

# The Long-Term Care Elephant In The Room – Risks and Rewards For Payers, Providers, Plans and Consumers

By: Kevin D. Harris, M.B.A., C.M.A. and Norbert I. Goldfield, M.D.

The Affordable Care Act (ACA) has advanced the ability of states' Medicaid and health and human service agencies to rebalance and encourage better coordination of long-term care programs and supports. Care coordination initiatives, dual eligible demonstrations, managed long-term care expansion, and an increasing focus on potentially preventable hospital admissions/readmissions have encouraged states, plans, providers and consumers to rethink integration of long-term care services across the entire long-term care continuum for relevant populations. These initiatives, however, have raised new challenges for stakeholders.

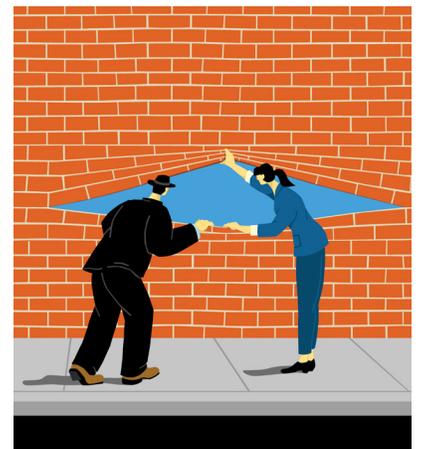
- » How do payers, plans and providers appropriately assess individual's long-term care needs, including clinical, functional, psycho-social, environmental and other behavioral requirements?
- » How will consumers with varying and complex long-term care needs receive quality coordinated care in an increasingly risk-based payment environment?
- » How can currently fragmented networks of institutional and home and community-based providers be aligned to address the requirements of the entire long-term care continuum, across so many different subpopulations? (Medicare/Medicaid dual eligibles, Medicaid expansion populations, state-funded and commercial populations)
- » How will payers and plans properly incent aligned networks through payment mechanisms that move from fee-for-service payment to partial risk to full risk mechanisms?
- » What types of data will be required to properly assess needs, access to care, quality of care and outcomes? What data will be needed to appropriately adjust payment for risk, considering the migration to eventual full risk payment?
- » How will state agencies and the federal government implement program oversight to ensure that quality of care and access to services are incented and provided, while hoping that greater coordination and streamlining of services will contain costs? How will consumers and advocates be best represented in this process?

## AUTHORS »

Kevin D. Harris, M.B.A., C.M.A.  
206.292.2387  
kharris@navigant.com

Norbert I. Goldfield, M.D.  
203.314.5621  
nigoldfield@mmm.com

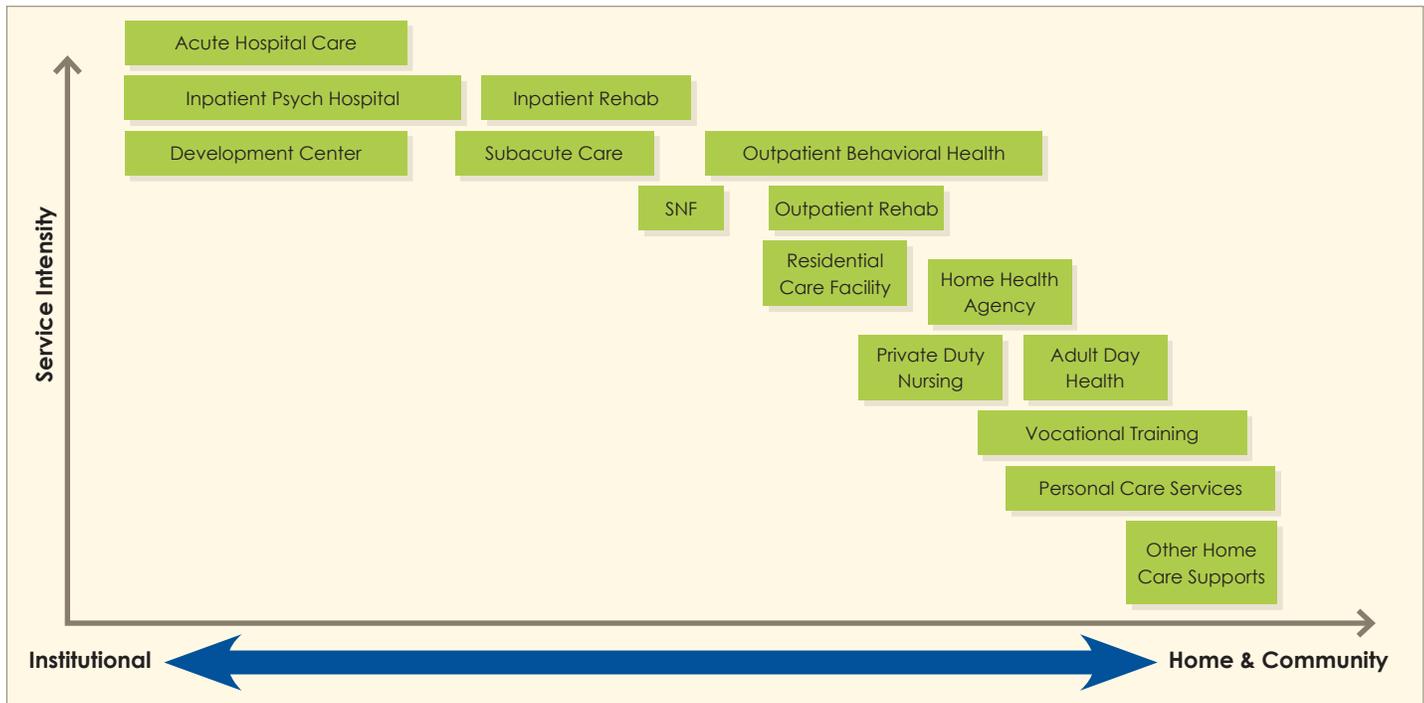
[navigant.com/healthcare](http://navigant.com/healthcare)  
[3Mhis.com](http://3Mhis.com)



The logo for 3M, consisting of the letters '3' and 'M' in a bold, red, sans-serif font.

NAVIGANT  
HEALTHCARE

## LONG-TERM CARE CONTINUUM »



Valuable care coordination lessons have been learned from the Program for All-Inclusive Care for the Elderly (PACE), Medicare Special Needs Plans (SNPs) and Social Health Maintenance Organizations (SHMOs). These programs have all been limited in scope, but have served to create important momentum for the change and integration of care delivery with the goal of improving outcomes.

States are swiftly shifting populations into coordinated care models, including health or medical home models and ACO financing mechanisms, which include at-risk managed care and managed fee-for-service options. Members of Congress are questioning the speed and scope of state initiatives and pilots, specifically regarding inclusion of certain subpopulations, such as developmental disabilities.<sup>1</sup> It may be time to take a thoughtful pause, and consider "next steps" to help assess network gaps and data holes that will need to be addressed to effectively serve these diverse long-term care populations in an effectively coordinated manner.

**Vignette #1:** Jane Smith is 48-years old and has multiple sclerosis and paraplegia. She is dually eligible for Medicare and Medicaid. Medicare pays for her hospitalizations, outpatient care and some of her medications. Medicaid pays for her Medicare co-pays and deductibles. In Jane's state, Medicaid would only pay for her nursing home long-term care – Jane would be on a waiting list to receive waived home and community-based services. Jane doesn't have many friends, doesn't leave her house often because of her depression, and misses many of her physician appointments. The depression and multiple sclerosis have interacted and led to multiple avoidable ED visits and hospital admissions/readmissions. What could coordinated long-term care offer Jane and how would those providers who deliver her services be paid?



1. Senator John D. Rockefeller IV letter of July 10, 2012 to Secretary Kathleen Sebelius.

Long-term care HCBS providers are typically fragmented in most states. Personal care aides and attendants; private duty nursing; adult day health centers; residential care/small group home options; mental health and substance abuse agencies, and a variety of many disjointed private and not-for-profit providers are funded through varying revenue streams and grants.

Compared to institutional and other acute care providers, many HCBS providers are typically not required to comply with cost and utilization reporting, assessments, claims or encounter data collection, or other data standards that provide the basis for traditional performance, cost or outcomes measurement. Although HCBS providers care for substantial and growing populations, few "best practices" have been developed for contracting between HCBS providers, traditional "clinical" and institutional long-term care providers, and "at-risk" entities. These data gaps create challenges for any public or private payer hoping to eventually set or negotiate risk-adjusted payments, based on bundles, capitation, or any type of budgeted payment mechanism. Although fee-for-service payments may remain in place for HCBS providers in the short-term, eventual transition to risk-based reimbursement will require more progress to standardize data reporting and collection efforts across the long-term care spectrum. In the absence of federal guidance, states might take the initiative to standardize these efforts, in conjunction with Electronic Health Record development, legacy cost reporting standards, universal assessment tool development and other related efforts. Transitional and coordinated care between clinical, functional and psycho-social needs will require standardized data that profiles the holistic status and needs of each individual consumer. In addition, improved data collection should reflect the fields necessary to implement long-term care risk-adjustment. Without appropriate risk-adjustment, a stable and relatively predictable integrated delivery system including chronic long-term care services is unsustainable.



Universal Assessment Tools are one mechanism that states are implementing to standardize holistic and detailed consumer profile data, establish long-term care levels of care and determination of need, and provide the basis for care plans. Design challenges include weighing the balance between including too much information versus payer and consumer burden, as well as too limited information versus value. In addition, existing state plan and waiver long-term care programs are typically delivered by multiple agencies, with limited data collection and assessment protocols. Private payers, plans and traditional providers typically have better coordination of data within integrated systems, although they are often do not coordinate beyond post-acute/rehab, nursing facility and home health agency models. Successful implementation of Universal Assessment Tools may provide a much needed piece of the HCBS coordination puzzle. Minnesota and Washington State are two states that have made considerable progress with the Universal Assessment Tool concept.

Further complicating matters, most of the long-term care populations served are heterogeneous, making data collection based on varying domains even more challenging. For example, dual eligible long-term care populations can be stratified into a variety of sub-populations, including those with lower acuity functioning and habilitation requirements, compared to consumers with extensive co-morbidities and significant chronic functional and psycho-social needs. The latter frequently require extensive behavioral services, which are often available in short supply.

**Vignette #2:** James Sanchez is 53 years old, and suffers from many co-morbidities, including diabetes and hypertension. In addition, James has Asperger's Syndrome and is high functioning, but needs guidance and counseling, as well as daily structure and vocational rehabilitation. James is Medicaid eligible, and participates in his state's developmental disabilities program. Pricing James' at-risk acute and long-term coordinated care service reimbursement between a "patchwork" of providers will require a systematic approach to data collection and risk-adjustment.

Placing plans and providers at significant financial risk needs to be exercised in a methodical manner that doesn't impede access to care or misutilization of services. Movement from long-term care fee-for-service to risk-based reimbursement should be done in a manner that encourages both an understanding of financial risk, as well as emphasizing payment for better outcomes. Furthermore, until there is a financial imperative to collect data validly, all information — claims, costs and assessments — will have low reliability.

Payers can achieve better outcomes via payment incentives that move away from fee-for service and towards case rates, bundled payment, episode of illness payment and eventual global payment or capitation. The risk adjustment, clinical classification system needs to be clinically meaningful, outcomes focused, and useful for management. A number of risk adjustment systems are available, including Chronic Disability Payment System (CDPS), Hierarchical Cost Conditions (HCCs) and Clinical Risk Groups (CRGs), but will need to be modified to address the full long-term care continuum, including behavioral needs.

It is important to encourage the use of risk-adjustment that is clinically meaningful. Traditional DRGs used to risk-adjust hospital prices have saved tens of billions of dollars and improve quality outcomes<sup>2</sup>. DRGs were successful, not only because they "set a reasonable price for a known product"<sup>3</sup> but also created a language that links the clinical and financial aspects of care for hospitalized populations, improving communication between administrators and clinicians. Similarly, assigning each consumer to a clinical group or "product" that includes long-term care, and setting the price for that product will help define a necessarily holistic structure that will allow for sustainable reimbursement for coordinated care.

With many of the complex individuals consuming the majority of health care dollars, claims data is necessary but often insufficient. Reliable claims data will help

accommodate payment and tracking of outcomes for many clinical conditions, such as diabetes and heart failure. However, additional data is needed to evaluate consumers with complex co-morbidities, particularly those requiring behavioral health and other long-term care services to help their functioning and well-being, and keep them out of the hospital.

The following types of data are increasingly available:

- » Pharmaceutical — The name and dosage of the medication can be quite useful for many chronic conditions, particularly behavioral health services. Risk adjustment classification systems should utilize this type of information in a categorical, rules-based and clinically meaningful manner. A categorical approach as opposed to a regression analysis avoids the possibility of multicollinearity which can be described as double counting. Pharmaceutical information is also useful to validate the presence of diagnoses that may not have been coded (such as insulin for diabetics, or clozapine for schizophrenics).
- » Functional Health Status — Functional Health Status is already collected in the post-acute care setting for Medicare prospective payment for home health (OASIS), rehabilitation (IRF-PAI) and nursing homes (MDS). Risk adjustment classification systems that use CRGs build health status measures into the classification system. For example, a consumer who suffered from a stroke and cannot feed or dress himself may be mapped to a higher severity of illness for a stroke CRG. Similar to any categorical model, one can track this consumer's severity of illness over time; different provider characteristics can then be correlated to changes in health status.

Such standardized datasets are an important beginning to the development of stable risk-based payment methodologies that include post-acute and chronic long-term care. Once the gaps in long-term care services are addressed, other functional, psycho-social and socio-demographic variables can be similarly incorporated.



2. Goldfield, N: The Evolution of Diagnosis-Related Groups (DRGs): From its beginnings in case-mix and resource use theory, to its implementation for payment and now for its current utilization for quality within and outside the hospital. *Qual Manag Health Care*. 2010 Jan-Mar;19(1):3-16.

3. Mayes, R and Berensen, R: Medicare Prospective Payment and the Shaping of U.S. Health Care. Johns Hopkins University Press. 2006.

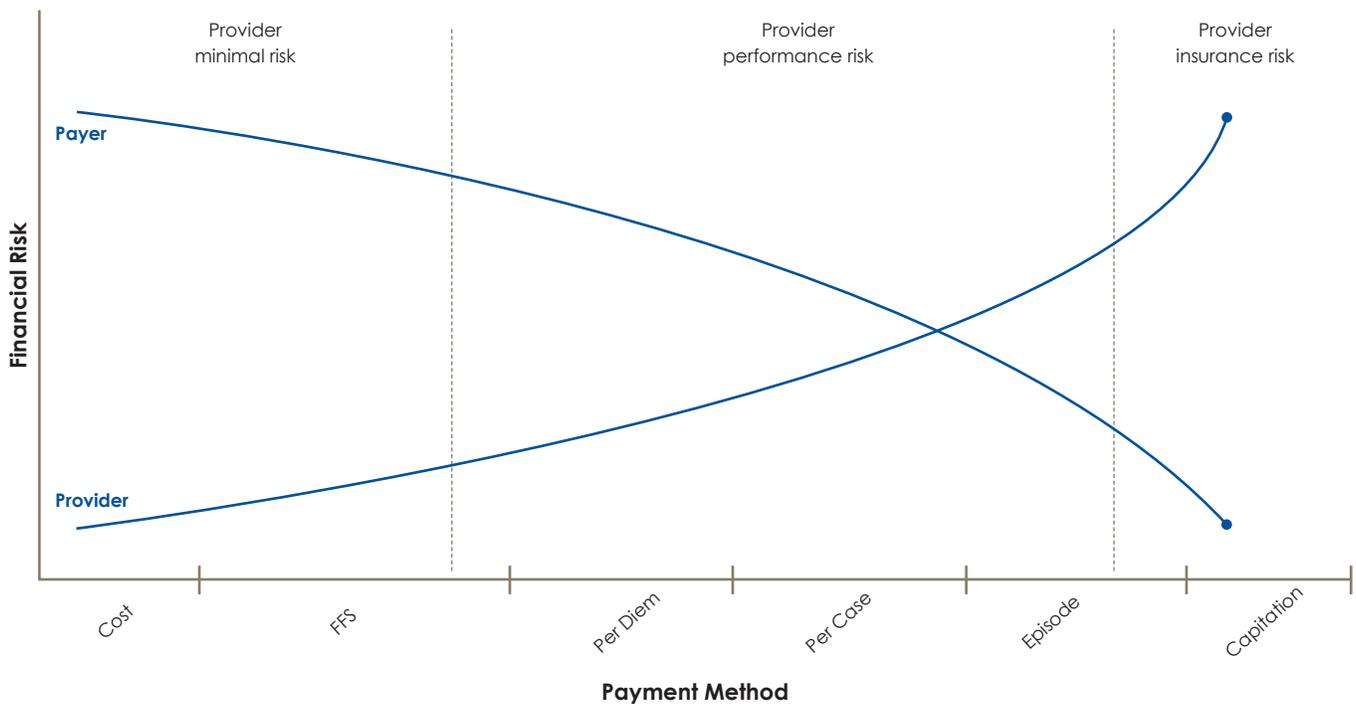
It is important to restrict the initial development of the risk adjustment methodology to those variables that **systematically** describe different demographic characteristics and data representing severity of illness of consumers, such as age, sex and health status. It is similarly important to **exclude** controversial policy issues that could initially skew development of the classification system. For example, foster care is a category that should be included, as it describes children who consume significantly greater resources and whose outcomes need to be distinguished from those who are not in foster care. In contrast, the number of times that a consumer moves may be very predictive of resource consumption, but becomes controversial when included in policy discussions related to homelessness. "Number of times moved" should be excluded from the methodology, as most of the explanatory power for this variable is likely already included when identifying individuals with behavioral health conditions.

Any other instrument can be mapped in this manner as payers and providers move deeper into long-term care risk-based payments. While clinically meaningful risk adjustment is key to the overall success of any coordinated care payment initiatives for these complex chronically ill populations, the analytics and collaborative learning required for providers, payers and consumers to understand the reimbursement and the outcomes achieved for these services is similarly critical to ensure program success.

#### Steps to take:

- » All stakeholders should evaluate the efficacy of their datasets, to assess to what degree they meet a "standard" for integrating care, developing coordinated care plans, allowing for meaningful development of risk adjustment techniques, and whether they will provide value for outcomes, performance and quality measurement and cost containment.
- › If such standards are not in place, where are the gaps, and how can they begin to be filled? A professional inventory may be one approach, to help define current practices, as well as gaps. Continuing to pay fee-for-service rates for some interim period, before long-term supports migrates into at-risk payment methods will not absolve payers and providers from collecting necessary data, if coordination efforts are to be successful and sustainable.
- › What types of long-term care coordinated efforts to collect appropriate data will be required from payers, plans, providers and consumers? A teamed approach between payers and providers to develop and implement training efforts may be worth pursuing, in the interest of furthering person-centered and HCBS program expansion goals.
- › Data should be validated and statistically tested for accuracy, as well as inter-rater reliability (in the case of assessments).
- › Consider categorical or rules-based risk adjustment models with or without the pharmacy module that can be used to identify gaps and opportunities for improvement in the data collection (for example, identifying quadriplegics who have normal functional status; or non-diabetic consumers who are on insulin).
- » From a payment perspective, Figure 2 outlines the trade-off between payer and provider risk, as payment methods migrate from cost-based to capitation models.





As a practical measure, we recommend a methodical approach that combines increased reliability of data collection through a phased timeline, in advance of the anticipated transitions between payment methodologies. Ideally, this would combine with an improved understanding of the types of services provided in a cost-effective manner for the populations served, with a solid relationship built between the contracting entities. For example, financial, market, administrative, or staffing circumstances might suggest capitation for some services (such as home health) and fee-for-service for others (hospitalizations).

- » We recommend becoming familiar with available risk adjustment tools. The classification system should meet all the criteria noted with the ability to track outcomes

and serve as a monitoring tool that identifies consumers who are over and underutilizing services. Again, the ability of the risk adjustment tool to perform these functions is dependent on the quality of the data collected.

- » Once standardized data is reliably collected and analyzed, a risk adjustment tool can be run to factor clinical, functional and psycho-social parameters, and create the mathematical functions that support risk adjustment.
- » Reliable risk-adjustment will support:
  - › The ability to move more rapidly towards long-term care risk-based reimbursement with confidence that payment is appropriate, and that outcomes metrics can be developed that include appropriate payment incentives.
  - › More robust payment methodologies that ensure appropriate provider payment and assumption of risk to care for both rehabilitation and chronic long-term care for the many varied consumer populations.



- › And encourage greater provider service longevity and access to care, improved apportionment of payments to the appropriate services, and resulting quality outcomes to consumers.
- › Building out HCBS networks, and connecting them to payers and traditional clinical and institutional LTC providers to provide greater care coordination and communication between stakeholders.

#### About the Authors

##### **Kevin D. Harris, M.B.A., C.M.A.**

Mr. Harris is a Managing Director with the Payer Strategy practice at Navigant Healthcare. Mr. Harris' national work includes twenty five years of experience assisting public payers with the design and implementation of long-term care service methodologies and rebalancing efforts. His work spans the long-term care continuum, including institutional and home and community-based services, serving Medicaid, dual-eligible and Medicare populations. He directs efforts to decrease long-term care network fragmentation, incent quality outcomes, and coordinate care delivery linking the long-term care continuum to more traditional acute, post-acute and chronic care delivery. Contact Kevin at [kharris@navigant.com](mailto:kharris@navigant.com) or 206.292.2387.

##### **Norbert I. Goldfield, M.D.**

Dr. Goldfield is a Medical Director with 3M Health Information Systems, an applied research group, and develops classification tools linking payment to quality. His work is used throughout the United States and overseas, by both public and private payers. Dr. Goldfield is a Board Certified Internist and practices at a community health center in Massachusetts. He edits the Journal of Ambulatory Care Management and has published more than 100 articles and books. Contact Norbert at [nigoldfield@mmm.com](mailto:nigoldfield@mmm.com) or 203.314.5621.

#### About Navigant Healthcare

Navigant Healthcare brings together more than 500 seasoned consulting professionals and industry thought leaders who assist payers, plans and providers with design, implementation and monitoring of programs that create high-performing and innovative healthcare organizations and delivery. Through a unique interdisciplinary approach leveraging the depth and breadth of our experience, Navigant Healthcare enables clients to build their capabilities and help transform the payment of publically funded healthcare services through varied and complex models of coordinated care and innovative reimbursement. More information about Navigant Healthcare can be found at [www.navigant.com/healthcare](http://www.navigant.com/healthcare).



#### About 3M Health Information Systems

Best known for its market-leading payment methodologies and ICD-10 expertise, 3M Health Information Systems delivers innovative payment, classification, and quality methodologies designed for federal, state and commercial payers as well as for leading providers, consultants, researchers and healthcare vendors. 3M's expertise in designing classification systems for inpatient, outpatient, episodic care, as well as its methodologies for understanding potentially preventable events are widely used for public reporting, pay for outcomes, quality improvement, accountable care, and efficiency improvement efforts. With nearly 30 years of healthcare industry experience and the know-how of more than 150 credentialed experts, 3M is the go-to choice for more than 5,000 health care organizations worldwide that want to improve quality and financial performance. More information about 3M Health Information System can be found at [www.3Mhis.com](http://www.3Mhis.com).

DISPUTES & INVESTIGATIONS • ECONOMICS • FINANCIAL ADVISORY • MANAGEMENT CONSULTING

© 2012 Navigant Consulting, Inc. All rights reserved. 00000781 Navigant Consulting is not a certified public accounting firm and does not provide audit, attest, or public accounting services.

See [www.navigant.com/licensing](http://www.navigant.com/licensing) for a complete listing of private investigator licenses. 3M is a trademark of 3M Company.