National Research Corporation

LONG TERM CARE REFORM:

The Case for Cautious Optimism

WHITE PAPER

About the Author

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Perspectives and Commentary

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Table of Contents

Preface

Another year, another national commission. The final report from the Commission on Long Term Care that was released in September 2013 was all but ignored by the national press while prompting at most a yawn from the policy and provider communities.

It deserved better. This tepid response was not altogether surprising given that the Commission had scant time or resources with which to plumb the depths of an exceedingly complex topic. Add the fact that its bipartisan makeup, being predisposed to divide along familiar partisan and ideological lines, found it impossible to advance any comprehensive new scheme of system financing. In the end, the Commission satisfied the low expectations that greeted its creation by Congress in 2012 as an afterthought to the demise of the CLASS Act, the ill-fated initiative tucked into the 2010 Affordable Care Act that sought to offer working individuals a degree of protection against the cost of paying for long term services and supports through a national, voluntary insurance program.

A fair reading of the Commission's report invites a more complimentary judgment on its work. In any event, its impact is unlikely to be any less than that of the Pepper Commission's 1990 report, which was blessed with more time and money. To its credit this recent commission was able to recommend a number of important policy changes at the margins, such as eliminating the archaic and problematic Medicare 3-day prior hospital stay barrier to post-acute skilled nursing services. Its greater contribution, however, lay in its effective identification of the many facets of the complex challenge of meeting the needs of the 12 million (and growing) population of Americans who require some degree of assistance, paid or unpaid, to enable them to maximize their independence and quality of life despite functional limitations. Of particular value are the panel's numerous recommendations touching on previously under-emphasized topics such as quality across care settings, the urgency of workforce support and development, and the contributions and needs of family caregivers. The report also importantly points to the diversity of subpopulations that require particular long-term services and supports (LTSS) within the larger dependent population.

Against the backdrop of the Commission's findings and recommendations, this paper will endeavor to set forth a series of observations with the hope of pointing to how continued progress can be made in the direction of meeting this important societal challenge.

Toward a Principled and Pragmatic Path to Reform

Premise 1

Seeking a "comprehensive" and "national" long-term care solution is a recipe for disappointment.

It is granted that long-term care lacks an adequate or coherent financing system, in consequence of which many families and individuals are exposed to substantial risks to their assets and income. However, in the current climate, public skepticism of "comprehensive" national reforms of anything important is very high and an often toxic partisanship prevails. A humbler, pragmatic preference for incremental change might lack sizzle, but emerges as necessary in confronting large and complex societal challenges.

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It is true that a clear overall vision for the future of long-term care, grounded in a consensus on first principles, is essential; otherwise all that remains are competing agendas. But believing the vision is just one Congressional silver bullet away from realization is an unlikely prospect. Moreover, agreement on the attributes of a better long-term care system is not the same thing as a prior consensus on the best ways and means of its realization, which must come as the fruit of experimentation, evidence-based validation, application, replication, and consumer acceptance.

It is surely not hard to imagine schemes more rational than the legacy Medicare and Medicaid programs represent, as indeed a number of plausible alternative financing schemes have been advanced from time to time over at least three decades. No doubt there are changes in national policy that would be beneficial to certain reforms at lower levels that touch people where they actually live. Some such ideas will resurface in future Congressional efforts to strike a "grand bargain" on entitlements, the tax system, and restructured federal and state responsibilities. It is widely conceded that public funding structures must, and can be, simplified, integrated, and meshed seamlessly with private funding options. Perhaps a federal stop-loss financing program is worthy of continued discussion. But in the interim, though many are impatient with the plodding pace of change, promising innovation is occurring—aided both by private sector creativity and seemingly small but important public policy changes that are enabling new configurations to be tried and refined. Because of this, there is reason to hope that new knowledge and experience generated from the ground up will drive wiser overall long-term care policy reform.

Premise 2

Pragmatic reform will logically focus on a defined, visible, high-value target.

Such a target has been obvious for years, and is now getting the focus so obviously required. The estimated 9 million Americans who are enrolled in Medicare and Medicaid account very disproportionately for the expenditures of both programs. The so-called "duals" or "MMEs" are older, poorer, and sicker; more likely to use hospitals, nursing homes, and other paid services; more likely to benefit from earlier and better coordinated care and support; and least likely to be able to make sense of the confusion presented to them by two large programs with different rules, benefits, and often different care providers. Younger disabled dual-eligibles, while often lacking access to services most appropriate to their needs, also account for high volumes of healthcare expenditures, including hospital and emergency services.

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A 2012 analysis by AARP, NASUAD, and Health Management Associates entitled On the Verge: The Transformation of Long-Term Services and Supports offered this observation:

> *"Many states are undergoing or are about to undergo a dizzying array of LTSS transformations. The lagging economy and the increased demand for publicly funded LTSS have put pressure on state policymakers to redefine the way LTSS are financed and delivered in order to maximize access and system capacity. The next few years will be critical, as the transformations discussed in this report go from policy and demonstrations to full implementation and affect the lives of some of our most vulnerable citizens."*

While a handful of states (for example, Tennessee and Florida) are addressing LTSS restructuring with only

Medicaid dollars contracted to managed care organizations, many more have either begun or will soon begin federally-approved demonstrations to integrate care for dual eligible individuals and other Medicare-Medicaid coordination initiatives. Medicaid-only strategies can only go so far, most agree.

Detailed information on state-level LTSS initiatives is available from the National Association of States United for Aging and Disabilities (NASUAD) Medicaid integration tracker. These programs differ in scope and the subpopulations of duals addressed, service packages offered, and the extent of Medicare-Medicaid program integration. All include at least the critical component of care coordination, even if retaining fee-for-service arrangements for provider payment for the time being. The more ambitious of these projects pool Medicare and Medicaid funds for duals to create comprehensive benefit plans administered through contracted managed care organizations (MCOs) throughout a state or in major population centers. For an example, see CalDuals.org

These demonstrations have the potential of being garden plots of innovation, but like the systems they are designed to eventually replace, they face a bevy of challenges. While

greater efficiency and quality are thought to be achievable in the longer term, no one should harbor the illusion that high-quality healthcare and long-term care services and supports can be realized on the cheap. A companion illusion is that cost control can be achieved by the crude artifices of depressing provider payments, short-changing the wages and benefits of healthcare workers, or restricting choice and access to essential services. Additionally, evolving integrated models of care will require both public and private investments in new knowledge, technology infrastructure, and development of models for pricing, risk-assessment, risk-sharing, network formation and contracting, enrollment, and quality measurement and reporting capabilities.

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To the extent that the managed care industry emerges as central to the operation of the new models, firms in that industry face financial risk, along with a learning curve, as some have experience in administering Medicare Advantage Plans (including MA Special Needs Plans); others have Medicaid managed care experience with younger populations, but not with the elderly or with LTSS; and most plans lack relevant experience with rural populations and providers and some subpopulations. For their part, many if not most of the needed providers have scant experience contracting and working with managed care plans on a large scale, let alone under arrangements that are performance-related and perhaps risk-shared as well.

Premise 3

Financing and service delivery reforms must migrate to a primary emphasis on individual service and support needs rather than site-specific and program-specific considerations.

Pre-cooked and disparate offerings of healthcare program benefits, often tied to specific care sites, will inevitably have gaps and rigidities that make care coordination problematic while embedding perverse incentives for providers and perpetual cost-shifting between programs and levels of government. Many also hold the view that fee-for-service purchasing from particular providers is fundamentally incongruent with care coordination and a guarantor of inefficiency.

The reform ethic and commitment will center on the needs of those who are the intended beneficiaries, as they personally define them. (This requires an understanding that while good clinical care is included among those needs, the greater focus of LTSS is on quality of life in its larger arc). From there, systems must be designed to flexibly allocate resources to those needs based on evidence of value and effectiveness.

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Successful reform will by definition be disruptive to current arrangements, hence the critical need for stakeholder collaboration to guide a transition by steps over time, but with the end always clearly in view.

Premise 4

Quality and value from payers and providers must be transparent, grounded in proven performance metrics accepted by key stakeholders, and aligned with financial incentives and overall funding that is realistic.

In a reformed system where financial allocations and incentives are tightly aligned to value and outcomes, it might be revealed that post-acute providers, nursing homes, home care agencies, or even family caregivers need to be better supported. Such a revelation will gain public acceptance only if grounded in hard evidence. The same can be said of the verdict that will be rendered on the performance of managed care organizations that assume a major role in organizing and coordinating new models of LTSS access. Therefore, all new models will require both adequate funding and transparent performance measurement at multiple levels that is timely, relevant, fair, financially sensitive, and understandable by the public and their elected representatives.

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Premise 5

The road to reform will have to proceed with neither an infusion of new public funds nor a demand for immediate savings.

This inconvenient but necessary conclusion borders on the obvious. In recent times, public confidence in the ability of government to execute major initiatives has ebbed almost as dramatically as public indebtedness has risen. Entitlement fatigue has set in. Major new investments in program benefits are not in the offing. It is more likely that demands will be made for countable savings from healthcare and LTSS reforms, even in advance of implementing them. (Some state agencies have withdrawn proposals for federal approval of demonstration projects for dual-eligibles in the face of CMS demands for guaranteed early cost-savings and for other reasons.) A more pragmatic expectation would allow LTSS system models to proceed within corridors of risk and reward that at least do not deviate significantly from current forecasted levels of expenditures for several years.

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Premise 6

Long term care, or LTSS as the new preferred terminology, is concerned not with one population, but with multiple subpopulations that have both needs that are common and needs that are distinct.

State Medicaid program administrators are keenly aware of this reality, as their programs more than any others have historically accepted the responsibility of being the insurer of last resort (without capital reserves) for the young and the old, the healthy and the frail, those with sound minds and those who are mentally and behaviorally challenged, and those wrecked by substance abuse. Balancing the needs of individuals from these diverse populations who require LTSS within newly-designed systems will require careful thought and planning, and could prove impossible or unwise to attempt within a single financing or administrative model.

Premise 7

Investments in preventing or managing chronic diseases and conditions deserve far greater attention.

If only in sheer economic terms, even marginally effective steps to prevent the onset of a handful of chronic conditions that are common as we age—and to manage or promote the self-management of them—would yield enormous savings and take pressure off formal care systems, including preventing many costly hospital admissions and readmissions.

According to the National Council on Aging:

- Nearly 92% of older adults have at least one chronic condition, and 77% have at least two.
- Four chronic conditions—heart disease, cancer, stroke, and diabetes—cause almost two thirds of all deaths each year.
- Diabetes affects 12.2 million Americans aged 60+, or 23% of the older population.
- An additional 57 million Americans aged 20+ have pre-diabetes, which increases their risk of developing Type 2 diabetes, heart disease, and stroke.
- 90% of Americans aged 55+ are at risk for hypertension, or high blood pressure. 77% of women aged 75+ have this condition, as do 64% of men aged 75+.
- Chronic diseases account for 75% of the money our nation spends on healthcare, yet only 1% of health dollars are spent on public efforts to improve overall health.
- In 2009, direct healthcare expenditures for chronic conditions in the United States totaled more than $262 billion.

Source: http://www.ncoa.org/press-room/fact-sheets/chronic-disease.html

Premise 8

New ways of thinking about short-term post-acute care and long-term care are essential to successful system reform.

This observation assumes that both types of care need to be more integrated, not less integrated, with the overall healthcare system. But they should be differentiated from each other in the context of the value that they represent within the broader picture.

By historical circumstance, licensed nursing homes have been traditionally positioned as default options for addressing both the immediate post-acute and longer term care needs of older people, and of more than a few younger disabled persons. While these services have been invaluable to millions of individuals and their families over the last half-century, there are tensions inherent in the often conflicting and incompatible demands placed on these facilities. More recently, as the menu of LTSS options has expanded, many nursing facilities have evolved as places where patients could be admitted with the likelihood of discharge to their homes or to a less restrictive setting. In an LTSS system that by design spans a broad continuum, not only of health and medical care, but of social services and living supports, nursing facilities would logically take their places at a point in the continuum that leverages their highest and best use as care sites dedicated to restoration and rehabilitation achieved during short to moderate lengths of stay. In this scenario, nursing facilities would reduce hospital admissions while serving as transitional sites for patients and residents who are able to be maintained in more natural surroundings. [Important caveat: Many nursing facilities will continue to fill a necessary function of caring for long term residents with substantial cognitive impairments that make them unpromising candidates for discharge to home or other settings.]

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Conversely and more commonly, home health agencies have essentially been vendors of Medicare services to those beneficiaries who require skilled nursing with necessary supportive care that can be appropriately delivered in their homes for a few weeks or months. Home care agencies devoted to supporting individuals with continuing personal care and support services for longer durations are less common and not as easily accessed, and in some states are numbered with nursing homes among the unenviable category of Medicaid-dependent providers.

Within integrated and care-coordinated models, these traditional "formal" providers will undoubtedly occupy critical points along a more rational care and service continuum, but only as their historical roles are adjusted. Both nursing facilities and home care agencies, particularly those who serve higher-acuity patients, are keys to achieving the dividends of lowered hospital and long-term nursing

home use. Hence, system economics will likely require that some portion of those dividends be directed to the goal of enabling those types of providers to continue generating overall system savings while also supporting the less intensive portion of the continuum. This is merely consistent with the principle of ensuring that available resources are properly allocated to their highest and best use, and measured not only in efficiency but also by the yardstick of meeting client needs in the most appropriate settings.

Premise 9

Nothing good is possible without a committed, well-trained careforce.

With deference to the wisdom of increasing targeted support to family caregivers, whose contributions can hardly be overstated, the outlook for the formal long-term care or LTSS workforce is not encouraging. We will not explore that challenge in depth here, as the literature is well-furnished with facts and trend data that accurately describe the deficits of nurses, nursing assistants, and personal care workers needed as the U.S. population ages over the next several decades. Suffice it to observe that just as the Affordable Care Act arguably failed to take sufficient account of the need for doctors, nurses, and other health professionals to serve a broader population of insured Americans, any plan to increase access to LTSS for an expanding cohort of frail seniors cannot succeed without a corresponding expansion of the caring workforce.

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While the very large question of the future supply of caregiving workers—an agenda item not just for the care system but more for the society at large—is confronted, providers and payers can take actions to accomplish the necessary augmentation of improving retention rates. My InnerView data from National Research reveal that when these provider organizations make retention a priority and address it by improving the work environment and employee satisfaction, better retention rates are the result even when it is not feasible to substantially improve compensation and benefits levels. Other data have consistently pointed to the exceedingly high cost of employee turnover, some

or all of which may be offset by improvements in the employee experience and workplace culture that need not involve significant new spending. Positive correlations between employee satisfaction and engagement with higher customer satisfaction and occupancy rates, lower workers' compensation and liability insurance exposure, all underscore the surpassing importance of staff stability as a central attribute of high performing and financially robust nursing facilities. It seems highly likely that these factors have their counterparts in home care and other care settings as well.

Correspondingly, public programs and managed care organizations have an obligation to ensure that their payment rates or prices enable providers to meet quality standards while achieving needed operating margins from reasonable returns on invested capital and efficiencies within the non-labor portion of their cost structures, without tapping funds needed for essential labor.

Premise 10

The free flow of information across the LTSS continuum, the larger healthcare universe, and across networks is essential to breaking down care and funding silos and outmoded habits, and delivering coordinated, customer-centric care and services in the most efficient manner.

This premise is applicable at multiple levels—from the client to the payer and all points in between. Successful care coordination requires the capacity to gather, report, and share relevant baseline client functional and situational assessments as well as patient-level encounter data. Metric data validating outcomes and relative value are essential for pricing, budgeting, and future service and benefit adjustments.

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Client satisfaction with health plans as well as individual providers, while relatively inexpensive to measure, are technology-assisted processes that provide important data for performance benchmarking and service improvement and are critical to sustaining a core customer-centric focus. Knowing what matters most in LTSS is not the invention or special property of experts, but comes from the appetite of professionals for understanding what matters most to those whose needs and preferences are at the system's center. This implies the need for a process that continually consults the perceptions of LTSS clients, their families, and their caregivers, and turns those data into knowledge that permeates the care culture and directs available resources to best practices.

In the LTSS context, technology is not an end in itself, but the means by which to isolate and deliver actionable (as contrasted with merely incidental or interesting) information—first, to understand the unique circumstances, needs, and preferences of individuals as people as well as program clients; and secondly, to enable those who work with them to plan and deliver the services they need in the most effective and personalized way.

Concluding Perspective

Long term care has continued to make periodic brief appearances on the front burner of national policy, only to quickly take its accustomed place at the rear of the stove. But this lamentable pattern will be interrupted by the sheer force of reality. Here is an example of that reality: Will Boomers Bust The Budget?

Until recently, no societies have experienced the phenomenon of large concentrations of very old people. But now the world is rapidly aging. Two billion people will be 60 years and older by 2050, more than triple the number in 2000, according to the World Health Organization. A recent Merrill-Lynch blog entry noted that "(T)his demographic change has global implications. Some of the world's largest economies are facing rising healthcare costs, a shrinking workforce, higher pension costs, and diminishing fertility rates."

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At the present time and for the foreseeable future, the United States, along with Japan, China, and Europe are facing unprecedented demographic inflection points impacting their cultures and economies. There is good news about healthy aging, but close along side is the critical need to creatively and humanely address the long-term dependency of millions of citizens on services and supports from others—others whose numbers are declining relative to the need for their caring and support.

Much more learning and diligent effort are required for the U.S. to meet this challenge. However, many are working hard and much has been learned already that awaits effective application. The power of information and evidence also offers important leverage toward enabling the solutions that are so critically needed.

Ultimately, the complex conundrum of long-term care is unlikely to be solved by a singular and collectivist rearrangement of national policy, but rather by the patient building of frameworks of public and private collaboration that put the dignity of those who must be served at center stage while conferring deserved honor upon those who serve them.

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