.

2/1/2017

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[1] 42 U.S.C. §1395d(a)(2)(A).

[2] John Hancock, "John Hancock National Study Finds Long-Term Care Costs Continue to Climb Across All Provider Options" (July 30, 2013), http://www.johnhancock.com/about/news_details.php?fn=jul3013-text&yr=2013.

[3] Ke Bin Wu, AARP Public Policy Institute, *Sources of Income for Older Americans 2012* (Fact Sheet), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/econ_sec/2013/sources-of-income-for-older-americans-2012-fs-AARP-ppi-econ-sec.pdf. Half of people age 65 and over had incomes of less than $16,904 in 2012.

[4] The National Nursing Home Survey reported in November 2010, that in 2004, 543,100 of 1,492,200 residents used Medicare at the time of admission. At the time of their interview, however, only 189,400 were using Medicare. Many residents had shifted to Medicaid. 518,700 residents used Medicaid at admission, but by the time of their interview, 890,200 relied on Medicaid. Table 8, "Number of nursing home residents by selected resident characteristics according to all sources of

payment at time of admission and at time of interview: United States, 2004,"
http://www.cdc.gov/nchs/nnhs/nnhs_products.htm (click on Series 13, No. 167).
[5] Medicare Payment Advisory Commission (MedPAC), *A Data Book: Health Care Spending and the Medicare Program*, 112, Chart 8-4 (June 2016), http://medpac.gov/docs/default-source/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf?sfvrsn=0.
[6] *Id.*8.
[7] Medicare Payment Advisory Commission (MedPAC), *Health Care Spending and the Medicare Program (A Data Book)* 112, Chart 8-4 (June 2016), http://medpac.gov/docs/default-source/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf?sfvrsn=0.
[8] HHS Inspector General, *Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy*, OEI-02-15-00020 (Dec. 2016), https://oig.hhs.gov/oei/reports/oei-02-15-00020.pdf.
[9] Charlene Harrington, Helen Carrillo, University of California, San Francisco, and Rachel Garfield, Kaiser Family Foundation, *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2009-2014* (Aug. 2015) 7, Figure 6, https://kaiserfamilyfoundation.files.wordpress.com/2015/08/8761-nursing-facilities-staffing-residents-and-facility-deficiencies.pdf.
[10] *Id.*
[11] Nursing home residents receiving Medicaid and those receiving Medicaid-financed home and community based services are the only Medicaid beneficiaries who have a second financial determination made *after* they are found eligible for Medicaid. In the "post-eligibility" financial determination, the state determines how much of his or her income the Medicaid beneficiary must contribute to the cost of nursing home or community based care. All income must be contributed, with limited deductions for health insurance premiums, costs of maintaining the home while a spouse or dependent child lives there, and a monthly personal needs allowance of $30 (which some states supplement). 42 C.F.R. §§435.832, 436.832 ("Post-eligibility treatment of income of institutionalized individuals; Application of patient income to the cost of care").
[12] 42 U.S.C. §1396p.
[13] 42 U.S.C. §1307a(a)(17)(D).
[14] 42 C.F.R. §447.15
[15] 42 U.S.C. §1396r-5.
[16] 42 U.S.C. 1395i-3(a)-(h), 1396r(a)-(h), Medicare and Medicaid, respectively
[17] More than 90% of nursing facilities participate in both Medicare and Medicaid. American Healthcare Association, *LTCStats: Nursing Facility Operational Characteristics Report*, Table 3, page 5 (March 2011), http://www.ahcancal.org/research_data/Pages/default.aspx (click on the report), based on CMS Form 671:F9. As a result, the repeal of Medicaid would not lead to the immediate loss of the Reform Law's protections as long as a facility continued to participate in Medicare. However, with immediate changes to Medicaid and changes to Medicare on the horizon, it seems likely that the federal standards of care would soon be substantially compromised.