

# At Home

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*With Mass Home Care*

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Al Norman, Editor



## Obama: “We Can Live Within Our Means”

On September 19th, President **Barack Obama** presented a message to Congress entitled “Living Within Our Means and Investing in the Future, The President’s Plan for Economic Growth and Deficit Reduction.”

Below are some excerpts from the President’s message that deal with changes in the Medi-

care and Medicaid health plans so important to seniors and people on limited incomes. Many of the President’s proposals are arcane and dense, while major issues---like raising the retirement age for Social Security or Medicare---were not on the list:

“This continues to be a time of challenge for our country. We face an economic crisis that has left millions of our neighbors jobless, and a political crisis that has made things worse. Millions of Americans are looking for work. Across our country, families are doing their best just to scrape by—giving up nights out with the family to save on gas or make the mortgage, or postponing retirement to send a child to college.

These men and women grew up with faith in an America where hard work and responsibility paid off. They believed in a country where everyone

gets a fair shake and does their fair share; they believed that if you worked hard and played by the rules, you would be rewarded with a decent salary and good benefits. If you did the right thing, you could make it in America.

For decades now, Americans have watched that compact erode. They have seen the decks too often stacked against them. And they know that Washington has not always put their interests first. Too often, our Nation's capital has been consumed by partisanship. Too often, the needs of special interests or politics have been put ahead of what is best for the country.

That is what must change. The American people work hard to meet their responsibilities. Now, as the Nation faces an economy that is not growing and creating jobs as it should, so must its leaders. While the continued recovery of our economy will be driven by the businesses and workers across our land, policymakers in Washington can take steps to help Americans right now and set the most favorable conditions we can for growth and job creation for years to come. We can live within our means and invest for the future.

## Medicare



The Medicare program helps give roughly 50 million seniors and individuals with disabilities access to affordable health care. While the Affordable Care Act helped extend Medicare's solvency by encouraging high-quality, efficient health care and addressing wasteful spending, the Medicare Trustees still estimate trust fund exhaustion in 2024. The new proposals would make changes to Medicare that are gradual, protect current and middle-class beneficiaries, and

strengthen Medicare overall. These proposals would save about \$224 billion over 10 years by better aligning payments with the costs of care and improving providers' payment incentives to provide high quality care.

The proposals also make structural changes that include reducing Federal subsidies for high-income beneficiaries and creating financial incentives for newly eligible beneficiaries to seek high-value health care services to achieve an additional \$24 billion in savings. These measures are expected to extend the solvency of the Medicare Hospital Insurance Trust Fund by about three years. These proposals are presented in the context of a Medicare baseline that assumes legislative action to permanently prevent current law reductions in Medicare physician payment rates consistent with the Administration's commitment to fix the sustainable growth rate policy in a fiscally responsible way. Failing to do so simply masks the worsening long-run deficit. To save money and strengthen Medicare, the Administration proposes to:

- **Adjust SNF payments to reduce hospital readmissions.** The Affordable Care Act created payment adjustments for inpatient hospitals with high rates of readmissions, many of which could be avoided through better care. However, a comparable adjustment does not exist for SNFs. MedPAC analysis shows that nearly 14 percent of Medicare patients that are discharged from a hospital to a SNF are readmitted to the hospital for conditions that could have been avoided. To promote high quality care in SNFs, this proposal reduces SNF payments by up to three percent beginning in 2015 for facilities with high rates of care-sensitive, preventable hospital readmissions. This proposal will save approximately \$2 billion over 10 years.

- **Align Medicare drug payment policies with Medicaid policies for low-income beneficiaries.** Under current law, drug manufacturers are required to pay specified rebates for drugs dispensed to Medicaid beneficiaries. In contrast, Medicare Part D plan sponsors negotiate with manufacturers to obtain plan-specific rebates at unspecified levels. The Department of Health and Human Services (HHS) Office of Inspector General has found substantial differences in rebate amounts and net prices paid for brand name drugs under the two programs, with Medicare receiving significantly

lower rebates and paying higher prices than Medicaid. Moreover, Medicare per capita spending in Part D is growing significantly faster than that in Parts A or B under current law. This proposal would allow Medicare to benefit from the same rebates that Medicaid receives for brand name and generic drugs provided to beneficiaries who receive the Medicare Low-Income Subsidy beginning 2013. Manufacturers previously paid Medicaid rebates for drugs provided to the dual eligible population prior to the establishment of Medicare Part D. The Fiscal Commission recommended a similar proposal to apply Medicaid rebates to dual eligibles for outpatient drugs covered under Part D. This option is estimated to save \$135 billion over 10 years.

• **Cut waste, fraud, and abuse in Medicare.** In this fiscal environment, we cannot tolerate waste, fraud, and abuse in Medicare—or any Government program. That is why the Administration has made this a priority through its Campaign to Cut Waste, together with long-standing efforts to boost program integrity and reduce improper payments (that is, payments made to the wrong person, in the wrong amount, or at the wrong time). The Administration is proposing a series of policies to build on these efforts that will save approximately \$5 billion over the next 10 years. Specifically, the Administration proposes to:



• **Recover erroneous payments made to insurers participating in Medicare Advantage.** Medicare Advantage plans receive payments that are adjusted based on whether or not beneficiaries have certain health conditions that result in higher costs. The Centers for Medicare and Medicaid Services

(CMS) audits a sample of plans' records to validate the accuracy of adjusted payments... This proposal will save approximately \$2.3 billion over 10 years.

• **Dedicate penalties for failure to use electronic health records toward deficit reduction.** Current law offers incentive payments to hospitals and physicians who become meaningful users of electronic health records. Beginning in 2015, Medicare providers that fail to become meaningful users are subject to a penalty, and the penalty is credited to a special account beginning in 2020. This proposal would instead use these penalties for deficit reduction beginning in 2021; this will save approximately \$500 million over 10 years.

• **Increase income-related premiums under Medicare Parts B and D.** Under Medicare Parts B and D, certain beneficiaries pay higher premiums as a result of their higher levels of income. Beginning in 2017, the Administration proposes to increase income-related premiums under Medicare Parts B and D by 15 percent and maintain the income thresholds associated with income-related premiums until 25 percent of beneficiaries under Parts B and D are subject to these premiums. This will help improve the financial stability of the Medicare program by reducing the Federal subsidy of Medicare costs for those beneficiaries who can most afford them. This proposal will save approximately \$20 billion over 10 years.

• **Modify Part B deductible for new beneficiaries.** Beneficiaries who are enrolled in Medicare Part B are required to pay an annual deductible. This deductible helps to share responsibility for payment of Medicare services between Medicare and beneficiaries. To strengthen program financing and encourage beneficiaries to seek high-value health care services, the Administration proposes to apply a \$25 increase in the Part B deductible in 2017, 2019, and 2021 for new beneficiaries. Current beneficiaries or near retirees would not be subject to the revised deductible. This proposal will save approximately \$1 billion over 10 years.

• **Introduce home health co-payments for new beneficiaries.** Medicare beneficiaries currently do not make co-payments for Medicare home health services. This proposal would create a home health copayment of \$100 per home health episode, applicable for episodes with five or more visits not preceded by a hospital or other inpatient post-acute care stay. This

would apply to new beneficiaries beginning in 2017. This proposal is consistent with a MedPAC recommendation to establish a per episode copayment. MedPAC noted that “beneficiaries without a prior hospitalization account for a rising share of episodes” and that “adding beneficiary cost sharing for home health care could be an additional measure to encourage appropriate use of home health services.” This proposal will save approximately \$400 million over 10 years.

• **Introduce a Part B premium surcharge for new beneficiaries that purchase near first-dollar Medigap coverage.** Medigap policies sold by private insurance companies provide beneficiaries additional support for covering healthcare costs by covering most or all of the cost sharing Medicare requires. This protection, however, gives individuals less incentive to consider the costs of health care services and thus raises Medicare costs and Part B premiums. Of particular concern are Medigap plans that cover substantially all Medicare copayments, including even the modest co-payments for routine care that most beneficiaries can afford to pay out of pocket. To encourage more efficient health care choices, the Administration proposes a Part B premium surcharge equivalent to about 15 percent of the average Medigap premium (or about 30 percent of the Part B premium) for new beneficiaries that purchase Medigap policies with particularly low cost-sharing requirements, starting in 2017. Current beneficiaries and near-retirees would not be subject to the surcharge. Other Medigap plans would be exempt from this requirement while still providing beneficiaries options for protection against high out-of-pocket costs. This proposal will save approximately \$2.5 billion over 10 years.

**Medicaid**

Medicaid is a critical source of health insurance coverage for approximately 56 million low-income beneficiaries including millions of children with disabilities and seniors in nursing homes. The ACA included provisions to increase anti-fraud efforts in Medicaid and placed a renewed focus on quality of care provided to Medicaid beneficiaries. To make Medicaid more flexible, efficient, and accountable, the following proposals would limit State financing practices that increase Federal spending, replace complicated matching formulas with a single

matching rate specific to each State, and strengthen Medicaid program integrity. These proposals are projected to save approximately \$66 billion over 10 years.

• **Reduce the Medicaid provider tax threshold beginning in 2015.** Many States impose taxes on health care providers to help finance the State share of Medicaid program costs. However, some States use those tax revenues to increase payments to those same providers, and use that additional spending to increase their Federal Medicaid matching payments. The Administration proposes to limit these types of State financing practices that increase Federal Medicaid spending, by phasing down the Medicaid provider tax threshold, from the current law level of 6 percent in 2014, to 4.5 percent in 2015, 4 percent in 2016, and 3.5 percent in 2017 and beyond. By delaying the effective date until 2015, the proposal protects States from reductions in the short term. This proposal is projected to save \$26.3 billion over 10 years.



• **Limit Medicaid reimbursement of durable medical equipment (DME) based on Medicare rates.** Under current law, States have experienced the same challenges in preventing overpayments for DME that previously confronted Medicare. The Medicare program is in the process of implementing innovative ways to increase efficiency for payment of DME through the DME Competitive Bidding Program, which is expected to save the Medicare program more than \$17 billion and Medicare beneficiaries approximately \$11 billion over 10 years. This proposal extends some of these efficiencies to Medicaid, starting in 2013, by limiting Federal reimbursement for a State’s Medicaid spend-

ing on certain DME services to what Medicare would have paid in the same State for the same services. This proposal is projected to save \$4.2 billion over 10 years.

• **Amend modified adjusted gross income (MAGI) for health insurance assistance programs to include Social Security benefits.**

Starting in 2014, Medicaid will be determined based on an individual's or families' MAGI, as defined under the Affordable Care Act. Similar to legislation currently under consideration by the Congress, the Administration proposes to amend that definition to include the total amount of Social Security benefits in the calculation of MAGI, rather than just the taxable portion, when determining eligibility for these programs to better target those in need. This proposal is projected to save \$14.6 billion over 10 years.

• **Reduce waste, fraud, and abuse in Medicaid.** Medicaid funds should not be wasted on fraudulent claims, abuses of the rules, or general waste in implementing the program. The following policies will save \$110 million over the next 10 years while reducing waste, fraud, and abuse:

• **Require manufacturers that improperly report items for Medicaid drug coverage to fully repay States.**

Federal law requires manufacturers to report a list of their "covered outpatient drugs" to CMS for Medicaid drug coverage, but some manufacturers improperly report items that do not belong (e.g., syringes). This proposal would recoup costs of covering improperly-reported items discovered after Medicaid reimbursement has occurred; the proposal leverages the Medicaid drug rebate program by directing manufacturers to pay a "rebate" equal to the amount the State paid for these items.

• **Track high prescribers and utilizers of prescription drugs in Medicaid.** States already have the capability to implement monitoring systems for prescription drugs, but are not currently taking full advantage of these systems' potential benefits. This proposal requires States to track drug claims for indications of waste, fraud, or abuse by providers or beneficiaries and to take steps to reduce wasteful or abusive prescribing practices.

• **Enforce Medicaid drug rebate agreements.** Under this proposal, HHS would, when cost-effective, conduct regular audits and surveys of Medicaid drug rebate agreements to ensure the Medicaid program is receiving proper prices and rebate amounts.

• **Increase penalties on drug manufacturers for**

**fraudulent non-compliance** with Medicaid drug rebate agreements. This proposal would increase the statutory civil monetary penalties on manufacturers that knowingly report false information under their drug rebate agreements for calculation of Medicaid rebates.

• **Require drugs to be properly listed with the FDA to receive Medicaid coverage.** Though FDA law requires manufacturers to list their drugs with FDA, compliance is inconsistent. Recently, Medicare required that drugs must be properly listed with the FDA to receive Part D coverage; this proposal would add the same requirement in Medicaid.

**Other Health Savings**



Beyond Medicare and Medicaid, there are a series of proposals in other health programs that will help reduce the deficit and provide consumers with more affordable pharmaceuticals; prioritize investments in public health outcomes proven to reduce drivers of health care cost growth; and provide States the flexibility to develop their own innovative strategies to ensure their residents have access to high quality, affordable health insurance. The Administration proposes to:

• **Prohibit "pay for delay" agreements to increase the availability of generic drugs and biologics.**

The high cost of prescription drugs places a significant burden on Americans today, causing many to skip doses, split pills or forgo needed medications altogether. The Administration proposes to increase the availability of generic drugs and biologics by authorizing the Federal Trade Commission (FTC) to stop companies from entering

into anti-competitive deals, known also as “pay for delay” agreements, intended to block consumer access to safe and effective generics. A 2010 Federal Trade Commission study that evaluated the universe of brand-generic settlements and 2008 drug expenditure data found that on average, these agreements delayed entry of a generic by 17 months and cost American consumers as much as \$3.5 billion per year. More recently, the FTC reported that the number of pay-for-delay agreements skyrocketed from 19 in 2009 to 31 in 2010. Such deals block access to generics and can cost consumers billions of dollars because generic drugs are typically priced significantly less than their branded counterparts. These agreements reduce competition and raise the cost of care for patients both directly, through higher drug and biologic prices, and indirectly through higher health care premiums. The Administration’s proposal facilitates greater access to lower-cost generics and will generate \$2.7 billion over 10 years in savings to Federal health programs including Medicare and Medicaid.

• **Reduce the exclusivity period for generic biologics.** Access to affordable lifesaving medicines is essential to improving the quality and efficiency of health care. The Administration’s proposal accelerates access to affordable generic biologics by modifying the length of exclusivity on brand name biologics to encourage faster development of generic biologics while retaining appropriate incentives for research and development for the innovation of breakthrough products. Beginning in 2012, this proposal would award brand biologic manufacturers seven years of exclusivity rather than 12 years under current law and prohibit additional periods of exclusivity for brand biologics. Reducing

the exclusivity period increases the availability of generic biologics to encourage faster development of generic biologics while retaining appropriate incentives

• **Accelerate the issuance of State Innovation Waivers.** This proposal empowers States to develop their own innovative strategies to ensure their residents have access to high quality, affordable health insurance achieving the same outcomes as the ACA. Similar to legislation previously introduced by Senators **Ron Wyden**, **Scott Brown**, and **Mary Landrieu** and endorsed by the President, it would make “State Innovation Waivers”

available starting in 2014, three years earlier than under current law. These State strategies would need to provide affordable insurance coverage to at least as many residents as without the waiver and must not increase the Federal deficit. The Administration is committed to the budget neutrality of these waivers; an allowance for these waivers is included to account for the possibility that CBO will estimate costs for this proposal.

In his message to Congress, the President told Congress “This plan is a balanced one that asks everyone to do their part. It includes nearly \$580 billion in cuts and reforms to mandatory programs, of which \$320 billion is savings from Federal health programs such as Medicare and Medicaid. These changes are necessary to maintain the promise of Medicare as we know it.



“The plan also realizes more than \$1 trillion in savings over the next 10 years from our drawdowns in Afghanistan and Iraq. And the plan calls for the Congress to undertake comprehensive tax reform that lowers tax rates, closes loopholes, boosts job creation here at home, cuts the deficit by \$1.5 trillion, and observes the Buffett Rule—that people making more than \$1 million a year should not pay a smaller share of their income in taxes than middle-class families pay. To assist the Committee in its work, I also included specific tax loophole closers and measures to broaden the tax base. Together with the expiration of the high-income tax cuts from 2001 and 2003, these measures would be more than enough to reach this \$1.5 trillion target.

“They include cutting tax preferences for high-income households, eliminating tax breaks for oil and gas companies, closing the carried interest loophole for investment fund managers, and eliminating benefits for those who use corporate jets.

“In sum, the plan I am sending to the Congress today is a blueprint for how we can reduce this deficit, pay down our debt, and pay for the American Jobs Act in the process. I have little doubt that some of these proposals will not be popular with those who benefit from these affected programs. And some of these changes are ones that we would not make if it were not for our fiscal situation. But we are all in this together, and all of us must contribute to getting our economy moving again and on a firm fiscal footing.

“After all, we are all connected. No single individual built America on his or her own. We built it together. We have been, and always will be, “one Nation, under God, indivisible, with liberty and justice for all.” We have always been a people with responsibilities to ourselves and with responsibilities to one another. This means that as Americans work hard to find a job, keep their businesses afloat and grow, and provide for their kids, their representatives in Washington must meet their responsibilities and make the tough choices needed to get our economy back on track.

“This plan lives up to a simple idea: as a Nation, we can live within our means while still making the investments we need to prosper. It follows a balanced approach: asking everyone to do their part, so no one has to bear all the burden. And it says that everyone—including millionaires and billionaires—has to pay their fair share.

“These may be tough times for our country, but I have a deep faith in the American spirit, and we are tougher than the times we live in and bigger than the politics we have recently seen. If we all put partisanship aside and roll up our sleeves, I have no doubt that we can meet the challenges of the moment and show the world once again why the United States of America remains the greatest country on Earth.”

## Bay State Ranks Low On Long Term Care Supports

On September 8, 2011, AARP, the Commonwealth Fund, and the SCAN Foundation released a new ‘report card’ study of long term care in which Massachusetts scored in the bottom half, at number 30, of

all states when it comes to the overall affordability and quality of long-term services and supports (LTSS).

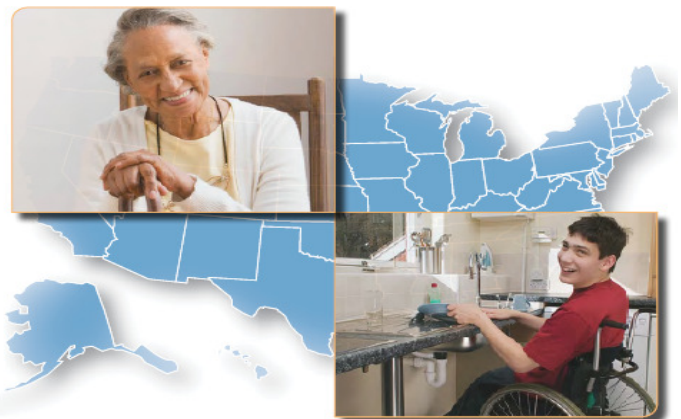
The new study included home care, adult day health services, residential services such as assisted living and nursing homes, and respite care as well as other support for family caregivers.

“This scorecard screams: More attention must be paid to long-term care services and support systems in Massachusetts,” says **Deborah Banda**, state director of AARP Massachusetts, which represents more than 800,000 members age 50 and older in the Bay State. “As a commonwealth, we pride ourselves as being ahead of the curve when it comes to health care reform, yet this critical piece seems to have been left in the dust.”

### Raising Expectations

A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers

Susan C. Reinhard, Enid Kassner, Ari Houser, and Robert Mollica  
September 2011



The report, entitled “*Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*,” looks at four key dimensions of LTSS performance:

- affordability and access;
- choice of setting and provider;
- quality of life and quality of care; and,
- support for family caregivers.

“While there is definite room for improvement in all areas, Massachusetts ranks too close to the bottom when it comes to the cost of care and an overreliance on institutional care,” explains Banda. “We have a unique

opportunity to address these issues now, as state leaders work to craft health care payment and systems delivery reform. Long-term services and support are part of health care delivery, across the continuum, and as such, should be included in payment reform discussions.”

Although Massachusetts ranked 17th overall for affordability and access, the state scored extremely low (46) in two key indicators within that dimension: “median annual nursing home private pay” and “median annual home care private pay” costs as a percentage of median household income.



*Deb Banda, AARP Massachusetts*

As for choice of setting and provider, the state ranked 14th, but that score was dragged down by a low grade (40) for the percent of new Medicaid LTSS users first receiving services in community. The state’s worst rankings among the four overall dimensions came in quality of life and quality of care (34) and support for family caregivers (39). In both, improvement is needed across the board, from adults with disabilities getting needed support in the community (27) and being satisfied with life (38) to the use of physical restraints in long-stay nursing homes (35) and intervention for pressure sores in home health plans for at risk patients (40).

“We say we are a ‘community first’ state, but this

study shows that our performance overall has been second-rate in the field of long term care,” says **Al Norman**, executive director, Mass Home Care. “Despite a 29% drop in nursing home days paid for by Medicaid over the past decade, only 39% of long term care dollars go into community care – which means that 61% is still going to nursing homes. This scorecard creates a benchmark from which to measure our progress in giving consumers the kind of supports they need to remain at home.”

Two bright spots for the Commonwealth: Massachusetts ranks third in the country on two key individual indicators, the percentage of low income disabled adults receiving health insurance assistance, and the functionality of Aging and Disabled Resource Centers.

“Bottom line: This scorecard reflects fragmentation in the long-term services and supports system,” says Banda. “While Massachusetts scored well on having tools and programs to help facilitate consumer choice, the state scored poorly on the percent of new LTSS users who first received services in the community. Since we know people prefer to remain in their own homes and communities as they age, that’s a disconnect.” Another AARP survey, “Voices of 50+ Massachusetts,” released earlier this year, finds having quality long-term care options when needed is a top concern for 85 percent of Massachusetts residents age 50 and older.

According to the scorecard, if Massachusetts improved its performance to the level of the highest-performing state:

- 10,203 more new users of Medicaid LTSS would first receive services in home and community based settings instead of nursing homes.
- 3,945 nursing home residents with low care needs would instead be able to receive LTSS in the community.
- 2,616 unnecessary hospitalizations of people in nursing homes would be avoided.
- 2,129 more low-or moderate-income (<250% poverty) adults age 21 and older with activity of daily living disabilities would be covered by Medicaid.

“We’ve got a demographic imperative to get this right,” Banda concludes. “With the first of the 76 million Baby Boomers turning 65 this year, there’s no time to waste when it comes to building a better system of long-term services and supports in this state – and in this country.”

In a *Boston Globe* story about the new LTSS

Scorecard report, the Secretary of Health and Human Services, Dr. **JudyAnn Bigby**, was quoted as saying that Massachusetts has improved since 2007, when it spent only 30 percent of its available money on community-based care. According to Secretary Bigby, the state is hoping to create more community-based group homes for elders who need care but who prefer to stay in the neighborhoods where they have long lived. She noted that the network of state and community agencies and organizations designed to help elders avoid nursing homes is fragmented and needs better coordination. "There is more we can do about this," the Globe quoted her as saying.

## Long Term Supports Critical To Duals Plan

Spending on long term care supports for people who are on Medicare and Medicaid and between the ages of 21 and 64 totals more than the combined spending on inpatient hospital care and physician care. This is just one of the surprising pieces of data from a new report that focuses on the health care costs of people called "dually eligible" for Medicare and Medicaid.

On September 12, the Massachusetts Medicaid Policy Institute (MMPI) released a report in collaboration with the Massachusetts Office of Medicaid ("MassHealth") entitled *Dual Eligibles in Massachusetts: A Profile of Health Care Services and Spending for Non-Elderly Adults Enrolled in Medicare and Medicaid*

The report was intended to support broad discussion of how to improve the coordination of care for dually eligible non-elderly adults in Massachusetts, roughly 105,000 people. With a grant from the Center for Medicare/Medicaid Services, the MassHealth program is currently developing a proposal to integrate the care and financing for people ages 21 to 64 enrolled simultaneously in Medicare and Medicaid in order to support improvement in the coordination, quality and cost-effectiveness of care for this population. That program is called the "Integrated Care Entity" (ICE) plan.

Key findings, based on 2008 health data, from the report include:

- Combined Medicare and Medicaid spending for

these duals totaled \$2.5 billion in 2008, which translates into an average of \$23,700 per person per year. However, average per person spending masks the wide variation in spending, and, in particular, the concentration of expenditures on high-cost individuals.

- Approximately six percent of all duals incurred 37 percent of combined Medicaid and Medicare spending for duals in Massachusetts, while seventy percent of duals accounted for only 16 percent of combined spending.
- The vast majority of duals live in their communities, not in institutions, with only 3 percent of the population living in either a nursing facility, an intermediate care facility or long term in a chronic or rehabilitation facility.
- Fewer than 20 percent of duals both resided in the community and received a high level of long term support services. On average, duals residing in the community and receiving a high level of long term support services cost roughly half of what duals residing in institutions cost.



- 35% of combined Medicare and Medicaid spending for duals went to long term support services—nearly half of that on home and community-based care.
- Spending on LTSS care at 35% was almost as much as spending on inpatient hospital care (22%) and doctor care (14%) combined.
- Home and community based care accounted for 45% of LTSS spending on duals.
- 63% of the duals are between the ages of 45 and 64, of whom 30% (30,500 people) are between the ages of 55 and 64.
- 78% of duals (82,000 people) need no or low levels of support services in the community.
- Around 19% (20,000 people) who need a high level of community support, with spending of \$56,200 per person. There are only 3,000 duals (3%) living in insti-

tutions, but their average annual cost is nearly twice as high as the high cost community consumers: \$101,900. Community care is 55% the cost of institutional care.

- Of the 20,000 duals needing a high level of community supports, Medicaid picks up 72% of that cost, and 63% of cost in institutions.
- Two out of three duals (67,600 people) have a behavioral diagnosis. 79% of duals (82,400 people) have a physical illness or disability. 14% (14,300) have a developmental disability.
- 60% of duals have two or more diagnostic categories (physical, behavioral and developmental), and account for 83% of spending. 47% of duals have both physical and behavioral diagnoses.
- Outpatient treatment of behavioral health issues came to only 2% of all Medicare and Medicaid spending.
- 38% of duals received more than 5 prescriptions per month
- Some of the most common medical diagnoses of duals include 24,700 people with chronic obstructive pulmonary disease (COPD), 23,200 people with diabetes, and 15,000 people with coronary heart disease.

## Groups Respond To Accountable Care Organization Plan

On June 3, 2011, the Massachusetts Executive Office of Health and Human Services (EOHHS) issued a Request for Information (RFI) to solicit information from interested parties regarding the initiative by state payers to use accountable care organizations (ACOs) throughout the Commonwealth to increase the coordination and delivery of integrated health care services.

EOHHS said it was evaluating the issues raised by a transition to ACOs, and sought to obtain additional information from interested parties as part of its evaluation process. EOHHS wants to encourage ACO formation in order to improve care delivery, coordination, and quality, and to be able to utilize alternatives to fee-for-service payment methods to compensate ACOs in a manner that will decrease total per capita expenditures, and the rate of growth in expenditures for health care in the Commonwealth.

Information received from the RFI may be used by EOHHS for developing one or more ACO

procurement and contracting initiatives. EOHHS was hoping for comments from such interested parties as physicians, health care organizations and delivery systems and other providers, purchasers of health care, carriers and health plans, as well as consumers, in order to develop a comprehensive plan to improve health care quality and delivery of integrated services while decreasing costs over the long term.



EOHHS said they expect to see “ACOs of different levels of integration, structures, and sizes,” and wanted to promote the development of a variety of ACOs throughout the Commonwealth. “ACO development is part of a broader effort to transform the health care system in Massachusetts by restructuring the delivery of care and changing reimbursement for health care services,” EOHHS said. “Massachusetts’ reform efforts include initiatives to develop patient-centered medical homes and changing the way primary care is reimbursed, bundled payments, integrated care models for the provision of services to individuals eligible for both Medicaid and Medicare (Dual Eligibles), and pending state legislation to promote ACOs and a multi-payer transition to the use of alternative payment methodologies throughout the Commonwealth.

Through these initiatives, Massachusetts seeks to support access to health care services across the continuum of care, improve care coordination across the health care delivery system, and create payment systems that hold health care providers accountable for the care they deliver. The goal is to reward quality, coordinated and integrated care that prioritizes the promotion of wellness as well as the treatment of illness and injury and to do so while optimizing efficiency

# At Home

October, 2011

# 11

and cost containment within the health care system.”

The federal government also recently issued proposed regulations for the Medicare Shared Savings Program under the Patient Protection and Affordable Care Act (section 3022).

EOHHS defines an ACO as: “An entity comprised of health care provider groups which operates as a single integrated organization that accepts at least shared responsibility for the cost and primary responsibility for the quality of care delivered to a specific population of patients cared for by the groups’ clinicians; which operates consistent with principles of a patient centered medical home, has a formal legal structure to receive and distribute payments; and complies with any federal requirements applicable to ACOs.” The extent of health care services is not defined, but it assumed that ACOs will provide not just primary and acute care, but long term supports and services (LTSS) as well.

In its RFI, EOHHS asked a series of questions about ACOs. One of the areas of questioning in the RFI had to do with an ACO’s “Stakeholder Collaboration.” One of the questions asked in this section was: *“How can meaningful partnerships be built between ACOs and non-clinical community services and neighborhood-based agencies to promote healthier conditions in patients’ lives?”*

More than 50 different entities responded to the EOHHS request for information, including Mass Home Care. Most groups did not answer the question on stakeholder collaboration, but here are some of the responses that were received on the issue of collaborating with community groups:

**Commonwealth Care Alliance:** CCA would propose utilizing the state’s Senior Care Options (SCO) program-ASAP relationship as a model to follow for the ACO demonstrations for high-risk populations. The ASAPs provide the SCO primary care team with an expertise in the breadth of community based long term care supports available in the aging network and the Geriatric Support Services Coordinator (GSSC) member of the team (who is employed by the ASAP) is often the team member who arranges for these services. The GSSC is usually involved in components of the assessment (such as ADLs, IADLs, home environment, family support)) and care planning. A parallel approach in

the under 65 system would call for relevant organizations related to the specific disabled population, such as ILCs (and/or ADRCs and/or RLCs) to have a formal relationship with the ACOs for the expertise that they offer for/to the particular disability community.”

**Atrius Health:** There is not an easy answer to this question. Several Harvard Vanguard Medical Associates’ sites and Southboro Medical Group are working closely with their local ASAPs to develop referral relationships. We can envision enormous benefit to patients who need these services to improve their quality of life. Conceivably we could reach a point where we would run out of resources at the ASAPs if all providers were actively pursuing these relationships. The state could develop “health regions” and do some health planning by region, then convene those ACO’s and other providers and non-clinical services in those regions to work together on top issues affecting the local patient population.



**Baystate Health:** Baystate and Health New England (HNE) have existing relationships with non-clinical community services and neighborhood-based agencies, including the neighborhood health centers which are a part of the Baystate system. Through our community benefits mission, we have well established, long-term relationships with neighborhood-based organizations. We believe ACOs should sponsor/endorse the Community Health Worker (CHW) model, a proven intervention, where an individual uses his or her natural communication skills to improve the health of people with chronic disease at the community level. CHWs, knowledgeable about healthcare and the community they live in, act as a liaison between the community and the health system

# At Home

October, 2011 12

and serve as trusted sources providing supervised health education in the community. ACOs also should encourage Community Partnerships with neighborhood-based organizations to introduce chronic disease management skills and tools to the community at large. The use of community platforms (e.g., faith-based organizations, neighborhood and civic associations) and Community Partnerships (e.g., nonprofit community-based organizations, Coalitions, Task Forces, Networks) will: Promote the integration of patients, medical homes and community resources and consequently provide better-coordinated, cost-effective patient care;

- Help ACOs overcome the barriers to care facing our communities;
- Increase access to care for under-served populations;
- Physically extend care into the community for vulnerable populations (e.g., children and seniors);
- Empower patients and other community stakeholders to address root causes of individual- and neighborhood-level health concerns; and
- Join together medical care, public health and community human service resources to promote healthier

**Mass Home Care:** ACOs should be required to demonstrate, as part of their core capacity, that they have in place an agreement to govern LTSS care coordination with health services. This is the most “meaningful partnership” that can come out of the ACO initiative that involves LTSS entities. Each ACO needs to demonstrate that it has in place a contractual agreement with an entity or entities which provide care coordination and care management services for individuals with LTSS needs. This linkage can be accomplished at the ACO contractual level, or evidenced through agreements at the medical homes level. EOHHS should work with EOE, MRC, DMH and other state agencies to ensure that any entities which they have designated as care coordinators of LTSS are made available to ACOs during the capacity building process. The state should ensure that an interdisciplinary team be required at each ACO to guarantee that medical services will become part of a large care plan for patients enrolled in ACOs.

**Mass Medical Society:** Professional membership associations of various provider constituencies could facilitate communication. One option would be to create community care teams that would pull together

key parties from the ACOs, non-clinical community services and neighborhood-based agencies that exist in the geographic regions of the ACOs on a routine basis that could serve as community based health activists promoting healthier lifestyles within their routine activities. Additionally, these community care teams could also serve as a form of surveillance and inform the ACOs if they notice any particular health issues or trends that may be occurring in the community that may need clinical attention on a higher level.

**Mass Senior Care** [nursing facility trade group]: Through appropriate collaboration across the continuum of care ACOs and non-clinical neighborhood-based agencies to promote healthier conditions. For example, an ACO could work with local Councils on Aging to develop simple programs to reduce the instances of falls in the community, based on successful programs developed and implemented by nursing facilities.



**Mass Hospital Association:** Many physicians and hospitals already have established relationships with community service providers. As ACOs form and grow, these relationships will become more important and will naturally develop and evolve as providers seek ways to care for the whole patient. For example, when discharging a patient from the hospital, it will be necessary not just to insure that the patient obtains necessary medications, but that he has a way to get back to the primary care physician for follow up appointments. For some elderly or low income individuals, this could be a barrier to further care. It will thus be in the ACO and patient’s best interest to insure that the patient has trans-

portation to his appointments.

**Massachusetts League of Community Health Centers:** Community health centers can provide many examples of participation in non-clinical community services, but, as mentioned in Section III.A.4, many of these services rely on grant funding or grass roots energy and are not within the control or the finances of the health center. We would be happy to provide an exhaustive list of these services ranging from projects which enable poor people to avoid foreclosure and manage their finances; to link people coming out of correctional institutions with community-based care; to work with refugee and immigrant resettlement programs; to locate farmers markets in their neighborhoods; to refer people to local gyms; and many more. It would be helpful to inventory these, following which the state could play a role in convening the philanthropic community to explore the relationship between what ACOs are intending to do to improve the health of people of the state and what funders might best support to facilitate this. To the extent that these are funded by DPH program dollars, which are generally subject to annual appropriation, where possible steps should be taken to guarantee stable funding over a longer period of time, possibly through a Public Health Trust Fund or similar mechanism.

**Visiting Nurse Associations:** Meaningful partnerships/relationships cannot be prescribed but system goals and outcome improvements can. The Commonwealth should revisit the roles and goals of Health Systems Agencies to recall community and provider partnerships when health planning was a priority.

## Senator Brown on the CLASS Act

On August 30, 2011, U.S. Senator **Scott Brown** sent the following letter to Mass Home Care about the CLASS act, a long term care insurance plan included in the Federal Affordable Care Act. CLASS, which had been championed by the late Senator **Ted Kennedy**, is a self-funded insurance plan that will not begin for years until members paying in have become invested.

In his letter, Brown notes that an effort is underway to repeal the CLASS Act, but Brown does not promise to defend the law. Here is the text of Senator Brown's letter:

" Thank you for contacting me regarding the Community Living Assistance Services and Supports (CLASS) program. As always, I value the input of my constituents on all issues, and appreciate hearing from you.

Like you, I support efforts to ensure that existing workers and seniors have access to affordable long-term care (LTC) insurance and services. Last year, the Patient Protection and Affordable Care Act passed through a deeply divided 111th Congress. Included in this law is the CLASS Act, which is intended to provide an additional financing mechanism for LTC services. Typically, funding for LTC services is provided through public programs, such as Medicaid and Medicare.



As passed, the CLASS program provides benefits to pay for support services in a community setting to eligible enrollees after a five-year vesting period. Severely impaired enrollees could apply their benefit toward the cost of residential care in a nursing facility. However, some recent reports question the long-term solvency of the CLASS program. The Congressional Budget Office (CBO) estimated that a reduction of benefit payments and increase in premiums will be needed to maintain the CLASS program after 2019. Others, however, suggest the CLASS program fills a void in an otherwise fragmented long-term care market.

As you may know, Senator John Thune (R-SD) introduced the Repeal the CLASS Entitlement Act (S. 720) on April 4, 2011. Currently, S. 720 is under review by the Senate Committee on Finance, where it awaits further action. While I am not a mem-

ber of this committee, I will be sure to monitor the progress of this legislation with your views in mind.”

## Governor Perry's Ponzi Scheme



On September 7, 2011, Texas Governor, and Republican Presidential candidate **Rick Perry** described Social Security as a “monstrous lie” for younger Americans. Perry told the audience: “It is a monstrous lie. It is a Ponzi scheme to tell our kids that are 25 or 30 years old today, you’ve paid into a program that’s going to be there. Anybody that’s for the status quo with Social Security today is involved with a monstrous lie to our kids, and that’s not right.”

Fellow Presidential hopeful **Mitt Romney** responded: “The issue in the book ‘*Fed Up*,’ governor, as you say that by any measure, Social Security is a failure -- you can’t say that to tens of millions of Americans who live on Social Security and those who have lived on it...Our nominee has to be someone who isn’t committed to abolishing Social Security but is committed to saving Social Security. We’ve always had at the heart of our party a recognition that we want to care for those in need, and our seniors have the need of Social Security.”

Romney was referring to the quote in Rick Perry’s book, *Fed Up*, in which the Texas Governor described Social Security as a failure that “we have been forced to accept for more than 70 years now.”

During the Republican debates, Governor Perry

also said that Social Security had to be fixed so that “our children actually know that there’s going to be a retirement program there for them.” Perry has also suggested in the past that Social Security, which provides basic income support for 56 million Americans, is undesirable, and that it may even be unconstitutional.

In *Fed Up*, Perry wrote that “by any measure, Social Security is a failure...a crumbling monument to the failure of the New Deal, in stark contrast to the mythical notion of salvation to which it has wrongly been attached for too long, all at the expense of respect for the Constitution and limited government.”

The *New York Times* has pointed out that during a book promotion tour last fall, Perry said: “Why is the federal government even in the pension program or the health care delivery program? Let the states do it.”

In response to pressure from Mitt Romney, Perry added: “If what you’re trying to say is back in the ’30s and the ’40s that the federal government made all the right decisions, I disagree with it. It’s time for us to get back to the Constitution. And a program that’s been there 70 or 80 years, obviously we’re not going to take that program away.”

Perry has now called Social Security a Ponzi scheme more than once. That term has special resonance for people in Massachusetts, since **Charles Ponzi** was from Boston, and ran his operations in the 1920s, promising high returns for investors, paying first-in investors using money from later investors---a scheme that collapses if the number of new investors coming in begins to slow down.

Social Security is a pay-as-you-go retirement system. Current workers and employers pay taxes that are used to pay benefits to current retirees. For almost all of its history, the program took in more money than it paid out, and invested the surplus — the “Social Security trust fund” — in U.S. Treasuries. In 2010, Social Security began paying out more in benefits than it received in taxes. As more baby boomers retire, and there is a shortage of new workers, that shortfall is expected to grow.

The Congressional Budget Office recently said that the combined Social Security trust funds would be exhausted in 2038. There are many options to keep the program solvent, such as raising taxes, expanding earnings subject to the payroll tax, rais-

ing the retirement age, cutting the cost-of-living increases, etc. Even if nothing is done over the next 27 years, the CBO says that tax collections will still be sufficient to pay 81% of the projected benefits.

In 2009, the Social Security Administration pointed out the differences between Social Security and a Ponzi scheme. "There is a superficial analogy between pyramid or Ponzi schemes and pay-as-you-go programs in that in both money from later participants goes to pay the benefits of earlier participants," it wrote. "But that is where the similarity ends." The SSA explained that a program with 40 million people receiving benefits, and 40 million people paying taxes, could be sustained forever. "It does not require a doubling of participants every time a payment is made to a current beneficiary, or a geometric increase in the number of participants."



The group "Strengthen Social Security" issued a statement after Governor Perry's comments about the Ponzi Scheme. "The future of Social Security is too important to the well-being of future generations of workers to be shaped by incorrect comparisons and misleading arguments by politicians, like Governor Perry, who seek to end Social Security," said **Eric Kingson**, co-chair of the Strengthen Social Security Campaign. "Social Security is America's most popular government program, which makes sense because it is more than a government program; it is the American people's program. They paid into it their entire working lives and they own it and they value the protections it provides to themselves, their families and their neighbors. This is why poll after poll shows that

Republican, Democrats and Tea Partiers are united in telling everyone in DC hands off Social Security."

"Governor Rick Perry's slanderous claim that Social Security is a Ponzi scheme -- an intentional criminal fraud -- is outrageous," said **Nancy Altman**, co-director of Social Security Works. "Anyone accusing thirteen U.S. presidents and 38 Congresses of criminally conspiring to defraud the American people is unfit to lead the nation. Social Security provides working Americans and their families with vital economic protection when wages are lost as the result of disability, death, or old age. Governor Perry obviously doesn't understand the first thing about current-funded pension plans, of which Social Security is a hugely successful example. Even more troubling, he clearly has no respect for the American people who understand Social Security a lot better than he does, and who value it highly." "Perry's statements about Social Security have been consistently false or misleading, and completely out of touch with the American people. At best, they reveal a dangerous ignorance about Social Security, a program that has provided essential economic security to America's working families for the past 76 years. At worst, they telegraph the candidate's willingness to disregard and distort the facts, and his deep desire to end Social Security."

## Will MA Balance Its Long Term Spending?

In September, the federal Department of Health and Human Services sent a letter to all state Medicaid Directors about a new federal offer of enhanced dollar match for community-based long term support services.

The starting date of October 1st is rapidly approaching, and it appears that the state has not decided yet if it is eligible or not to take advantage of this federal financial support. According to one Administration source, the state is still "analyzing this opportunity and our eligibility for it...to take a fresh look at the numbers."

Historically, some States have been successful at rebalancing their long-term care systems toward community-based care. The "Balancing Incentive Program" (BIPP) targets those States that need assistance starting up their rebalancing initiatives, offering support in

# At Home

October, 2011

# 16

the form of increased federal matching funds (FMAP.) States can qualify for a five percentage point increase in FMAP through Balancing Incentive Program if less than 25% percent of the total LTSS expenditures for medical assistance under the State Medicaid program for fiscal year 2009 are for non-institutionally based LTSS. States can qualify for receiving a two percentage point increase in FMAP through the Balancing Incentive Program if less than 50% of the total LTSS expenditures for medical assistance under the State Medicaid program for fiscal year 2009 are for non-institutionally based LTSS. These States must achieve a benchmark of 50% of total Medicaid expenditures on home and community-based LTSS, and complete the required structural reforms, no later than September 30, 2015. States may not restrict eligibility for LTSS more than eligibility standards, methodologies, or procedures in place as of December 31, 2010.



It has been suggested that Massachusetts would qualify for the 2% increase in its federal matching level under BIPP. This is a non-competitive grant, so if the Massachusetts total LTSS expenditures are under 50% for community-based care, the state would qualify for enhanced funding. According to a state grant submitted to the federal government for another program, Medicaid LTSS combined spending on elders and disabled individuals in FY 2009 was 54% in the community,

which would make the state ineligible for BIPP funding. But MassHealth spending for elders was only 34%.

In the federal letter to state Medicaid Director's here is how the BIPP program is described:

“This letter provides guidance to States on the implementation of Section 10202 of the Affordable Care Act, which establishes the ‘State Balancing Incentive Payments Program.’ hereafter referred to as the Balancing Incentive Program.

The Balancing Incentive Program provides a strong financial incentive to stimulate greater access to non-institutionally based long-term services and supports (LTSS). This provision will assist States in transforming their long-term care systems by improving systems performance and efficiency, creating tools to facilitate person-centered assessment and care-planning, as well as enhancing quality measurement and oversight. In addition, the Balancing Incentive Program provides new opportunities to serve more individuals in home and community-based settings, adding to the available tools for realization of the integration directive included in the Americans with Disabilities Act (ADA), as upheld by the Olmstead decision.

“The funding authorized in Section 10202 of the Affordable Care Act will provide an increased Federal Medical Assistance Percentage (FMAP) payment to States participating in the Balancing Incentive Program for non-institutional LTSS and will be made available as a non-competitive grant to States. This letter and the accompanying application serve as a notice of this funding opportunity.

“Effective October 1, 2011, the Balancing Incentive Program offers a targeted increase in the FMAP for non-institutional LTSS to States that undertake structural reforms to increase access to non-institutional LTSS. The enhanced matching payments are tied to the percentage of a State's non-institutional LTSS spending, with lower FMAP increases going to States with a less significant need for reforms. Total funding over the four-year period (October 1, 2011 – September 30, 2015) cannot exceed \$3 billion in Federal increased matching payments.

“As part of the Balancing Incentive Program application, the State agrees to make the following structural changes:

**1. A No Wrong Door–Single Entry Point system (NWD/SEP);**

**2. Conflict-free case management services;** and

**3. A core standardized assessment instrument.** States must provide a letter of commitment to make the required structural changes and submit a work plan for the implementation of the structural changes within six months from the date of application submission. The draft work plan must demonstrate that the structural changes will be in effect no later than September 30, 2015 and that States will meet the statutory rebalancing spending targets.



“This opportunity aligns with other provisions and activities that move toward the development and implementation of these important structural changes. CMS will work with States to help accomplish these changes. CMS will monitor compliance with the structural changes required under the program and agreed to under the State work plan. Failure to meet required changes under the work plan will result in loss of the Balancing Incentive Program increased FMAP...”

“We hope the guidance set forth in the application increases the likelihood of States’ participation in this exciting opportunity to support balancing the States’ long-term services and supports system. We look forward to working with States, individually and collectively, to provide assistance and to facilitate collaboration in im-

plementing this new grant program. CMS would like to reiterate that this option is but one tool among many in current law and Affordable Care Act that States can use to improve service delivery for all people, not just those with chronic conditions or those covered by Medicaid.

According to the Centers for Medicare and Medicaid Services., states who wish to receive the higher federal matching funds must have a “conflict-free case management system to develop a service plan, arrange for services and supports, support the beneficiary in directing the provision of service and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary’s needs and achieve intended outcomes.” CMS refers to persons or entities responsible for the independent evaluations and care planning as “agents.” CMS explains that conflict-free care management is important because “inherent conflicts” can exist, “such as interest in retaining the individual as a client rather than promoting independence..in many cases they are outgrowths of inherent incentives or disincentives built into the system that may or may not promote the interests of the individual receiving services.” To mitigate any explicit or implicit conflicts of interest, “the independent agent should not be influenced by variations in available funding...the plan of care must be based only on medical necessity, not on available funding.

Conflict-free care management prohibits certain types of referrals for services when there is a financial relationship between the referring entity and the provider of services. Payment to the independent agent for evaluation and assessment, or qualifications to be an independent agent, cannot be based on the cost of the resulting care plans.”

CMS says it “recognizes that the development of appropriate plans of care often requires the inclusion of individuals with expertise in the provision of long term services and supports or the delivery of acute care medical services...this is not intended to prevent providers from participating in these functions, but to ensure that an independent agent retains the final responsibility for the evaluation, assessment, and plan of care functions.”

If Massachusetts decides it wants to pursue this additional federal financing for long term supports, it will have to embrace this conflict-free care management concept.