Written Testimony of

Delivered by

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Chairwoman Madden, Chairman Mentzer, and members of the House Aging and Older Adult Services Committee: thank you for the opportunity to testify and offer input from the community providing health care services to Pennsylvanians.

My name is Zach Shamberg, and I am the president and CEO of the Pennsylvania Health Care Association, or PHCA. We are proud to represent long-term care across the commonwealth, including government-run, nonprofit, and for-profit nursing homes, as well as personal care homes and assisted living communities. The residents our members serve are Pennsylvania seniors in need of care or adults with mental or physical disabilities.

The state's Medicaid program is critical to helping low-income residents access care they couldn't otherwise afford. It is a public program that is relied upon by nearly 45,000 individuals receiving care at Pennsylvania nursing homes. And that number is only growing as our senior population is rapidly increasing.

With more than 70 percent of all nursing care paid for by Medicaid, you can understand why a disruption in the Medicaid approval process can impact one's care — or the provider 'fronting' the money for all of the costs of delivering that care.

Typically, nursing home providers only have about 30-60 days worth of reserve funds on hand. This became a great concern earlier this year, when Change Healthcare experienced a cybersecurity incident that prevented Medicaid payments from getting to providers on time. Fortunately, Medicaid approvals are not all done at the same time, but the approval process does similarly create financial jeopardy concerns because a resident's unapproved Medicaid status leaves providers footing the cost for care without reimbursement until a determination is made — and without approval, reimbursement ultimately isn't made at all.

To add to this financial stress during a sometimes long and arduous process, the reimbursement rate could be dramatically affected the longer the delays play out.

To put this into perspective: just one of our provider members is waiting to be reimbursed more than **$5.5 million dollars** ($5,578,181.64) for the care of residents at four buildings in western Pennsylvania. All of these residents have yet to be approved for Medicaid. And aside from not being paid back for their services, this same provider is just as discouraged by the lack of communication throughout this process to even know where things stand.

For those who aren't well versed on how Medicaid works as it relates to a provider, an elderly individual in need of 24/7 care could be admitted to a nursing home after being discharged from a qualifying hospital stay. They enter the nursing home with Medicare or Medicare Advantage — a more restrictive reimbursement plan than traditional Medicare — initially covering their costs, but that only lasts for so many days. If nursing care needs to continue, the resident can enroll with Medicaid to have their services paid for — but the resident has to be approved. The nursing home will work with the resident and the resident's family to apply for Medicaid, but

there is a lot of documentation required to qualify, and obtaining those records takes time and can be problematic.

Federal rules allow for an application and approval process of 45 days to submit all necessary records, which includes five years worth of bank statements, insurance policy information, retirement details, as well as for the caseworker to review and make a decision. More often than not, the entities with the records, including banks, are not forthcoming with that personal information. And that 45-day window can often close quickly while the fight for records continues and the resident has gone from Medicaid-pending to being denied.

All the while — and here's the reason why I'm speaking with you today — providers are still fronting all costs for that resident's care because that resident is their responsibility. They can't turn them away. They want to provide care, and too often there is nowhere else for the resident to go. Providers make a sacrifice to absorb a tremendous financial loss because they care.

We've heard from many providers within the past few weeks that applications are being denied because caseworkers claim the necessary documentation was not submitted. That's understandable if records are missing, but our providers are telling us that caseworkers aren't even reviewing what has been submitted. So how can we possibly expect that the current process is working?

If there are additional records that are needed, the applicant must obtain them and then file for an appeal to overturn the Medicaid denial. An appeal date could take another 30-60 days — we are now talking about three months of costs for a provider with absolutely no reimbursement. But it doesn't end there. Family members and other conflicts can delay the appeal hearing.

With every passing day, these allocated state funds sit in accounts managed by the state and managed care organizations hired by the Department of Human Services (DHS) to distribute these funds.

A PHCA member in northeast PA is experiencing this now, as all the requested records were submitted and the applications were denied because new records were requested. This provider currently has six residents — just six — in one building that have gone 12 months — an entire year — trying to finalize the application process for approval.

In Berks County, a PHCA member helped submit 36 Medicaid applications at one facility between January and June for their residents. Only seven were approved. Twenty-nine were denied and appealed. Eleven of those denials have since been approved, while 15 are still under an active appeal. And only three were denied in appeals and ruled uncollectable.

In that example, the application approval rating eclipsed 50 percent; yet, it was only an initial approval rating of 19 percent for this one facility. So why are county assistance offices denying applications that end up being ultimately approved, and why is the state allowing millions of dollars to not be reimbursed to providers in a timely manner?

When you and I go to work, we get paid so we can pay our bills. If a provider does their job — their mission of caring for others in need of health care services — they are left months or even a year without getting paid or reimbursed to pay for their bills. This does nothing but create unnecessary financial jeopardy for organizations trying to care for people.

House Bill 2320, sponsored by Rep. Venkat, is a good start to addressing this issue. We think that we can help build upon this piece of legislation by offering further insight today.

We'll start with the application process. To help complete the application process within the 45-day window, an immediate recommendation would be to have the Department of Human Services leverage the agency's authority to help providers and applicants obtain the records they need to complete the application. This would greatly limit extra time by all parties to have to go through appeals and it would help providers secure reimbursement more quickly. Federal rules also state this is an obligation of the Department to assist.

We also recommend that caseworkers review and act on any additional information that has been obtained either during the 45-day application window or after the appeal has been filed and within 10 days of obtaining the new records. This could expedite the process by finalizing the application process without going through an appeal hearing, which could take weeks to schedule.

Above all else, and in its simplest form, we need caseworkers within the Country Assistance Offices to communicate with providers. Ignoring providers, not responding in a timely manner, and not adequately reviewing all components of the application is a disservice to Pennsylvanians in need of care. Providers and applicants are following the requirements of the approval process, but the process is failing them. So much of this can be avoided if the case workers would be more communicative.

We also recommend that the state's veteran homes, which are PHCA members, be included in this legislation. House Bill 2320 suggests that veteran and county homes not be included in the definition of a provider that would be eligible for the benefits of a more efficient process.

Finally, we have questions about the structure of the payment that is proposed in the bill. How will that be distributed, and will those dollars be federally matched?

You've heard PHCA speak countless times before about insufficient Medicaid reimbursement rates in Pennsylvania. That issue is real. But even when the legislature makes significant investments, we still struggle to allocate those dollars to providers to repay them for their services.

We want to help Rep. Venkat and this committee address the issue, and we welcome any opportunity to provide further information and solutions.

Thank you for your time today.