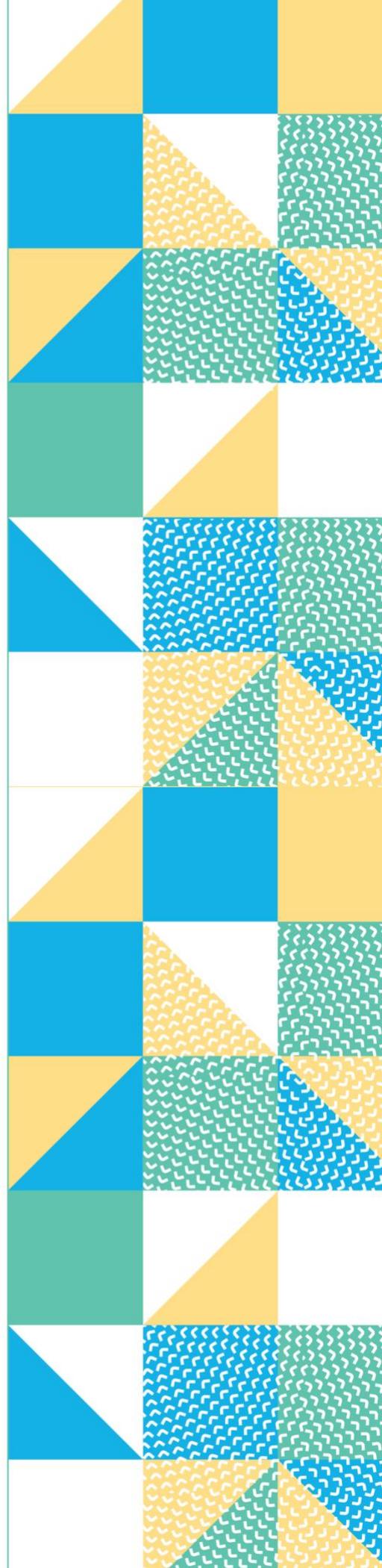


IMPROVING CARE FOR OLDER ADULTS

*Convergence Dialogue on
Reimagining Care for Older Adults*

Final Report

CONVERGENCE



About Convergence Center for Policy Resolution

Convergence is the leading national organization in the fields of problem-solving and bridge-building, distinguished by its collaborative dialogue process which brings people together from across the ideological spectrum to improve the lives of Americans. Reports and recommendations issued under our auspices reflect the views of the individuals and organizations who put the ideas forward. Convergence itself remains neutral and does not endorse or take positions on recommendations of its dialogue participants.

Learn more at: <https://convergencepolicy.org>

About this Report

During October 2020, Convergence assembled nearly 50 experts on long-term care to brainstorm in a series of three meetings on the topic of “[Rethinking Care for Older Adults](#).” These conversations helped to [frame the challenges and opportunities](#) to improve the care of older adults by creating a system of supports and services that would enable them, wherever they call home, to live with dignity, choice, and self-determination.

Building on this, Convergence launched a major project in the summer of 2021 to bring together over 30 stakeholders. In addition to policy experts, these stakeholders included individuals from organizations involved in the provision of care, the caregiving workforce, family caregivers, the financing and management of care, and other aspects of care. For the next year, the group met regularly to explore issues in caregiving and to identify concrete steps they could agree on. The focus was on policy and practice actions that would help trigger immediate change and reframe the public discussion of longer-term reform.

These meetings were made possible with the support from [The John A. Hartford Foundation](#) and [The SCAN Foundation](#).

The role of Convergence in the project was to facilitate meetings of the stakeholders and, using a professional facilitator and project team, to assist the group in developing a [vision for the future of care](#), finding areas of agreement, and formulating reform proposals. This Report sets out the vision and a set of recommendations to achieve that vision that were agreed to by the stakeholders. The participants who support these action steps are listed below.

Stuart M. Butler, PhD, Project Principal Investigator
Caryn Hederman, JD, Project Director

August 2022

Members of Convergence Dialogue on Reimagining Care for Older Adults

Gretchen Alkema
Independent Consultant *

William (Bill) Altman
Independent Consultant

Donna Benton, PhD
USC Leonard Davis School of
Gerontology +

Alice Bonner, PhD, RN
Senior Advisor for Aging, Institute
for Healthcare Improvement (IHI) + *

James Carlson
Retired, CEO & President,
Oregon Health Care Association

Marc Cohen
Co-Director, LeadingAge LTSS
Center @UMass Boston; Research
Director, Center for Consumer
Engagement in Health Innovation,
Community Catalyst *

Kris Engskov
Co-Founder and CEO, FHCC

Robert Espinoza
PHI +

Oleta Garrett Fitzgerald
Children's Defense Fund; Southern
Rural Black Women's Initiative for
Economic & Social Justice

Marc Freedman
Encore.org

**Arthur "Tim" Garson, Jr., MD, MPH,
MACC**
Clinical Professor, Health Systems
and Population Health Sciences,
College of Medicine, University of
Houston; Chairman, Grand-Aides
USA and International +

David Gifford
American Health Care Association
(AHCA) +

Howard Gleckman
Urban Institute + *

Bruce Greenstein
LHC Group

Ruth Katz
LeadingAge +

Gail Kohn
Age-Friendly DC +

Robert (Bob) Kramer
Founder,
Nexus Insights; Co-founder, NIC
(National Investment Center for
Seniors Housing & Care) +

David Lindeman
UC Berkeley, Center for
Information Technology Research
in the Interest of Society

Naomi Lopez
Goldwater Institute +

Marcella Maguire
Corporation for Supportive
Housing

Kate McEvoy
Milbank Memorial Fund

Toni Miles
Pope Eminent Scholar, Rosalynn
Carter Institute, and
Morehouse School of Medicine +

Anne Montgomery
Independent Consultant

Dana Ritchie
American Health Care
Association/National Center for
Assisted Living (AHCA/NCAL) +

Susan Ryan
The Green House Project

Rani Snyder
The John A. Hartford Foundation *

Robyn Stone
LeadingAge +

Jill Sumner
American Health Care Association
(AHCA) +

Nora Super
Milken Institute +

Rodney Whitlock
McDermott Consulting +

Michael Wittke
National Alliance for Caregiving

+ Dialogue members have joined in their individual capacities, and institutional affiliations are provided for identification purposes only.

* Dialogue Steering Committee Members



Convergence Dialogue on Reimagining Care for Older Adults Project Staff and Consultants

Stuart Butler, Principal Investigator

Caryn Hederman, Director

Isabel Hinstrosa, Program Manager

Pat Field, Facilitator (Consensus Building Institute)

Breelyn Stelle, Intern

Samaya Patel, Intern

Improving Care for Older Adults

The *Convergence Dialogue on Reimagining Care for Older Adults* works to build and share consensus-based recommendations to reimagine the care of older adults in nursing homes and the range of settings they call home. The lives lost and sacrifices endured during the COVID-19 pandemic demonstrated profoundly that status quo would continue tragedy and gave urgency to changes to ensure a future of better care.

Our Vision

Convergence Dialogue members came together to improve supports and services for older adults so that, wherever older adults call home, they may live with dignity, choice, and self-determination.

The needs, lived experiences, goals, and preferences of older adults must shape the resources needed to achieve this vision. We envision a more inclusive system where older adults can, as much as possible, control their own destinies.

Achieving this goal requires coordination by all partners in care. Families and friends, paid caregivers, providers, community-based organizations, government, and private payers support older adults with care needs. As much as possible, social supports must be available, well-coordinated, affordable, and supportive of family and friends and other caregivers.

Our shared vision acknowledges and supports certain important shared understandings:

- Older people live well and thrive in settings best suited to their individual needs.
- Policies, practices, programs, and services must not perpetuate inequities or limit people's potential to age with dignity.
- When possible, family members should be part of care delivery teams and receive meaningful support and assistance as they serve in that role.
- Housing should support the physical and cognitive limitations of aging as well as residents' integration and engagement within their communities.
- Robust choices of housing arrangements are needed including private homes, nursing homes, residential care residences, and other supportive housing models. In all settings, residents with needs should have access to necessary care and services to maintain their best physical, mental, and psychosocial well-being in accordance with comprehensive assessment and care plans.
- Congregate care settings are vital to the vision of older adults' dignity, choice, and self-determination. Policy makers should support financially viable business models that respond to residents' needs and preferences.
- Government and private payers should encourage and adequately fund innovation, safety, and quality in residential care environments and a robust continuum of care.
- Technologies are integral to emerging care delivery. They should be designed with older adults to enhance health, autonomy, safety, affordability, and personal connections.
- Older adults who can afford it should share the cost of their care. All levels of government have roles to play to ensure older people receive the care they need in their communities.
- Caregivers need to be appropriately trained and paid. Opportunities for increasing the supply of all staff, in particular direct care workers, and advancement within paid care work should be encouraged and expanded. Government programs should provide necessary and consistent financial support for such supports and services.

Achieving the Vision

Advances in medical care and public health, with increased life expectancy and economic improvement, has changed what it means to age in America. For most older adults there are opportunities for self-fulfillment today that could barely be imagined a generation ago. But there are also often barriers and limitations to that self-fulfillment. Opportunities are influenced by a person's economic and social background. Health is also often a significant factor in successful aging; most older adults will need care and supportive services at some point – some for a brief period and some for many years.

For those who do need care and supports, our system does not fit well with the reality of aging today and the corresponding themes we have laid out in our vision. It is a patchwork influenced by financing streams, programs and regulations that reflect earlier visions of aging and has not adequately kept up with the preferences and life goals of older adults.

It is time to take steps towards a system of care and supports for those who need these services that reflects their preferences and the realities of aging today and in the future. That system should retain and expand what is working while fostering the adaption of services, settings, and programs to better fit these preferences and realities. In our view that requires a focus on three broad areas:

- **Creating a constellation of care settings** with viable business models, so that preferred options are available as a person ages.
- **Ensuring that there are enough caregivers** qualified to provide needed care and to support family caregivers.
- **Adequately funding the system of care**, with payment systems and other features that are aligned with the reality of aging.

1. Establish a broad constellation of financially sound and adaptable care settings that reflect the desires and needs of older adults.

Most people in America wish to age in their own communities and in their preferred home setting to the extent that is feasible. For that to be possible, there needs to be a wider array of financially viable housing and living arrangements in which care services can be delivered, from home-based care to nursing homes.

Establishing such a constellation of arrangements requires us to consider some realities and opportunities. Living at home may be the ideal for most older adults. But for many frail people, living at home and being cared for by family members is a challenging reality due to the availability (or unavailability) of family members, the aging demographics of family caregivers and the cost of supplementary care. On the other hand, there is growing interest in how the community or neighborhood can be the locus of care, with new models of housing arrangements and supports, as well as residential institutions that are more integrated into the community and that can offer better ways to support and supplement family caregivers.



AGING AT HOME

Making home-based help as feasible and safe as possible is an essential element of our vision of enabling older adults to live well and thrive in the setting that is best suited to their individual needs and preferences. Addressing the challenges of overstretched family caregivers and achieving affordable professional care will be essential to reaching that goal. Despite severe staffing shortages, home-based care is in several ways becoming more practical for more people, thanks to advances in home-based medical care, improved monitoring and communication technology, and quality-improving interventions. Several steps by government would help expand these developments in the availability and quality of home-based care. Therefore:

- Centers for Medicare & Medicaid Services (CMS) has supported experiments in enhancing wellness and quality of life in the home. It should add evidence-based interventions and supports shown to positively affect wellness and quality of life for people aging at home, such as the Community Aging in Place–Advancing Better Living for Elders (CAPABLE) program, to the covered benefits in traditional Medicare and encourage Medicare Advantage (MA) plans to include those interventions. States should also seek to add such interventions and supports to their Money Follows the Person programs. CMS should evaluate the potential of other initiatives to improve the safety and wellbeing of people aging at home that might be added to Medicare and Medicaid.
- The federal government and the states should continue to prioritize improved broadband and encourage innovative telehealth solutions to care needs, coupled with digital literacy training for professional and family caregivers. The federal government and states should make permanent those Section 1135 emergency public health regulations that assist home-based care and continue to expand reimbursement for different types of services and technologies – including for older adults living with dementia and their caregivers. More effort should be made to leverage available technology to help integrate care teams, support paid and family caregivers, and expand access to care.
- The federal government should make permanent other COVID-19-related temporary regulatory flexibilities that enhance person-centered care in Medicare and Medicaid. Examples include modifications to MA requirements related to telehealth, risk adjustment and midyear benefit enhancements to support person-centered care, modifications to provider licensure, and scope of practice. Other examples include temporary qualifications and payment rates to expand the workforce (affecting direct care workers and paying family caregivers) and widening the availability of self-directed home and community-based services (HCBS) as well as long term services and supports (LTSS or long-term care) through modifications of financial eligibility rules.



NEW CARE SETTINGS

Expanding the range of innovative care settings would broaden the opportunities for older adults to live in their community in the way they prefer and with services and supports that meet their needs. Many organizations and facility owners, together with architects and local officials, are exploring new models of care. Government programs and regulations need to align with and thus support a wider range of living and care arrangements. Therefore:

- The U.S. Department of Health and Human Services (HHS) and the U.S. Department of Housing and Urban Development (HUD), with advice from the U.S. Department of Veterans Affairs (VA), should review regulations and grants affecting health-housing partnerships to encourage more forms of living arrangements with services for people needing care, and take steps to make it easier to braid housing and health funding. This review should include the HCBS Settings Rule; while it is a key to fostering home and community care it can also be an obstacle to expanding the range of community services that can be provided by residential institutions. In addition, HUD should revise those Fair Housing Act policies that create impediments to new forms of housing-care partnerships for older and disabled people, including mortgage insurance rules that can inhibit nursing homes from diversifying and expanding services. HUD should also encourage the use of project-based vouchers to support partnerships with long-term care providers to enable more efficient use of Medicaid assisted living waiver funds. Further, the IRS should amend its Community Benefit regulations for nonprofit hospitals to expressly classify supportive housing as a community benefit.
- HHS should expand demonstrations and support for capitated and value-based payment programs, such as the Program for All Inclusive Care for the Elderly (PACE) and Dual Eligible Special Needs Plans (D-SNPs), to encourage a greater range of housing-based service settings that include paying for housing.
- Pathways should be created for broader interdisciplinary/interagency waivers. For example, state Medicaid and Housing agencies should be encouraged to apply to CMS and HUD for a joint waiver to pair comprehensive medical with supportive housing.
- The federal government should remove barriers to the growth of innovative small-scale residential care settings, such as Small Houses and ways to create smaller communities with supports within larger buildings and residential settings; small-scale care settings are often held back by regulations emanating from the Hill-Burton era, which fostered large-scale settings. States should also reconsider certificate of need (CON) requirements and local governments should review building codes that inhibit the creation of smaller settings. The federal government should provide grants and technical assistance, as well as re-assess cost-reporting, to foster small-scale residential settings.



INSTITUTIONS AS PART OF THE COMMUNITY

Integrating nursing homes and other facilities more effectively into the local community would have many benefits for older adults needing care. It would reduce the isolation felt by many residents, for instance. It could also encourage partnerships to make nursing homes members of networks of institutions, including health clinics and community-based organizations, that provide services to people in their homes. In addition, older people in the community could have greater access to resident services in these buildings. Today, some nursing homes and assisted living facilities are only minimally integrated into their surrounding communities. However, other nursing homes and assisted living facilities are integrating into the community, and many are exploring other aging service lines. Some are opening their gyms and certain health services to their local community. Some are exploring how they can become PACE providers. Some offer temporary respite services that help family caregivers. Some even offer housing to students in exchange for hours worked. But payment systems and regulations can impede these efforts. Steps can be taken to encourage maximal community integration. Therefore:

- To help assess the potential for integrated services, HHS should survey existing examples and the potential for services that nursing homes and assisted living facilities could provide to their local communities, either directly or in partnership with community institutions such as Federally Qualified Health Centers (FQHCs) and volunteer Villages, including how PACE could be integrated. The surveys should include such services as short-term respite care and adult daycare, training for family caregivers, mental health and cognitive care resources and support from diagnosis onward, bereavement assistance, and emergency response and monitoring services.
- Based on the results of the survey, CMS should develop pilots with groups of nursing homes to test ways to facilitate and finance integration; the federal government, states and local jurisdictions would simplify or waive certain regulations and CON requirements for residential settings and CMS would permit payment flexibility to allow for testing and evaluating new community integration models.
- Licensing and federal and state requirements for training care workers should be designed to produce more workers with “location-agnostic” qualifications, so that care workers will have more flexibility to work in institutions, home-based care, and other care settings. A more flexible workforce would permit more integrated services. Such workers might have special training in some services but would be trained and licensed to provide a range of services in different settings.
- The HCBS Settings Rule should be reviewed in the context of integrating community and institutional services to determine if barriers still exist for nursing homes and assisted living facilities seeking to provide co-located HCBS in their community. The aim should be to make it easier to link HCBS, adult day programs, and nursing home services using shared staff and resources.



QUALITY AND CHOICE

The experience of COVID-19 brought increased national attention to concerns about quality in nursing homes and more broadly about the entire care system. That scrutiny in turn raised questions about the very meaning and components of “quality,” and how quality should be measured and rewarded in a payment system. Moreover, progress in creating a broad constellation of settings makes it very important that older people and their families have better information, with meaningful quality measures to guide their choices. In the case of nursing homes, for instance, today’s five-star system does not provide information on lived experience. Therefore:

- CMS should redesign its five-star rating system for nursing homes to capture and reflect the quality of life and lived experience of residents, with ratings that include input from diverse residents and family members and demographics. To be most usable, the rating system must include this information as well as staffing and safety metrics, and permit comparisons both within and across states.
- In conjunction with other relevant agencies, CMS should further explore the relationship between a more comprehensive view of quality throughout the care system and patterns of ownership change, forms of ownership, staffing, the types of capital investment, and other possible factors affecting quality.
- As quality measures are improved, the payment system for care should increasingly incorporate value-based models. (See Finance section)

2. Ensure There Are Enough Caregivers

The system of caregiving begins with family caregivers. The great majority of older adults needing care receive it at home from unpaid family and friends, often supplemented by services supplied by paid caregivers. However, family caregivers are often overstretched, under-supported, and ill-equipped for the tasks they undertake; the system of the future must provide better support for these caregivers.

Quality, person-centered care depends on a sufficient supply of knowledgeable, well-trained, and well-managed paid staff providing direct services and supporting family caregivers. But we are far short of achieving that requirement, and we are faced with a chronic shortage of paid caregivers. Near-term, high-priority actions are needed to address economic insecurity among paid caregivers, workforce shortages, burnout and exhaustion, and turnover. In parallel, longer-term actions are needed to broaden the “pipeline” of caregivers and create a true caregiving profession with ladders of advancement.



SUPPORTING FAMILY CAREGIVERS

Unpaid family and friends are the backbone of the caregiving system and need to be seen as essential partners in the care of older adults. But they are usually ill-prepared for the challenges involved. The future care system must provide these caregivers with the support they need as the cornerstone of an integrated system. Therefore:

- The philanthropic community and the federal government should fund research and demonstrations on how best to strengthen the partnership between family caregivers and direct care workers in home care delivery and other long-term care settings. CMS should develop and introduce culturally sensitive procedures to help assess the training and support needs of family caregivers and provide ongoing support. HHS should also expand the National Family Caregiver Support Program.
- Family caregivers need continued access to coaching and training and counseling if they desire it for the often-complex tasks they have to undertake. These tasks in practice often include administrative oversight and care coordination. While these caregivers cannot replace trained healthcare professionals, federal and state organizations should include techniques to train family caregivers and payment systems to cover the cost of such training and related supports. Managed LTSS (MLTSS) programs can be a vehicle for such supports.
- The federal government, the states, and nongovernment organizations should improve and expand matching service registries to help older adults and their families, and direct care workers, to help them to easily find each other based on preferences, needs and availability.
- Full-time, unpaid family caregivers sacrifice current income, employer-sponsored insurance, and future Social Security Retirement benefits to provide these services. To support this component of the caregiving system, CMS should explore policies that would provide economic support for family caregivers experiencing the greatest hardship.



INCREASING THE SUPPLY OF DIRECT CARE WORKERS

Compensation for direct care workers is well below the level needed to assure quality and safety in virtually all care settings and needs to be adjusted to livable, competitive levels. Low compensation and impediments to the supply of workers makes recruiting staff difficult and leads to high turnover rates as trained care workers are enticed to leave for positions in other parts of the health system and other occupations. Therefore:

- While there is broad agreement that basic pay and benefits need to be increased, public support is undercut by perceptions of the workforce. Provider organization leaders, advocates for the workforce, and other interested parties should undertake a “recognition and awareness campaign” to educate the public about the functions and necessary skills of caregivers as essential frontline workers and members of the interdisciplinary team. The campaign should also stress the importance of establishing a caregiving profession, and the complex and demanding nature of caregiving.
- Basic pay and conditions should be increased to a level commensurate with goals for quality and competitive with similar workers in health systems. CMS, the Administration for

Community Living, the Health Resources and Services Administration, and the U.S. Department of Labor (DOL) should consult with interested parties to devise a national compensation strategy. The federal government and states should revise Medicaid payments accordingly. For workers paid through MLTSS programs, the federal government should encourage states to require, through the bidding and contracting process, that managed-care organizations serving the LTSS population contract only with providers paying at least a certain wage level.

- HHS and DOL should lead a taskforce of agencies and, in conjunction with the states and including state boards of nursing and other organizations, review recruitment procedures and develop strategies to increase the “pipeline” of caregivers. The task force should explore a range of approaches to expand the number of caregivers. These approaches might include making greater use of volunteers and workers over age 55 (including Grand-Aides and the National Senior Service Corps), expanding apprenticeship opportunities, revising credentialing requirements, restoring financing for the Health Professional Opportunity Grant Program, and removing administrative barriers to recruiting qualified individuals.



TRAINING AND PROFESSIONAL ADVANCEMENT

Federal and state training requirements are generally insufficient to prepare paid caregivers to provide quality care to older adults in most settings. Training and licensing are also generally ill-suited to creating a true profession with a career ladder, or for preparing workers to provide support and training to family caregivers. Therefore:

- As part of the task force referenced above, CMS and DOL should convene a working group to identify a national minimum set of core competency standards across settings.
- In tandem with establishing core competency standards in training, the federal government and states should devise standards that would enable care workers to be licensed to work across different care settings: such universal “location-agnostic” training would provide a base of knowledge for direct care workers to be able to deliver person-centered care in any LTSS setting. This would also help encourage greater integration of nursing homes and assisted living facilities into the community. Payment systems should ensure that facility-based workers can provide such services in the community.
- States and the federal governments should take several steps to help create a true profession of caregiving. One step would be to permit aides to operate at the top of their license to encourage a team approach to care. Another would be for the CMS Innovation Center to launch demonstration projects to explore expanding the roles of care workers, and for payments to be adjusted based on the results.
- Training procedures and standards need to be updated and strengthened, especially for personal care aides. Among other things, improved training will require more attention to enhancing skills, training for advanced roles, and specialty training (e.g., for conditions such as dementia and cardiovascular disease). To help create a better ladder for advancement as professionals, more training needs to be available for administrative and executive roles.
- Paid caregivers should be better trained to provide guidance and support to family members who have care responsibilities. Providing that assistance to family members should also be a feature of payment systems.

3. Finance the Future Care System

Over the coming decades the nation will need to commit significantly more resources, and use resources more efficiently and creatively, to pay for older adults' supports and services. Making our shared vision of making quality care available to those who need it a reality will require an intergenerational commitment of resources over a long period by federal and state governments, the private sector, and individuals. This financing challenge must be recognized, as must the need to take steps we have recommended above to encourage the development of options and innovations that can help reduce some costs over time while improving quality.

In addition to planning for sufficient resources, we also need to begin a more comprehensive discussion about the best way to integrate and deliver the public funds available for care. In the future that will require the nation to revisit the roles of Medicaid and Medicare, and to do so in the context of these programs' structural financing problems. That in turn will force a conversation about the appropriate balance of financial responsibilities among the federal government, the states, and families.



ADEQUATE PAYMENT FOR EACH FORM OF CARE

Financing should be adequate to provide care both for short-term post-acute and long-term care needs delivered through managed care or traditional fee-for-service. Currently it is not, especially in the case of state-administered Medicaid payments for people needing long-term care in nursing homes. Payments need to be set at a sufficient level to provide LTSS in the most appropriate and preferred setting, including home and community-based care residential care settings. In addition, payment levels to Medicaid-financed nursing homes need to be made sufficient to provide quality care and to eliminate the need for nursing homes to use Medicare payments designed for short-stay Medicare fee-for-service post-acute care patients to subsidize the costs of caring for long-stay residents. Therefore:

- CMS should explore and ultimately devise transparent payment systems to assure adequacy for post-acute care and for long-term care in all settings. This necessarily means that in each case payments must cover reasonable costs and assure measurable, accountable quality care. Specifically, CMS should explore value-based alternative payment models (APM) to deliver high-quality and efficient care for short-term post-acute patients. CMS should also continue to develop separate APMs to cover the full spectrum of costs for individuals requiring long-term care, including acute care episodes for long-stay nursing home residents. In addition, Medicaid payments – which currently are often inadequate – should be made sufficient to cover long-term care costs without cross-subsidies from Medicare and in all settings, including HCBS care. These payments should encourage fully integrated health care and long-term care models.



PUBLIC AND PRIVATE FUNDING

Improved quality measures, better oversight, greater innovation in care, and better use of available facilities and housing, are among the steps needed to ensure existing resources are used more efficiently. Even with these steps there will continue to be chronic underfunding. Additional resources will be needed to reach the goal of quality care in all settings, to deal with inadequate workforce compensation and other shortcomings, and to address a growing demand for care as the population ages. Committing new resources, particularly public funds, will be difficult in the near future—and new public funding could never be sufficient to meet future goals. Thus, there needs to be a long-term approach, with both public and private sector financing, to build the future system of care. Therefore:

- In addition to using existing resources more efficiently, the nation needs to commit to a substantial expansion in private and public financing to improve quality, pay and conditions for caregivers, to address current underfunding, and to anticipate the projected future need for care.
- Transparency and oversight is needed for both public and private financing. Private investment and ownership patterns need to be monitored and made more transparent to address concerns that the business goals and incentives of some investors are not always consistent with achieving quality care. On the other hand, many of the most innovative approaches to care and housing are being pioneered with private capital. Thus, regulation and oversight should not discourage private investment and nonprofit financing and it should encourage investors to explore new models of quality care across residential settings.



FINANCIAL PROTECTION FOR OLDER ADULTS

Many middle-class individuals hoped that their existing savings or insurance would be sufficient to cover possible long-term care needs, only to quickly exhaust their resources within a few years. Others mistakenly believe Medicare covers long-term care. Many will have to rely on Medicaid. Others will not be eligible for Medicaid but will have insufficient resources to pay for quality care on their own. Steps are needed to address this problem, to provide a degree of financial protection for middle-income individuals and to relieve future pressure on federal and state Medicaid budgets. Therefore:

- To provide middle-class families with better public and private insurance protection against catastrophic long-term care costs, Congress should enact an intergenerational self-funded catastrophic public insurance program (similar to the WISH bill, which would create such a program). This would limit the potential out-of-pocket cost of long-term care for an individual, reduce projected Medicaid long-term care costs, and may encourage more private long-term care insurers to enter the market by limiting their “tail end” insurance risk for true catastrophic costs.
- Policymakers should take steps to make private long-term care insurance more available as additions to life insurance and Medicare Supplemental (Medigap) Insurance coverage. They should also explore the pros and cons of allowing the use of 401(k)s and other retirement vehicles for purchases of long-term care insurance, bearing in mind concerns about the

inadequacy of most households' retirement savings and the need for transparency for consumers.

- As another potential strategy to help address the long-term care needs of individuals not eligible for Medicaid, and to help coordinate medical and long-term care services, CMS should explore the feasibility of creating a new part of Medicare with its own separate financing sources. Finance for a new Medicare LTC benefit should not include funds from other segments of the health system, such as Medicaid or other parts of Medicare. Such a new part of Medicare should, much like Part D, be available as a stand-alone benefit and included in the benchmark for Medicare Advantage plans.

Acknowledgments

We would like to thank Jean Accius and the AARP policy team, and the AHIP policy team, for providing thoughtful feedback throughout the Convergence Dialogue on Reimagining Care for Older Adults. Our work also benefitted from the expertise and advice of leaders from other ongoing national and state-level policy initiatives and efforts. We would like to thank in particular Anne Tumlinson, Moira O'Neil, Susan Reinhard, Wendy Fox-Grage, Jody Shue, Joanne Lynn, and Benjamin Veghte for sharing their expertise and insights.

Convergence Dialogue on Reimagining Care for Older Adults is proudly supported by The John A. Hartford Foundation and The SCAN Foundation.



About The John A. Hartford Foundation

The John A. Hartford Foundation, based in New York City, is a private, nonpartisan, national philanthropy dedicated to improving the care of older adults. The leader in the field of aging and health, the Foundation has three areas of emphasis: creating age-friendly health systems, supporting family caregivers, and improving serious illness and end-of-life care.

Learn more at: <https://www.johnahartford.org/>



About The SCAN Foundation

Supported by a grant from The SCAN Foundation - advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence.

For more information, visit www.TheSCANFoundation.org

Convergence Center for Policy Resolution

1133 19th Street NW, Suite 410
Washington, DC | 20036
(202) 830-2310

www.convergencepolicy.org

 <https://www.linkedin.com/company/convergence-center-for-policy-resolution>

 <https://www.facebook.com/ConvergenceCtr>

 <https://twitter.com/ConvergenceCtr/>

 https://www.instagram.com/convergence_ctr/

 <https://www.youtube.com/channel/UCRg673fG1XvUjEwM7hw4aqA>

Convergence is a national non-profit based in Washington, DC that convenes individuals and organizations with divergent views to build trust, identify solutions, and form alliances for action on issues of critical public concern. Reports and recommendations issued under our auspices reflect the views of the individuals and organizations who put the ideas forward. Convergence itself remains neutral and does not endorse or take positions on recommendations of its dialogue participants.

© 2022 Convergence Center for Policy Resolution

Reproduction of all or part of this publication may be authorized only with consent and acknowledgment of the source.