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Medicare and Long Term Care

Testimony for the

Commission on Long-Term Care

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I am pleased to appear today at this hearing to discuss how the United States can improve its woefully inadequate system of long term services and supports. As the Commission, I am sure, is fully aware, our current makeshift patchwork of public and private programs leaves many people without adequate care and contributes to inefficiencies and perverse incentives for behavior. But I am concerned that the title of this panel suggests a modest incremental approach to improvements for this dysfunctional system rather than a broader solution to the problem. Recognizing that the current "system" is seriously flawed, my focus is on that broad solution, along with some more modest Medicare improvements.

The Medicare program could be a good place to build a viable long term supportive services program. It is, despite the criticisms leveled at it, a remarkably successful program. It has provided care to the sickest members of our society at rates lower than what would be the case in the private market (both in terms of absolute amounts and in rates of growth over time), it has innovated many changes in the health care system, and it is among the most popular of government programs.[1] Certainly, there are improvements needed in the program to meet its acute care needs, but it could offer a number of advantages in creating a more comprehensive environment for providing care to those requiring long term supportive services. I will discuss some of these issues further below.

A suggestion to expand Medicare's scope when the current program is under assault as being "unsustainable" or in need of major reform may seem surprising. But the philosophy to cut Medicare that is currently in vogue actually contributes to what is wrong with our health care system for the elderly and disabled in the United States. Too much attention is on reducing costs of specific programs with little regard to what this means for the needs of the beneficiary population or what it does to overall costs of care for society. By focusing solely on the costs of a program like Medicare or Medicaid, solutions are often suggested that merely shift the burdens (in the form of greater costs or foregone care) elsewhere. Nowhere is this more evident than in the long term care world where the gaps in the system lead to extraordinary costs on some individuals and to others being deprived of much needed care. Particularly in the latter case, this also leads to higher acute care costs that come back to burden our public programs. Considerable research indicates exactly how lack of supportive services and basic treatment of chronic care needs result in higher hospitalizations and other otherwise unnecessary care.[2] We may decide to tolerate this environment, but we should not be proud that we have done so little to improve the lives of our most vulnerable citizens. The issue is really one of willingness to provide resources for these needs and of whether we will do so collectively.

The Medicare program has always had an uneasy alliance with long term care services. Although it offers skilled nursing facility (SNF) and home health services, these are intended to be skilled services only—supplementing other acute care treatments. This is, however, an artificial distinction and one that Medicare has struggled with over many years, seeing periods of expansion in services and then contraction as rules and enforcement change in an attempt to hold back the growth of SNF, home health, and other post-acute care benefits. Moreover, Medicare's

payments to long-term care providers (albeit for post-acute rather than long-term personal care) are substantial—totaling $48 billion in 2012. [3]

As continuity of care needs and the benefits of coordination of services become more widely recognized, the distinction between acute and long term care needs becomes increasingly inappropriate. But, at present, there is no way to achieve a comprehensive system for those who are in need of both acute and long term care. The fragmented way in which we deal with health care for those with complicated needs leads inevitably to higher costs and poorer quality. Concerns about the costs of Medicare, for example, cause policy makers to focus on how to more carefully restrict use of home health and SNF care, rather than to consider how it should best be used in a broad treatment plan. And any effort to "strengthen Medicare" with that restricted view in mind will ultimately do little to improve the system of care for these vulnerable patients. Thus, it is critical to take a broader look at what is desirable,

Experiments such as the On Lok program--and its successor PACE--demonstrate that care can be improved and overall costs reduced with better coordination between acute and long term care services. In practice, however, this is difficult to achieve in our fragmented system which focuses more on care within a particular program rather than on the totality of needs for the population being served.

It does not follow, however, that turning over either Medicare or long term care needs to private insurers will resolve these challenges. Too many of the proposals to "capitate" the payments for Medicare and turn the problem over to the private sector reflect a desire to limit liabilities to the federal government rather than to truly find a solution to the difficult challenge of improving the coordination of care.[4] Mountains of evidence suggest that only a limited number of private plans operating under the Medicare Advantage program do much at all to coordinate care nor have they been successful in holding down costs.[5]

It is equally undesirable to turn the responsibility for beneficiaries who are dually eligible for Medicare and Medicaid over to the state Medicaid programs as is currently underway with the coordinated care demonstrations.[6] Medicaid managed care plans that have served low income families are ill-prepared to handle people with significant acute and long-term care needs. Rapid movement in this area, with payment cuts up front, are similarly more budget-driven than solution-driven. Why should the most vulnerable beneficiaries in Medicare be handed over to state governments that are ill-equipped to handle them and where there is likely to be enormous variation in the quality and quantity of care provided? And perhaps most important, creating a comprehensive system of acute and long term services should not be viewed as a problem only for those with low incomes. Even firmly middle class families can face disaster when long term care needs arise. From the beginning, the bulk of spending on the elderly has rested with the federal government; this is a national responsibility and one in which risk management is best handled at the broadest possible level.

Thinking the Unthinkable

Many years ago, I wrote a paper called "Taking the Plunge" in which I advocated a federal long term care program that was not means tested. The basic rationale remains the same today. None of us know in our twenties, thirties, or even sixties if we will end up needing supportive care over a long period. It is foolish in such an environment to be a "risk pool of one" and try to save enough to cover all such needs. This is an obvious role for insurance. But at the same time, private insurance has had a very long time to expand into this area and it remains a poor option for most. A voluntary system of public financing, such as was contemplated with the CLASS Act faces the same difficulty as private insurance; buying into such a program is a tough sell: many other priorities trump worrying about the need for long term care sometime in the future. And for those who would buy, the costs would be very high because of adverse selection. The most reasonable solution for this market failure is a system of social insurance like that provided by Medicare.

How could a program work through Medicare? There are a number of intriguing options that may someday again be thinkable. Below I suggest a few of these.

If Medicare offered a fully comprehensive system of care, it could achieve the efficiencies that are currently touted for coordinated care in which the right level of services could be provided at the right time. This could lower the overall costs of care to society, although it would certainly increase the costs to the Medicare program. Folding home health and SNF care into a long term care benefit could yield both greater efficiencies and improved coordination, and a Medicare program could take substantial burdens off current Medicaid spending. Thus, substantial resources that are already committed at the federal level would become available to contribute to a comprehensive program. The challenge then would be to find resources sufficient to fund the benefit without placing the existing Medicare program at greater risk.

Because Medicare has already crossed into the realm of reducing the level of benefits available to persons with higher incomes (via the income-related premium), it could expand this concept for a long term care benefit. That is, both the premiums charged and any deductibles and copays could be assessed on the basis of income, reducing the costs of the program. This could be quite different than the much more punitive Medicaid program that treats the majority of a person's life savings as the deductible and most of a person's income as the copay. Middle income individuals—with resources above the normal Medicaid limits but too low to afford care on their own—are the most disadvantaged by our current system and the most likely to forego needed care. A more reasonable approach to asking individuals and families to contribute to the costs of their long term care on an ability to pay basis would go a long way toward reducing incentives to game the system while protecting those in the middle class. Medicaid could then concentrate on the role it is intended to play—as a safety net for the poor.

Although currently overblown, any concerns about hiding assets and understating income would be considerably less under such a system. Individuals would be paying taxes to cover a substantial portion of their care, and would not be asked later to totally spend down or substantially curtail their incomes in a manner that invites abuse from people who find the system unfair and punitive. Tax revenues to support the program could also be designed recognizing that higher income individuals would now benefit from this new program: estate taxes have sometimes been identified as a resource to support long term care benefits, for example. Similarly, increased taxes on capital gains, or lengthening the period before gains are termed "long term" could also serve as a source of revenues. Arguments against such changes are often linked to the importance of asset income to retirees, but if devoted to improving access to affordable long term care might well be justified.

Other countries have achieved success with approaches that allow people to take their benefits in the form of cash or services, and this is something that ought to be considered as well. A well-managed program that coordinates care but steers patients in the direction of the most efficient services could be offered to all beneficiaries. But those who wish to remain at home when institutional care is called for or who want to put together their own private supports, for example, could be allowed to do so by opting for a cash benefit. This would allow tighter controls on a system that is difficult to manage and for which individuals may have strong feelings.

Many issues would need to be addressed to establish a comprehensive program using Medicare, but this approach would be preferable to the muddling-through philosophy that is popular today. The awkward combination of payments from multiple programs conditioned upon arbitrary distinctions in the type of care received (from Medicare) and punitive eligibility requirements (in Medicaid) and an inadequate private insurance market can never be sufficiently jerry-rigged to achieve a reasonable system of long term care. Only a more radical restructuring of the system can avoid the pain and suffering that we now continue to inflict upon our citizens. Wishing that this awkward system would somehow become adequate will not take the place of a willingness to collectively support these most vulnerable members of our community.

Improving the Current Benefits Under Medicare

If, as seems likely for some time to come, we decide to muddle along with the current Medicare coverage of some of the needs of beneficiaries through SNF and home health, a number of changes will be needed. It is crucial to ensure that changes are not just ways of artificially holding down the costs of care, but, instead, target treatment where it is most needed. The more arbitrary the restrictions are, the stronger the incentives for both beneficiaries and providers of services to game the system.

The lack of strong information and consensus on what care is necessary in the arena that is usually referred to as "post-acute" care has led over time to vast swings in the amount of care available and to substantial variation in use of such care across the United States. For example, the recently released IOM report on geographic variation in Medicare spending finds that much of the variation is attributable to differences in use of post-acute care.[7] On the acute care side, we are moving slowly toward studying what treatments work and are most effective; but there has been little definitive work in this realm for long term supportive services. And undertaking such studies is difficult since such services are often tied closely to other factors that would be difficult to control for: the presence of others in the household and their willingness and ability to supplement care, for example. Nonetheless, work is needed in this area to improve the prospects of better targeting of care.

One example of a change that could improve care would be to replace the three day hospitalization requirement for eligibility for skilled nursing care with a more needs-based approach. In today's health care system, a three day stay is lengthy. Should a beneficiary or her physician push to stay longer to ensure that SNF care will be available afterwards? The answer is undoubtedly yes even if a longer stay is not needed. This raises acute care costs; but even more important, the appropriate question is whether the person with a two day stay has needs equivalent to that of the beneficiary who currently qualifies for SNF care. Specific criteria concerning the need for SNF care should be the determining factor, not an arbitrary three day rule. This will require additional study and to some extent will remain arbitrary in terms of what is skilled versus supportive, but at least shifting away from the three day requirement could deal with one major inequity in the system.

Home health is another area in which substantial reforms are needed, in this case around the reimbursement system currently in place. In an attempt to move away from the piece rate fee for service approach, an episode-based payment system was introduced for home health. That has shifted the problem from one of encouraging too many visits for individuals to one in which providers benefit from limiting visits; but, these limits have made the system lucrative for providers who skimp on care while receiving full episode-based payments. They now benefit from signing up customers, particularly those who are less in need on average. This payment system does not serve either patients or the federal government well and needs to be reformed. But the home health benefit as currently designed will always face the difficult challenge that when people need skilled home health care, they likely need more basic services that we attribute to traditional support services. How to separate the two and when to stop skilled treatment when supportive services are still needed will always create difficult choices and be subject to gaming of the system by providers and patients.

Finally, one approach now under consideration is to bundle SNF, home health and other post-acute care services with other acute care to encourage a more coordinated approach to care when, for example, a hospitalization needs to be followed by specific care.[8] For treatments that are relatively straightforward and clear, this can be a good approach because it will cause the

responsible care coordinator to use the less expensive and intensive services when appropriate. Safeguards would need to be established to protect against under-use of care and many details need to be studied further. But bundling is essentially aimed at coordinating acute care services with needed follow-on care. It is certainly not an approach to strengthening long term supportive services for the population.

In short, incremental changes in Medicare's post-acute care services will not do much to address challenges of long term care needs. At best, these reforms will better coordinate acute and post-acute services. The bigger challenge is to better coordinate post-acute and long term supportive services. And short of more sweeping changes, this will remain a major disjuncture in our health care system.

Conclusion

I have only touched on a number of issues that this Commission ought to grapple with to improve the lives of all Americans, since we all face at least the risk of needing long term care services and are largely unprepared. But no real improvements are possible without a decision to commit serious resources to the effort and to a recognition that the risks we face are ones best handled with a social insurance approach.

Endnotes

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[2] The Lewin Group, *Individuals Living in the Community with Chronic Conditions and Functional Limitations: A Closer Look*, Office of the Assistant Secretary for Planning and Evaluation, DHHS, January 2010. Randall Brown, *The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illness*, National Coalition on Care Coordination, March 2009; Harriet Komisar and Judy Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*, Center for American Progress, October 2011..

[3] Congressional Budget Office, May 2013 Medicare Baseline.

[4] Henry Aaron and Austin Frakt, "Why Now is Not the Time for Premium Support," *The New England Journal of Medicine*, March 8, 2012.

[5] Medicare Payment Advisory Commission, *Report to the Congress*, March 2012; Brian Biles, Grace Arnold, and Stuart Guterman, "Medicare Advantage in the Era of Health Reform: Progress in Leveling the Playing Field," The Commonwealth Fund Issue Brief, March 2011; Government Accountability Office, *Medicare Advantage: Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk Score Adjustments*, January 2013.

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[8] Gage, B., L. Smith, M. Morley, et al. 2011. *Post-Acute Care Payment Reform Demonstration: Report to Congress Supplement—Interim report*, prepared under contract to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, Baltimore, MD: CMS; Medicare Payment Advisory Commission, *Report to the Congress*, June 2013.