



## **Summary of Proceedings**

### **Long Term Services and Supports in Health Reform Solutions Summit**

Convened by

**The National Advisory Board on Improving Health Care  
for Seniors and People with Disabilities  
and  
George Mason University Long-Term Care  
Educational Foundation  
and  
Amerigroup Public Policy Institute**

The Capitol Hill Visitor Center  
September 23, 2009

# HEALTH CARE REFORM:

## Improving Long Term Services and Supports (LTSS)

### PARTICIPANTS

#### ORGANIZERS

Lex Frieden	Convener, National Advisory Board
Nancy L. Grden	Executive Director, Amerigroup Public Policy Institute
Mark R. Meiners, PhD	George Mason University, Long-Term Care Educational Foundation

#### SPEAKERS

##### FIRST SESSION

Anne Montgomery	Senior Policy Advisor, Senate Special Committee on Aging
Robyn Golden	National Coalition on Care Coordination (N3C)
Cheryl Schraeder	N3C
Eric De Jonge, MD	Director of Geriatric Care, Washington Hospital Center, Medical House Call Physicians

##### SECOND SESSION

Manuel E. Jimenez, MD	Health Advisor to Senator Susan M. Collins (R-Maine)
Taryn Morrisey, PhD	U.S. Senate HELP Committee
Christa Shively	Legislative Assistant for Representative Earl Blumenauer (D-Ore.)

##### THIRD SESSION

Manuel E. Jimenez, MD	Health Advisor to Senator Susan M. Collins (R-Maine)
Taryn Morrisey, PhD	U.S. Senate HELP Committee
Christa Shively	Legislative Assistant for Representative Earl Blumenauer (D-Ore.)

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### ATTENDEES

Jodie Anthony	National Association of State Medicaid Directors
Kathy Brill	Parent to Parent, USA
Sarah Buckerman	Senate HELP Committee
Julie Carroll	National Council on Disability
Matthew Davies	National Advisory Board
Berthy De La Rosa-Aponte	National Advisory Board
Merrill Friedman	Amerigroup Corporation
Howard Gleckman	Urban Institute
Chuck Graham	National Advisory Board
Chris Hilderbrant	ADAPT
Geoff Hoffman	Congressional Research Service
Hunter Hurst	National Advisory Board
Bilal Javed	George Mason University
Sidney Johnson	George Mason University
Mark Johnson	Shepherd Center/National Advisory Board
Carol Jones	Shepherd Center
Enid Kassner	AARP
Leonard Kirshner	National Advisory Board
Marie Kodadeck	George Mason University
Harriet Komisar	The Hilltop Institute, UMBC
Pamela Larson	National Academy of Social Insurance
Barbara Manard	American Association of Homes and Services for the Aging
Tim McDonald	Amerigroup Corporation
Jeannine Melly	New York Academy of Medicine/N3C
Sam Morgante	Genworth Financial, Inc.
Deanna Okrent	Alliance for Health Reform
Carol V. O'Shaughnessy	National Health Policy Forum, George Mason University
Karl Pelzer	National Center for Assisted Living
Julie Stone	Congressional Research Service
Rob Sweezy	National Advisory Board
Eileen J. Tell	Long Term Care Group, Inc.
Anne Tumlinson	Avalere Health
Kathleen Ujvari	George Mason University
Josh Weiner	RTI International
Jane Woods	National Advisory Board
Janice Zalen	American Health Care Association

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### INTRODUCTION

The Long Term Services and Supports (LTSS) Health Reform Summit was opened with welcoming remarks from Nancy L. Grden, Executive Director, Amerigroup Public Policy Institute. Ms. Grden reiterated the purpose of the meeting was to provide a forum for key Congressional staff, policy analysts and LTSS experts to come together to:

- Review the role and relevance of LTSS in health reform
- Synthesize health reform proposals with LTSS principles, experience and evidence
- Discuss how the major strategies for broad-based health reform can include LTSS for seniors and people with disabilities

Ms. Grden noted the important and timely context of the meeting with key amendments being offered throughout the day to the America's Healthy Future Act, sponsored by Senator Max Baucus (D-Mont.), which recently was introduced for public review by the Senate Finance Committee. In the context of the current Congressional debate on health care reform, she noted the importance of ensuring the interests of the vulnerable elderly and persons with disabilities remaining highly visible to legislators. She hoped the forum would help highlight the shared interests of the participants and their constituencies and move us toward agreement on a policy framework and recommendations for incorporating LTSS into health care reform.



Lex Frieden, Professor of Health Informatics, University of Texas at Houston, and Convener of The National Advisory Board (NAB), added his welcome to the participants. Dr. Frieden noted that the NAB members represent a culturally diverse community of interests and expertise encompassing policy, administration, research and advocacy. As a group, the NAB members feel strongly that it is essential to have a systematic, coordinated plan for services and supports that will be available to people of all income levels. This type of network is a matter of survival to people who have functional limitations. Dr. Frieden said the reality is you have a one in two chance of being disabled before the age of 65, and, after that, the chance increases radically—to 72 percent—after you retire.

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The six foundational principles developed and promulgated by the NAB then were reviewed by NAB member Mark Meiners, Health Policy Professor at George Mason University. Dr. Meiners, who organized and facilitated the Summit discussion, indicated the unifying theme “LTSS in Health Reform” has its roots in the six principles outlined in the NAB “Declaration for Independence”:

1. Enhance Self-care through Improved Coordination
2. Encourage Community Integration and Involvement
3. Expand Accessibility of Services and Supports
4. Uphold Personal Preference
5. Empower People to Participate in the Economic Mainstream
6. Invest in Improved Technology

Chronic illness and disability are involved in an estimated 75 percent of our health care expenditures, and if we want to bend the cost curve in the right direction, long-term care no longer can be the step child in the health reform debate.

Acute and long-term care vested interests must break out of their silos and move toward integrated systems of care. To help bring this about, care coordination strategies must empower people to take an active role in their own health care. Care systems must encompass the broader community of relevant interests, including support services, housing and transportation. The array of health and social services must be interconnected and accessible for all people to participate in the social, economic, educational, and recreational activities available through community living.

The NAB principles also recognize that best practices of successful long-term services and support programs embrace both personal preferences and personal responsibility. To support this, people must be encouraged and supported in seeking employment and establishing careers. In addition, cost saving technology development that helps individuals remain in their communities must receive increased support.

### RECOMMENDATIONS

Incorporating long term services and supports within Health Reform legislation:

- Authorize health system reforms that support person-centered, assessment-based care coordination through interdisciplinary primary care teams
- Establish a high-level office within the Centers for Medicare and Medicaid Services (CMS) to provide strong and replicable improvements in the integration of acute and long-term services and supports (LTSS)
- Re-authorize Medicare Special Needs Plans (SNP) to provide models of high quality care coordination for vulnerable populations
- Incent state governments to combine and coordinate physical health, behavioral health, and LTSS services for Medicaid recipients
- Authorize the Medicare Transitional Care Act to cover coordinated institutional discharge planning and follow-up
- Authorize the Independence at Home Act to cover in-home medical service that can help patients in need of LTSS
- Include eligibility of chronic care and LTSS as part of accountable systems of care and medical home programs
- Include LTSS within programs to support and evaluate new payment methodologies and structures
- Incorporate LTSS eligibility within health IT networks and systems
- Fund workforce development initiatives that address service gaps, such as home health staff, social workers, and nurse practitioners
- Authorize the Community Choices Act to provide equal access to home and community-based alternatives to institutional care
- Support the extension of Aging and Disability Resource Centers to help individuals make informed health and social service choices
- Support return to work programs for people with disabilities, without losing insurance
- Enact the CLASS Act, a voluntary long-term care insurance option, with support for private insurance, tax credits, and quality improvement.

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### DISCUSSION SESSION ONE: CHRONIC CARE IMPROVEMENT

LTSS policy has begun to intersect with research and program development in three broad categories of interest that served as the basis for discussion sessions. In each section, Congressional staffers were invited to outline key legislative proposals of health reform. The first was broadly described as chronic care improvement, which concerns issues of care coordination, medical home and home care physicians.

Anne Montgomery, Senior Policy Advisor, Senate Special Committee on Aging, started the discussion by noting that there has been considerable activity dealing with chronic care improvement in various pieces of legislation that focus on either Medicare or Medicaid populations, as well as those dually eligible for both programs. Ms. Montgomery noted that Special Needs Plans (SNP) programs in Wisconsin, Massachusetts and Minnesota were reauthorized for three years and allowed to expand into new areas. These states are recognized as the leaders in putting together programs that integrate acute and long-term care.

One piece of legislation specific to chronic care improvement is the RE-Aligning Care Act (S. 1004/H.R. 2307), introduced by Senators Blanche Lincoln (D-Ark.) and Susan Collins (R-Maine) and Representative Gene Green (D-Texas). It authorizes coverage of geriatric assessment and care coordination services for geriatric fee-for-service patients. It also directs the Secretary of Health and Human Services (HHS) to conduct outreach to inform consumers about these assessments and services and to evaluate their effect on Medicare quality and expenditures.

Care coordination has received considerable support in legislative efforts on Capitol Hill due to the work of the National Coalition on Care Coordination (N3C). Robyn Golden, one of the co-chairs, noted that the N3C was formed in 2008 from many groups that shared concerns and believed that care coordination can help improve our health system. The N3C is advocating that care coordination should:

- Be patient-centered
- Be supportive of family and informal caregivers
- Be accessible
- Take an interdisciplinary approach
- Focus on chronic care and health care transitions
- Bridge health and social services
- Employ a comprehensive assessment
- Implement and monitor a flexible care plan.

N3C aims to improve the care of vulnerable elders by educating state and federal policymakers on care coordination so they will

#### NOTABLE N3C REPORTS

- *The Promise of Care Coordination: An Analysis of Care Coordination Models that Can Reduce Hospitalization and Expenditures Among Medicare Beneficiaries and Improve Quality of Care*, by Randall Brown, PhD, of the Mathematica Policy Institute, Inc. It found that care coordination can reduce hospitalizations and Medicare costs and improve the quality of care for chronically ill older adults, as long as the programs involve direct engagement of interdisciplinary teams with close communication among all providers involved in a patient's care, and empower patients with caregivers to manage their own care.
- *Structuring, Financing, and Paying for Effective Chronic Care Coordination*, by Robert Berenson, MD, a Fellow at the Urban Institute and an expert in Medicare policy, and Julianne Howell, PhD, an independent technical consultant to The New York Academy of Medicine's Social Work Leadership Institute and the Centers for Medicare & Medicaid Services (CMS). This paper will be important for the Congressional consideration of how best to pay for care coordination.

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frame new policies to bring down the barriers imposed by silos. In recognition of the need for evidence-based research and policy-specific recommendations, the N3C recently issued two reports worth noting.

Evidence-based research on transitions in care, one of the key care coordination themes, is the subject of legislation introduced by Senator Jeanne Shaheen (D-N.H.) and Representative Earl Blumenauer (D-Ore.). Christa Shively, legislative assistant for Representative Blumenauer said a Medicare benefit for 90 days of transitional care coordination was being incorporated into the Senate Finance Bill. This is from HR 2773, the House version of the Senate transitional care bill S.1295.

Manuel Jimenez, MD, led the discussion on the Medicare Transitional Care Act of 2009 (S 1295), which has been referred to the Senate Finance Committee. Dr. Jimenez, a pediatrician with Children's National Medical Center, acts as advisor to Senator Collins, the bill's sponsor. Co-sponsors are Senators Maria Cantwell (D-Wash.) and Sheldon Whitehouse (D-R.I.). The bill's provisions are based on the Transitional Care Model of Mary Naylor, PhD. The bill proposes covering the costs for a clinician to meet with a patient 24 hours before hospital discharge for planning and patient education, particularly on medications from which a home care transition plan is developed. The coverage would extend for 90 days after discharge to allow the clinician to ensure home safety, caregiver education and follow-up with the physician.

In response to questions, Dr. Jimenez said transitions from all types of health care institutions were covered, including hospital to skilled nursing, rehab and LTC facility to home, not just transitions from hospital to home. Also, Senator Baucus is considering to transitional care pilot programs, whether based on Dr. Naylor's Transitional Care model or others, such as Coleman's Care Transitions Program.

Another piece of legislation highly relevant to chronic care improvement is the Independence at Home Act of 2009 (S.1131/H.R. 2550), co-sponsored by Senator Ron Wyden (D-Ore.) and Representative Edward Markey (D-Mass.). Under this legislation, Medicare recipients with multiple chronic conditions could receive medical services in their homes, coordinated by a primary care team. Eric De Jonge, MD, a leading practitioner and advocate for medical house calls, noted this approach allows vulnerable elders who need a primary care team to use their home as a base, instead of the provider's office. A coordinating home-based primary care team in his organization is composed of a physician, a nurse practitioner, a social worker and coordinating staff. Once a patient joins them, the team follows the patient through all settings, including the hospital and any other necessary institution, until the patient dies. The team is the hub of the coordinating wheel. They have dealt with 2,000 people over two years. The group coordinates the Medicaid side of services for dual eligibles by assigning social workers, who are Medicaid waiver providers, as care coordinators.

Under the Independence at Home Act, the financial incentive would be payment under a shared savings model. The savings accrued to Medicare by covering treatment at home would be shared with the team of providers who helped to create the savings. Responding to questions, Dr. De Jonge said that the savings are not accounted for on a case-by-case basis. In his practice, they are expected to meet a predicted overall cost for a given number of patients. The group's hospital readmissions have been reduced by 50 percent. His group targets the most needy and expensive 10 percent of the vulnerable senior population. This Medicare population is identified by clinical criteria (multiple conditions), need for assistance with two or more activities of daily living, and history of requiring high-cost services in the last year. The group was able to show savings by intervening in time to prevent hospital admissions and readmissions. In the proposed legislation, CMS will be expecting practices to work with the top 20 percent to try to help delay the later stages of chronic conditions.

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Highlighting the relevance to LTSS goals of aging in place, Dr. De Jonge confirmed the doctors actually make the house calls, and more will be willing to do so if the savings incentives are implemented. Technological advances have provided many devices that make home care possible. The discussion helped to clarify that this approach to chronic care improvement is not the same as the Medical Home model. The House Call model is home based; the Medical Home model is based in the doctor's office where patients and their primary care providers are supported with community-based services that coordinate with primary care. A major advantage of home visits is to relieve patients and their supporting agencies of the cost of transportation. He noted that younger people with disabilities would benefit from a similar team approach, but the team would have to be made up of different medical personnel.

It should be noted that Senator Baucus' Chairman's Mark calls for the creation of an Innovation Center (IC) within CMS to test, evaluate and expand different payment structures and methodologies that aim to foster patient-centered care, improve quality and slow the rate of Medicare cost growth. The IC would be required to evaluate each model tested, including an analysis of the extent to which the model results in:

- Coordination of health care services across treatment settings
- Reduction of preventable hospitalizations
- Prevention of hospital readmissions
- Reduction of emergency room visits
- Improvement in quality and health outcomes
- Improvement in the efficiency of care
- Reduction in the cost of health care services covered under this title
- Achievement of beneficiary and family-caregiver satisfaction

Consistent with the NAB call for investment in technology, the proposed IC is required to consider testing health Information Technology (IT) networks that support care coordination for chronically ill Medicare beneficiaries through a health IT-enabled network that includes a chronic disease registry, home telehealth technology and care oversight by the beneficiary's treating physician.

Before moving to the next array of topics, a caution was noted. Care coordination itself can become over-compartmentalized instead of fostering integration. A key point of this session is that those who focus on chronic care improvement strategies and those who focus on LTSS must break out of the medical vs. social service silos they work in and often advocate for. Many in the medical community know little about the social service needs of patients once they leave the office or institutional setting. LTSS advocates often are equally unfamiliar with the fact that primary care medical providers who care for older and disabled patients are part of the solution and in short supply.

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### DISCUSSION SESSION TWO: INVESTMENT IN SAFETY NET PROGRAMS

LTSS policy has begun to intersect with research and program development experience in a second major area: safety net programs that are a large focus of state Medicaid efforts to improve financing and delivery options. Here again, Congressional staffers were invited to outline key legislative proposals that are being worked on as part of health care reform. Home and Community-based Services (HCBS) alternatives to institutional care, dual eligible integrated care programs, and workforce development all are receiving legislative attention as part of health care reform.

Ms. Montgomery noted the overlap with issues covered in the first session, because many of the strategies being pursued to improve Medicare are equally relevant to seniors and people with disabilities cared for by Medicaid safety net programs. In fact, one of the key areas Congress has noticed is the need to improve the care of those eligible for both Medicare and Medicaid (known as dual eligibles). The dual eligible patients are among the most costly to care for under the Medicare and Medicaid programs. They comprise about 14 percent of the beneficiaries in each program but account for about 24 percent of Medicare costs and 42 percent of Medicaid costs

**Dual eligible needs are among the most costly, comprising about 14 percent of the beneficiaries in each program but accounting for about 24 percent of Medicare costs and 42 percent of Medicaid costs.**

Senator Baucus' bill establishes a new Office of Coordination for Dually Eligible Beneficiaries (OCDEB) within CMS. The office would be responsible for identifying and leading agency efforts to align Medicare and Medicaid financing, administration, oversight rules and policies for dual eligibles. It would be required to prepare annual reports for Congress documenting dual eligible spending with separate subtotals for Medicare and Medicaid, as well as dual eligibles' health outcomes and access to services by subtype of beneficiaries.

Other Medicaid provisions that complement similar strategies proposed for the Medicare program include a new Medicaid state plan option under which Medicaid enrollees with chronic conditions could designate a provider as their medical home. Qualifying providers would have to demonstrate they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in house or by contracting with a team of health professionals. Required services include: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to relevant community and social support services, if it were feasible to use health IT to link such services. The option would be evaluated based on its impact to hospital admission rates, chronic disease management and coordination of care for the chronically ill. The Healthy Futures Act also establishes a bundled payment demonstration project under Medicaid in up to eight states.

The Home and Community Balanced Incentives Act (S.1256), sponsored by Senators Maria Cantwell (D-Wash.) and Herbert Kohl (D-Wis.), also has been introduced into the Senate Finance Bill. This bill would enable state Medicaid services to expand without having to get waivers.

Senator Kohl, along with Representative Janice Schakowsky (D-Ill.), also has co-sponsored the Retooling the Health Care Workforce for an Aging America Act of 2009 (S.245/H.R. 468). This requires the HHS Secretary to amend the Public Health Service Act to expand training for health professionals in the fields of geriatrics, long-term care and chronic care management.

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Taryn Morrissey, PhD, staff member on the Senate Health, Education, Labor, and Pensions (HELP) Committee, said workforce development proposals in the HELP Committee were focusing on incorporating IT and IT training into small practices so that physicians would have connections to social workers and nurse practitioners to promote more seamless coordination of care. HELP is seeking to promote the extension of primary care. The Community Choices Act (S. 683/H.R. 1670), co-sponsored by Senator Tom Harkin (D-Iowa) and Representative Danny Davis (D-Ill.), is also part of the HELP Committee's efforts to provide individuals with disabilities and older Americans equal access to HCBS alternatives to institutional care.

Comments from the participants in support of these workforce initiatives emphasized that working in health care needs to be made more attractive. Consumer-directed care, good in itself, may fragment the workforce. States can intervene with policies that stabilize the workforce.

During the discussion, participants were reminded that HCBS themselves may cost more. There is no firm answer to controlling HCBS costs, but several methods are being tried. Vermont has a 1115 waiver with a global cap. Wisconsin has a 1915 (c) waiver that permits monitoring of provider data. Additional examples of states that have decreased administrative costs and diverted funds to HCBS are Washington and Oregon. Michigan and California struggle with costs. The Home and Community Balanced Incentives Act would provide incentives by increasing the Federal Medical Assistance Percentage in proportion to the use of HCBS.

System improvements—standardized assessment instruments, “No Wrong Door” policies—are helpful. Better case management and data collection can be promoted through funding for IT. Some studies show that expenditure on them saves costs elsewhere, so the total cost is less. Participants mentioned studies conducted by Montefiore Medical Center and the Department of Veterans Affairs that reported reduced hospital readmissions and a reduction in the total cost of care. Medicare demonstration projects have not agreed in finding cost savings, however. Congress would be interested in knowing what research agenda would help in finding savings.

In this session, again the idea was expressed that administrative and policy silos need to be broken down. Typically, services cannot be tailored to individual need. People with disabilities lose their health insurance if they work. The opinion was expressed that one advantage of the “public option” in health reform would be to enable people with disabilities to work without losing health insurance. This was also noted as an advantage of having a National Insurance Exchange Plan. People with disabilities need equal opportunity in access to education and employment, but some also need to be free not to work.

Others noted that the costs and benefits are not equitably shared between Medicare and Medicaid, limiting program development and creating irrational coverage. Suggestions offered from around the table included:

- Replacing Medicaid long-term care with a voluntary federal long-term care insurance program, with base coverage plus additional coverage on a sliding scale
- Standardizing assessments and integrated plans of care for dual eligibles
- Creating accessible, affordable housing in the community as an alternative to institutions
- Transferring all elderly persons to Medicare

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- Reconsidering benefits—why should Medicare pay for surgery but not for activities of daily living?
- Increasing involvement of state governors in the discussion
- Guaranteeing transparency of billing process
- Increasing Medicare sponsorship of research on Medicaid programs
- Expanding support for public-private long-term care insurance.

### THIRD DISCUSSION SESSION: LONG-TERM CARE FINANCING

As with the previous discussion topics, there have been legislative proposals dealing with financing strategies that seek improvements to both the public and the private opportunities to prepare for the risk of high long-term care costs. Attendees understand that form follows finance, and, in the case of LTSS, the financing is often too little, too confusing and too late to avoid depending on Medicaid. There is also recognition that Medicare and Medicaid payments are being examined by Congress as part of health care reform, though this topic did not come up for discussion at this meeting, other than what has been previously noted.

Connie Garner, PhD, Policy Director for Disability and Special Populations, Senate HELP Committee, presented information on the Community Living Assistance Services and Supports (CLASS) Act (S. 697/H.R. 1721) co-sponsored by the late Senator Edward Kennedy (D-Mass.) and Representative Frank Pallon (D-N.J.). The CLASS Act proposes a voluntary public long-term care insurance option, financed with payroll deductions (opt-out enrollment). Benefits are not contingent on poverty, and recipients are allowed to work. The act is designed to help individuals with functional impairments and their families pay for needed services and supports while having choices about community participation, education and employment.

Dr. Garner noted that the CLASS Act provides an alternative to the present practice, which is to provide services through Medicaid, for which one now has to qualify by becoming impoverished. Private long-term care insurance can also help prevent the descent into poverty, but the market penetration has been much smaller than is needed to address the public policy concerns of people being uninsured for this risk. The measure is not intended to compete with private insurance. Rather, the intention is to provide an alternative form of insurance, a basic provision to which more benefits could be added, paid for by private insurance.

Other details offered are that the program has a vesting period. If the person has been in the program five years or more, he or she can get the benefit regardless of any kind of underwriting. If the person has a disability and is working under a program that allows him or her to work, he or she may do so under the CLASS Act. The benefit is paid in cash (not less than \$50), set at enrollment and increased with general inflation, and able to be applied to nonmedical services and supports to maintain independence at home or in another setting of choice. The bill is not intended to be too prescriptive; HHS can decide how to implement it.

The underlying ideas have been vetted for a number of years. Senator Michael DeWine (R-Ohio) and the late Senator Edward Kennedy (D-Mass.) first introduced this bill in 2005. In July 2009, the Society of Actuaries (SOA) issued an independent review of the bill, raising concerns that have since been put forward to Congress. The SOA review indicated premiums in the original version offered at that time (\$65 per month) were inadequate and needed to be substantially increased (to \$160 per month) to keep the program solvent. Issues

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related to the opt-out/opt-in provision and the underwriting criteria related to “activity-at-work” and non-working spouse were suggested as adjustments that could affect the needed level of premiums for long-term solvency.

Adjustments that meet Congressional desire to keep the program solvent for up to 75 years have been negotiated. The Congressional Budget Office scored the revised bill with premium increases factored in, and Dr. Garner reported that in the sixth year of its 10-year window, Medicaid savings begin.

A participant in the discussion commented that public-private, long-term care insurance partnerships are tricky to manage successfully. Public insurance advocates worry that private insurers will not provide coverage that meets the needs of those who will use long-term care. Private insurance advocates worry that any kind of public insurance approach like the CLASS Act will crowd out the market for their products. There will need to be a concerted cooperative effort to get the message out that CLASS Act offers a very small benefit that will need to be supplemented by private insurance. Private insurers might see the CLASS Act benefit as helping to set up market interest in which they could compete to win.

It was noted that tax credits for long-term care insurance have been included in Senator Baucus’ America’s Healthy Future Act of 2009, along with including such coverage as part of a cafeteria plan. Ms. Montgomery also noted that the provisions in the Confidence in Long-Term Care Insurance Act (S.1177) had been offered by Senator Wyden as an amendment to the Baucus bill. This provision calls for greater consumer protection, increased consumer information and choice, and increased competition among private insurers.

The HELP Committee activities on LTSS also were represented by Lee Perselay, Disability Council for Senator Harkin. He and Dr. Garner have been working closely on the Community Choice Act, 2009 (S.683/H.R. 1670), which was introduced by Senator Harkin and Representative Danny Davis (D-III.). The act benefits people who are eligible for Medicaid and wish to live in the community, not a nursing home. Benefits would be available to those with functional disabilities and would not exclude mental retardation. The Supreme Court ruled in *Olmstead*, 1999, that the Americans with Disabilities Act required states to provide HCBS rather than institutional placement. This act serves a much broader part of the population than current waiver programs. The Community Choice Act and CLASS Act are designed to complement each other, providing support for current and future LTSS needs.

The Community Choice Act will be considered in the Finance Committee Chairman’s Mark. Enhanced federal matching funds of 6 percent will be offered to the states as an incentive. An argument against this proposal was that an enhanced match rate could be an inducement for people to move to assisted living, but there is the problem that Medicaid does not pay for housing if the person is not in a nursing home. Concern was also expressed that the opportunities to substitute HCBS for institutional care seem optional for states and therefore less likely to happen, especially during tough economic times, which for state Medicaid programs are more the norm than the exception.

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### CONCLUDING COMMENTS AND CALL FOR REFLECTION AND FEEDBACK

The health care reform legislative process can be frustrating and convoluted, but it is important to be “at the table” when health care reform decisions are being made. In the past, long-term care has been the stepchild in the health care reform debate. It is clear from this day of dialogue that many provisions relevant to LTC/LTSS are being considered for inclusion in the final bill. Many of these provisions reflect the lessons learned over years of experimentation with our safety net program, sponsored by Medicaid, which is heavily burdened by the need to find cost containment as it serves growing numbers of vulnerable citizens. Medicare has explored chronic care improvement strategies. However, these investments in financing and delivery system improvements need to be further supported. The LTSS Summit participants were encouraged to look for links to one another’s programs and to resolve differences. While some issues remain open-ended, there has been a convergence of interests among the perspectives represented by the participants. Participants were encouraged to reinforce the health reform legislation being made to improve LTSS.

### RECOMMENDATIONS

Incorporating long term services and supports within Health Reform legislation:

- Authorize health system reforms that support person-centered, assessment-based care coordination through interdisciplinary primary care teams
- Establish a high-level office within the Centers for Medicare and Medicaid Services (CMS) to provide strong and replicable improvements in the integration of acute and long-term services and supports (LTSS)
- Re-authorize Medicare Special Needs Plans (SNP) to provide models of high quality care coordination for vulnerable populations
- Incent state governments to combine and coordinate physical health, behavioral health, and LTSS services for Medicaid recipients
- Authorize the Medicare Transitional Care Act to cover coordinated institutional discharge planning and follow-up
- Authorize the Independence at Home Act to cover in-home medical service that can help patients in need of LTSS
- Include eligibility of chronic care and LTSS as part of accountable systems of care and medical home programs
- Include LTSS within programs to support and evaluate new payment methodologies and structures
- Incorporate LTSS eligibility within health IT networks and systems
- Fund workforce development initiatives that address service gaps, such as home health staff, social workers, and nurse practitioners
- Authorize the Community Choices Act to provide equal access to home and community-based alternatives to institutional care
- Support the extension of Aging and Disability Resource Centers to help individuals make informed health and social service choices
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- Enact the CLASS Act, a voluntary long-term care insurance option, with support for private insurance, tax credits, and quality improvement.

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### ABOUT THE SPONSORS

#### **About the National Advisory Board on Improving Health Care Services for Seniors and People with Disabilities**

The National Advisory Board was established by Amerigroup to provide advice and guidance on how to deliver high-quality health care to people with serious, chronic illnesses. Its members include nationally recognized health care policy experts, public officials and advocates for seniors and persons with disabilities. The Board's convener, Lex Frieden, is Professor of Health Informatics and Rehabilitation at the University of Texas Health Science Center at Houston.

#### **About George Mason University Long-Term Care Educational Foundation**

The mission of the Long-Term Care Educational Foundation is to conduct research and convene educational forums to help public and private stakeholders achieve long-term care financing and delivery system improvements. Forums have focused on Long-Term Care Insurance Partnerships, Medicare Special Needs Plans, and Long-Term Care Integration. The LTCIF operates under the direction of Mark R. Meiners, Professor of Health Administrating and Policy, College of Health and Human Services at George Mason University.

#### **About the Amerigroup Public Policy Institute**

The Public Policy Institute, a joint venture of Amerigroup Corporation and the Amerigroup Foundation, examines a wide range of issues related to Medicaid, Medicare and other government health care programs that serve almost 100 million Americans. The Institute's goal is to identify, assess and promote innovative solutions that help control the cost of Medicaid and Medicare and that help Americans who depend on these programs live healthier, more independent lives.

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### NATIONAL ADVISORY BOARD MEMBERS

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