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Al Norman, Editor

Elder Groups to Gov: Stop Cuts to Home Care

Six elderly groups sent a joint letter to Governor **Charles Baker** asking him not to cut elderly home care funds any further in the current fiscal year. Excerpts from their letter are shown below:

Dear Governor Baker,

We are writing to urge you not to impose further 9c cuts to elderly home care.

On October 19, 2014, Governor **Deval Patrick** made a total of $2.37 million in 9c cuts to Elder Affairs line items, including $1.52 million to home care services. Protective services, congregate housing and meals programs were also cut.

In October of 2008, Governor Patrick chose to make a total of $15.511 million in 9c cuts to the Executive Office of Elder Affairs (ELD) line items (9110 accounts). The accounts lost 5.3% in overall funding. The impact of these cuts are still felt today in the ELD accounts, seven budget years later.

Among the programs hardest hit were the home care purchased services item, and home care case management, which lost $6.77 million. The home care line items never recovered from the 9C cuts of FY 2009. Funding in FY 2015 is roughly where it stood—or lower--than eight budgets ago in FY 2007.

Previous 9c cuts have not only affected the 28,200 elders in this program, it has resulted in lower CHIA rates for this program, since Chapter 257 rates are based largely on restrained historic levels of funding. It has also pushed up caseloads to over 100 per worker at some agencies, and depressed salary levels.

At the same time, the home care accounts have had a significant positive financial impact on the state's bottom line by reducing spending in nursing facility appropriations. Home and community based services have dramatically changed nursing facility use by MassHealth.

Between FY 2000 and FY 2014, the number of nursing home patient days paid for by MassHealth fell by 4,500,000 days (-34.4%). In FY 15, the median cost of a MassHealth SNF patient day is $189.64. The costs avoided from 4.5 million fewer patient days is $853.38 million. This "home care dividend" is a smart investment, which provides the state with an immediate ROI. When we keep an elder out of a MassHealth nursing facility bed today, that same day we provide them with care in the community for less than half the cost. Home care spending also attracts more federal FFP bonuses from CMS.

For all the above reasons, we ask you not to impose further 9c cuts to the home care accounts. Our elderly clients have already paid a significant price for 9c cuts over the past seven years.

Yours,

Al Norman, Mass Home Care
Michael E. Festa, AARP Massachusettts
David Stevens, Mass Councils on Aging
Carolyn Villers, Mass Senior Action Council
Chet Jakubiak, Mass. Assoc. Of Older Americans
Lisa Gurgone, Home Care Aide Council of Mass.

State Drops Controversial Assisted Living Limit Regulation

On January 5, 2015, the Executive Office of Elder Affairs filed final regulations with the Secretary of State governing Assisted Living Residences (ALRs). The proposed regulations had drawn fire from ALR groups, and from Mass Home Care.

In testimony submitted to EOEA on December 15, 2014, Mass Home Care pointed out that the ALR state law is internally inconsistent. One the one hand, the law says: "Every resident of an assisted living residence shall have the right to: Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community." It also gives residents the right to "Directly engage or contract with any licensed health care professionals and providers to obtain necessary health care services, in the resident's unit or in such other space in the assisted living residence as may be made available to residents for such purposes to the same extent available to persons residing in private homes."

Christopher Heights, Marlborough

But the same ALR law also says that "No assisted living residence shall admit any resident who requires twenty-four hour skilled nursing supervision. No assisted living residence shall provide, or admit or retain any resident in need of skilled nursing care unless all of the following are the case: The care will be provided by a home health agency certified under Title XVIII of the Social Security Act…or an entity licensed under chapter one hundred and eleven, on a part-time, intermittent basis for not more than a total of ninety days in any twelve-month period, or by a licensed hospice." State law further limits ALR residents to those for whom "the skilled nursing care is provided is suffering from a short-term illness," which is defined as "either a medical condition for which recovery can be expected to occur with not more than ninety consecutive days of skilled nursing care or a medical condition requiring skilled nursing care on a periodic, scheduled basis."

Mass Home Care testified that the ALR law "creates a favorable status for potential residents based

on whether their illness is short or long—episodic or chronic---forcing applicants with long term chronic conditions to be referred to more segregated settings---like a nursing facility---and denying them their protected rights under section 9(a) of the same ALR statute to the "highest possible level of independence, autonomy, and interaction within the community."

The group Leading Age Massachusetts says it has been told by EOEA that "the final regulations will not include language prohibiting an ALR from admitting or retaining individuals that require more than 90 consecutive days of skilled nursing care." This vindicates Mass Home Care's position, but the fact remains that the law itself, Chapter 19D, still has conflicting language that requires ALRs to reject applicants who needs 24 hour nursing supervision, or has a long-term illness. Until the law is changed, the regulatory changes remain clouded. The regulations now do not implement the statute.

Federal Court Overturns Overtime For Home Care

A U.S. District Court in Washington, D.C. ruled on January 14th in favor of the Home Care Association of America in its litigation against the U.S. Department of Labor and its so-called "companionship rule" for the 1974 amendments to the Fair Labor Standards Act. The decision will have a major impact on the pay of many home care workers.

In September of 2013, DOL issued a final rule that limited use of the "companionship exemption," which said that workers considered to be "companions" did not have to be paid overtime wages. DOL's latest amendment narrowed the exemption, and would have required more workers to be paid the added benefits. The new rule proposed by DOL would have limited the use of the companionship exemption to direct care workers not employed by home care agencies and other third parties. Family members and workers whose services are contracted for directly by the person served remain not subject to minimum wage and overtime requirements of the Fair Labor Standards Act. The rule both narrowed the definition of companionship services, which are exempt from the minimum wage and overtime requirements under the Fair Labor Standards Act (FLSA), and prohibited third-party employers from claiming the companionship exemption.

But where a worker has a "joint employer" like the state, as in the Personal Care Attendant program, PCAs would have to be paid time and a half for hours worked above 40 hours per week. The final rule also clarified that direct care workers who perform medically-related services for which training is typically a prerequisite are not companionship workers and therefore are entitled to the minimum wage and overtime. Individual workers who are employed only by the person receiving services or that person's family or household and engaged primarily in fellowship and protection (providing company, visiting or engaging in hobbies) and care incidental to such activities, will still be considered exempt from the FLSA's minimum wage and overtime protections.

When DOL released its new regulations in 2013, the agency said: "Fulfilling a promise by President Obama to ensure that direct care workers receive a fair day's pay for a fair day's work, the U.S. Department of Labor announced a final rule today extending the Fair Labor Standards Act's minimum wage and overtime protections to most of the nation's workers who provide essential home care assistance to elderly people and people with illnesses, injuries or disabilities. This change will result in nearly two million direct care workers

— such as home health aides, personal care aides and certified nursing assistants — receiving the same basic protections already provided to most U.S. workers."

The DOL announced in October of 2014 that it would not bring enforcement actions against employers for violations during the first six months after the effective date.

Before the rules took effect, the Home Care Association of America sued the DOL, and the United States District Court for the District of Columbia vacated the minimum wage and overtime provisions of the regulation, noting that for more than 40 years, "Congress has exempted third-party providers of home care services from having to pay either minimum or overtime wages to their employees who provide domestic companionship services to seniors and individuals with disabilities, or to pay overtime wages to live-in domestic service employees."

According to the court's 13 page decision, Congress was concerned with the services being provided, not whether the wages were paid by a third-party provider or by the individual or family needing assistance. The court also pointed out that Congress made several recent attempts to change the exemption, and noted that the DOL issued its regulation only after those bills failed to advance, finding this a "thinly-veiled effort to do through regulation what could not be done through legislation."

Advocates for the disabled praised the decision because they said disability rights groups were not consulted by DOL, and that the new rules would have resulted in hours being cut, because Congress did not authorize the additional funding need to pay time and a half for overtime.

The disability rights group ADAPT, issued a statement shortly after the hearing applauded the court's decision. "This decision ensures that people with disabilities will not lose their attendants due to an unfunded mandate," ADAPT said. "The Department of Labor (DOL) developed this rule without adequate involvement of the Disability Community which was concerned that without additional Medicaid funding, attendants would lose income that is vital to their lives and individuals with disabilities would be forced into institutions. Instead of addressing these serious concerns, DOL implemented the rule over our objections and even refused to extend the effective date to give states sufficient time to fund these changes in their Medicaid programs."

The Department of Labor could appeal this ruling, but ADAPT hopes they will first address "the serious unintended consequences" for attendants and attendant service users." ADAPT said it "stands ready" to work with organized labor and worker groups to fight for improvements in attendant wages and benefits "in a manner that doesn't sacrifice the rights and freedom of people with disabilities."

"While the Department of Labor's concerns about the wages of home care workers is understandable," Judge **Richard Leon** wrote, "Congress is the appropriate forum in which to debate and weigh the competing financial interests in this very complex issue affecting so many families."

Boston Mayor Asks For Affordable Elder Housing

On January 13th, Boston Mayor **Martin J. Walsh** delivered his first State of the City Address. In his speech, he made special mention of the housing needs of the elderly in Boston, and a plan to lower their utility costs.

"I recognize that our success brings challenges," the Mayor said. "Demand for housing in Boston is at a historic high: putting prices and rents out of reach for too many. So we're acting now to meet this need. Guided by the groundbreaking new Housing Plan we unveiled in October:
-We're making $20 million available for affordable housing.
-We're marking out transit corridors in South Boston and Jamaica Plain to create housing for middle-income families where it is needed most.
-After getting the first-ever census of off-campus student housing, we're asking our universities to build more dorms…

I can announce tonight that we are preparing 250 city-owned parcels to create homes for low- and middle-income families. And we're asking the State Legislature to help by passing two bills: one that creates tax incentives for middle-income housing; and another that requires the Affordable Housing Trust Fund to create homes for our low-income seniors.

As a son whose mother lives in her own home: I know our seniors face special challenges making ends meet. Seniors at home right now in Mission Hill and in Mattapan are wondering if they'll have to choose this month between utilities and medications. Starting today, the Boston Water & Sewer Commission will boost the water discount for all senior and disabled homeowners to 30%. And I've asked all the utilities to follow suit.

Nothing is more important to me than protecting our most vulnerable neighbors, whether the addicted or the homeless, our children or our seniors. I will always move swiftly to keep them safe. But that urgency has to be sustained: through the hard work it takes to turn a life around; and build lasting solutions. This isn't just policy to me. It's Personal.

Court Forces State To Finish Human Services Rate Setting

Timing is everything. On January 12, 2015 Massachusetts Superior Court Judge **Mitchell Kaplan** issued a final order in a legal complaint brought against the Secretary of the Executive Office of Health and Human Services, **John Polanowicz**, for "failure to establish program rates by the dates directed [and] failure to pay these providers for services provided at such properly and timely established rates."

Judge Kaplan ruled that the state had, in fact, failed to meet the chronology for setting rates under a 2008 state law known as Chapter 257---and that EOHHS had to fully implement human services rates by July 1, 2015. In his decision, the Judge acknowledged that EOHHS "admitted it had not promulagated all new rates by January 1, 2014. "There was a clearly stated duty to set rates for social services providers by a date certain," the court ruled, "and the Secretary has failed to complete that task."

Former EOHHS Sec. John Polanowicz

The decision followed a complaint filed against the Secretary by a coalition of 4 human services groups called "The Collaborative," which included the Association for Behavioral Healthcare, the Association of Developmental Disabilities Providers and the Massachusetts Council of Human Services Providers, and the Children's League of Massachusetts. The Collaborative charged that the Patrick administration had set new rates for only 68% of the contracted services and had failed to pay for $52.1 million of the rates set at the beginning of the year.

EOHHS, in its defense, tried to argue that the rates were "subject to appropriation" and the pressures of adequate funding." But the court disagreed. But Judge Kaplan said Chapter 257 does not

direct payment or bind the Legislature to make an appropriation, but rather specifies how new rates shall be set.

The plaintiffs also wanted the court to order the Secretary to retroactively set rates and pay for services already contracted for and provided at such rates. But Judge Kaplan said such a court ruling was beyond the bounds of this case.

"This is the outcome we were hoping for and expecting, and we look forward to working with the Baker administration to ensure the spirit of Chapter 257 is fulfilled," said **Vic DiGravio**, President/CEO of the Association for Behavioral Healthcare and a member of The Collaborative. "Judge Kaplan's ruling is great news not only for hundreds of nonprofit providers who have been waiting to be fairly reimbursed for the work they have been doing, but for hundreds of thousands of individuals and families who depend on human service providers for their safety and well-being." During a campaign forum in Faneuil Hall, gubernatorial candidate **Charles Baker** said, "I feel like 257 is the train that never gets to the station. I can promise you as governor it will be funded."

The Collaborative filed suit against the Patrick administration last summer after repeated delays in the implementation of the law. The Collaborative had agreed to two implementation delays in 2008 and 2011, but all rates were required to have been set by January 1, 2014 and implemented by July 1, 2014. "It was never our desire to have this be determined by the courts, but justice has been served and we're thrilled for our members," DiGravio said. "There are some rates that have not been reviewed since 1987, so this ruling is a lifeline for countless people and service providers who require these much-delayed funds for the delivery and receipt of quality services."

After the ruling, DiGravio told the *State House News*, "The Commonwealth has an obligation to set fair and adequate reimbursement rates in a transparent manner." But unfortunately, neither the complaint, nor the court's decision, addresses the core issue of whether the state sets rates that are, in fact, "fair and adequate." Under Chapter 257, the state is supposed to establish rates that are "reasonable and adequate to meet the costs which are incurred by efficiently and economically operated social services program providers." For several years since Ch. 257 came into effect, Mass Home Care has testified that its rates are neither reasonable, nor adequate, and that the state has no criteria to measure whether an agency is "efficiently or economically" operated.

Train # 257 that never gets to the station

"What the state does during rate-setting is look at historical spending levels, and add a small cost of living adjustment to that," explained Mass Home Care's Executive Director, **Al Norman**, who has testified often at rate setting hearings. "Historic spending is based on available appropriation at the time---not on what was 'reasonable or adequate.' As a result, past inequities are built into future rates, and the arbitrary process gets memorialized into future rates." Norman said Kaplan's ruling "did not touch the issue of reasonable and adequate rates—just the promulgation timeline for inadequate rates."

Mass Home Care said it did agree with one observation made by Judge Kaplan: "The decision of how much to pay for certain services is a political one."

Mass Sites Score Well In Federal Care Transtions Study

On January 2, 2015, the federal Centers for Medicare and Medicaid Services released its first evaluation report of an innovative new plan called the Community-based Care Transitions Program (CCTP) to lower hospital and emergency department visits. The CMS report opened the agency up

to nationwide criticism for its early evaluation of the program, which includes 3 sites in Massachusetts. CMS itself called the findings "interesting," but said they should be viewed as "suggestive rather than definitive."

The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program. There are 101 participating sites involved in the Community-based Care Transitions Program, but only 47 were included in the first evaluation.

Care transitions occur when a patient moves from one health care provider or setting to another. Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—are readmitted within 30 days, at a cost of over $26 billion every year. Hospitals have traditionally served as the focal point of efforts to reduce readmissions by focusing on those components that they are directly responsible for, including the quality of care during the hospitalization and the discharge planning process. But there are multiple factors that impact readmissions, and identifying the key drivers of readmissions for a hospital and its downstream providers is the first step towards implementing the appropriate interventions necessary for reducing readmissions.

According to CMS, the CCTP seeks to correct these deficiencies by encouraging a community to work together to improve quality, reduce cost, and improve patient experience. The CCTP, launched in February 2012, is scheduled to run for 5 years. Community-based organizations (CBOs) were awarded two-year agreements that may be extended annually based on performance. An innovative feature of the CCTP is that it uses a CBO to lead the project, not health care providers, and mandates a partnership approach to solving what has been seen in the past as a purely medical problem.

CBOs use care transition services to manage Medicare patients' transitions and improve their quality of care. Up to $300 million in total funding is available for 2011 through 2015. The CBOs are paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and of implementing systemic changes at the hospital level. CBOs are paid once per eligible discharge in a 180-day period for any given beneficiary.

In Massachusetts, there are currently 3 CCTP projects led by Mass Home Care member agencies: Elder Services of Merrimack Valley, Elder Services of Worcester Area, and Somerville Cambridge Elder Services. Mystic Valley Elder Services and Baypath Elder Services are also partners in CCTP projects.

The 67 page evaluation released this month by CMS admits that its findings only cover the 1st ten months of the project, and are "limited." CMS says: "Key findings of this early evaluation are limited but suggest direction for the more comprehensive evaluation activities that will be conducted over the next 4 years…While these results provide interesting preliminary information for the evaluation, there are a number of reasons why they should be viewed as suggestive rather than definitive." The agency also notes that "the 47 initial sites entered at three different time periods and had participated for differing numbers of months at the time this analysis was conducted, which would affect the likelihood of success in meeting the average monthly target enrollment measures and their success in performance

on both measures." CMS concludes that for the key outcome measure of 30-day hospital readmission rates, the CCTP "produced limited evidence of early effectiveness of the program, with a handful of hospitals achieving significant reductions in readmission rates when adjusting for internal and/or external comparison hospitals." But CMS adds this disclaimer: "however, these findings are based on a limited number of hospitals that were operational in the first full year of CCTP operation. No hospitals had a full year of program operation, and many of the first three cohorts had been operational for only a few months. In addition, the results reported are based on the early experience of only 47 CCTP sites and their hospital partners; an additional 54 CCTP sites entered the program in early 2013. Future analyses will be able to incorporate data on the all the CCTP sites."

When the CMS report was issued, several media outlets emphasized that "partial, early results" showed "only a small minority of community groups produced significant results" in reducing readmissions when compared with sites that weren't part of the CCTP program. The *Washington Post* quoted one health care consultant as saying: "It's really too early to tell. Can you really evaluate this when it's been such a short period of time?" The *Post* also quoted an HHS spokesman as saying: "This is really the first glance of the first two waves of the program. It's too early to determine whether this model is failing or not. We will have successes."

The National Association of Area Agencies on Aging (n4a), which represents many of the CBOs managing these sites, issued a press release saying that CBOs like Area Agencies on aging "are a key part of an important paradigm shift in the health care delivery model." N4a said the "rigid and resistant medical model of health care delivery" is beginning "to realize and respond to the fact that, once released from the hospital, the critical support for an individual's health and recovery happens at home and in communities." N4a lists a number of implementation challenges that local sites had to navigate: "an unforeseen and last-minute 40% cut in the program's budget from Congress; ill-defined readmissions and enrollment metrics; costly non-reimbursable program start-up costs averaging over $165,000 per site; lack-of buy-in and communications challenges with partner hospitals; unclear performance expectations; and an overly ambitious ramp-up time."

"Despite these challenges," N4a says, " many CCTP sites are experiencing successes in reducing readmissions and positively affecting patient lives." N4a points out that the CMS-defined measure of CCTP site success is largely based on a 20% all-cause reduction in hospital readmissions, a metric that has been expanded since the first sites were contracted. N4a conducted its own survey of CCTP sites in October of 2014 and reported that more than 95% of respondents indicated their programs were achieving positive results in reducing readmissions despite falling short of this benchmark. 93% of those sites falling short of the technical benchmark for success were still demonstrating cost savings to Medicare in many cases totaling millions of dollars."

N4a says that "CMS should invest in the start-up and full program costs; allow flexibility to ensure investments build infrastructure and support partnerships to reach patients where they want to be served; evaluate programs on responsive, not rigid, performance metrics that accommodate both lessons learned and reflect the time it takes to create an efficient and cost-effective system…failing to provide a balanced and comprehensive picture of CCTP challenges and successes undermines the very goal of CMS' Innovation Center."

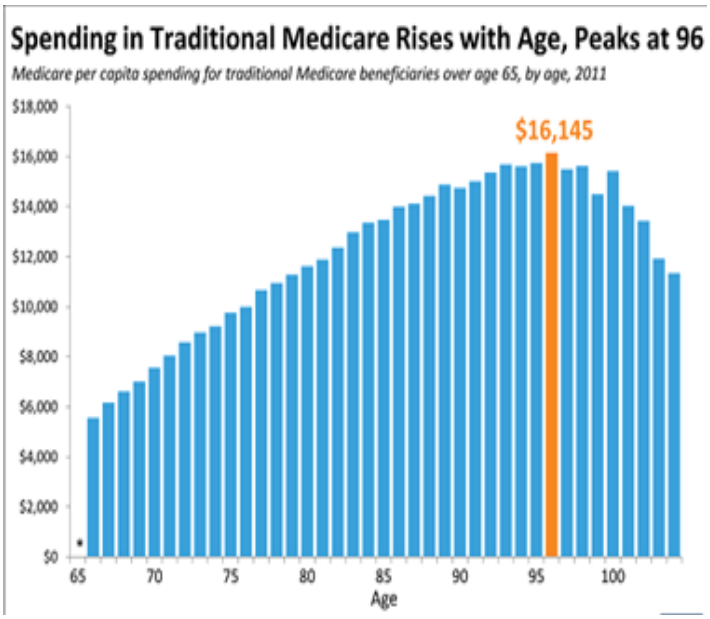
The 3 CCTP projects in Massachusetts have all performed well, as evidenced by the fact that CMS has renewed their contracts. The CCTP project led by Somerville Cambridge Elder Services, with partner Mystic Valley Elder Services as the CBO leads,

was singled out by CMS as one of 4 sites nationally that "had a significant reduction in readmission rates." The SCES/MVES project had the largest impact on readmission rates of any project in the nation, a -3.74% reduction in 30 day readmission rates.

These are very early findings, but Massachusetts ASAPs, with their experienced care management staff and long-standing connections in the community, are leading the way in the care transitions field.

The following hospital networks are part of the Massachusetts CCTP Projects: **Anna Jacques Hospital, Holy Family Hospital, Holy Family Hospital at Merrimack Valley, Lawrence General Hospital, Lowell General Main Campus and Saints Campus, UMass Memorial Healthcare System Hospitals, Tenet's MetroWest Medical Center and St. Vincent's Hospital, Cambridge Health Alliance, and the Hallmark Health System at Melrose Wakefield Hospital, and Lawrence Memorial Hospital.**

Patients With Chronic Conditions & Functional Needs Cost More



A new report called *The Rising Cost of Living Longer,* from the Kaiser Family Foundation takes a detailed look at per person Medicare spending by age and by service among the nearly 30 million people covered by traditional Medicare in 2011. The study concludes that as adults live into their 80s and beyond, they are more likely to live with multiple chronic conditions and functional limitations. This combination of chronic illnesses and functional deficits---compared to having just chronic conditions only--is associated with a greater likelihood of emergency department visits and inpatient hospitalizations as well as higher Medicare spending for inpatient hospital, skilled nursing facility, and home health services. "Thus," the report says, "it is not surprising that Medicare per capita spending is higher, on average, for older beneficiaries compared to those in their 60s and 70s. At the same time, the pattern of increasing per capita spending until beneficiaries are in their mid-90s raises questions as to whether beneficiaries are getting the appropriate mix of services as they age and whether more could be done to improve the management and delivery of medical care for aging Medicare beneficiaries." The study concludes that focusing on ways to improve the management and coordination of care for high-need, high-cost patients, many of whom are among Medicare's oldest beneficiaries, will be essential to meet the needs of an aging population.

This new research examines the relationship between Medicare per person spending and advancing age, providing new data to inform ongoing federal budget discussions and efforts to improve care for an aging population. Medicare beneficiaries age 80 and older account for a disproportionate share of Medicare spending and are expected to triple as a share of the 65+ population by 2050.

Key findings from the report include:

• Medicare per capita spending for seniors rises with age, as expected, but does not peak until age 96— more than doubling between the ages of 70 and 96, from $7,566 to $16,145 — before declining for the small number of beneficiaries living into their late 90s and beyond.

• The age at which Medicare per capita spending peaks has increased over time, rising from age 92 in 2000 to age 96 in 2011.

• The increase in spending by age is not entirely explained by end of life care; in fact, average Medicare spending per person for beneficiaries in traditional Medicare who died during 2011 declined with age, from about $43,000 among 70-year-olds to $20,000 among 100-year-olds.

• Spending on inpatient hospital care, the largest component of per capita Medicare costs, rises with

age and begins to decline only when beneficiaries reach their mid-to-late 90s. At the same time, skilled nursing facility and hospice per capita spending increases dramatically for beneficiaries in their late 80s and 90s.

Between 2010 and 2050, the United States population ages 65 and older will nearly double, the population ages 80 and older will nearly triple, and the number of nonagenarians and centenarians—people in their 90s and 100s—will quadruple. The aging of the population has important implications for future Medicare spending. The Kaiser study found that Medicare's octogenarians, nonagenarians, and centenarians account for a disproportionate share of Medicare spending. In 2011, beneficiaries ages 80 and older comprised 24 percent of the traditional Medicare population, but 33 percent of total Medicare spending on this population. In contrast, beneficiaries between the ages of 65 and 69 comprised 26 percent of the traditional Medicare population, but just 15 percent of total Medicare spending.

The amount of average Medicare per capita spending on many Medicare-covered services in 2011 generally increased with age for beneficiaries in their 70s and 80s and then began to decline for older beneficiaries; the main exceptions were skilled nursing facility (SNF) and home health per capita spending, which increased for beneficiaries in their 90s before declining, and hospice spending which generally increased with age through the 90s and beyond. In contrast, per capita Part D drug spending was roughly constant among beneficiaries in their 60s, 70s, 80s, and 90s

In 2011, Medicare per capita spending on hospital inpatient services increased more than 2.5 times from $1,848 among 66-year-olds to $4,799 among 89-year-olds before declining among older beneficiaries. While per capita inpatient spending peaks at age 89, spending on inpatient care is relatively similar for beneficiaries between the ages of 84 and 97 (plateauing at around $4,500 per beneficiary.)

Despite a gradual reduction in Medicare per capita spending for Part B providers, services, and supplies for beneficiaries beginning in their mid to late 80s, per capita spending continues to climb into the mid-90s due to persistent levels of inpatient hospital spending and a sharp rise in skilled nursing facility and hospice spending in the late 80s and 90s. Between ages 86 and 96, Medicare per capita spending on skilled nursing facility services increased by more 50 percent (from $2,043 to $3,149) while per capita spending on hospice tripled (from $706 to $2,299).

The relatively high per capita spending among beneficiaries in their mid-to late-90s in 2011 is influenced by skilled nursing facility (SNF), hospice, and (to a lesser extent) home health spending; excluding spending on these services, overall per capita spending peaks at age 89.

According to the Kaiser study, Medicare per person spending rises steadily with age, more than doubling between ages 70 and 95 in 2011, and peaking at age 96, before declining for the relatively small number of beneficiaries at relatively older ages. The cost of care for Medicare beneficiaries who died in 2011 contributes to higher average per capita Medicare costs at all ages, but does not alter the pattern of per capita spending nor does it affect the peak age of Medicare spending in 2011. And over time, Medicare per capita spending has peaked at older ages, from age 92 in 2000 to age 96 in 2011, based on inflation-adjusted dollars.

As noted earlier, when adults live into their 80s and beyond, they are more likely to live with multiple chronic conditions and functional limitations, and this combination (compared to having chronic conditions only) is associated with a greater likelihood of emergency department visits and inpatient hospitalizations as well as higher Medicare spending for inpatient hospital, skilled nursing facility, and home health services. Kaiser questions whether beneficiaries are getting the appropriate mix of services as they age and whether more could be done to improve the management and delivery of medical care for aging Medicare beneficiaries.

The Affordable Care Act (ACA) launched several payment and delivery system reforms that could alter patterns of care and spending for people on Medicare. Several of these initiatives aim to maintain or improve the quality of patient care and lower costs by reducing unnecessary care, managing care for high-need, "at risk" patients, and treating beneficiaries in the most appropriate (least cost) setting. The ACA also included provisions that aim to reduce unnecessary, preventable hospitalizations, better manage transitions follow-

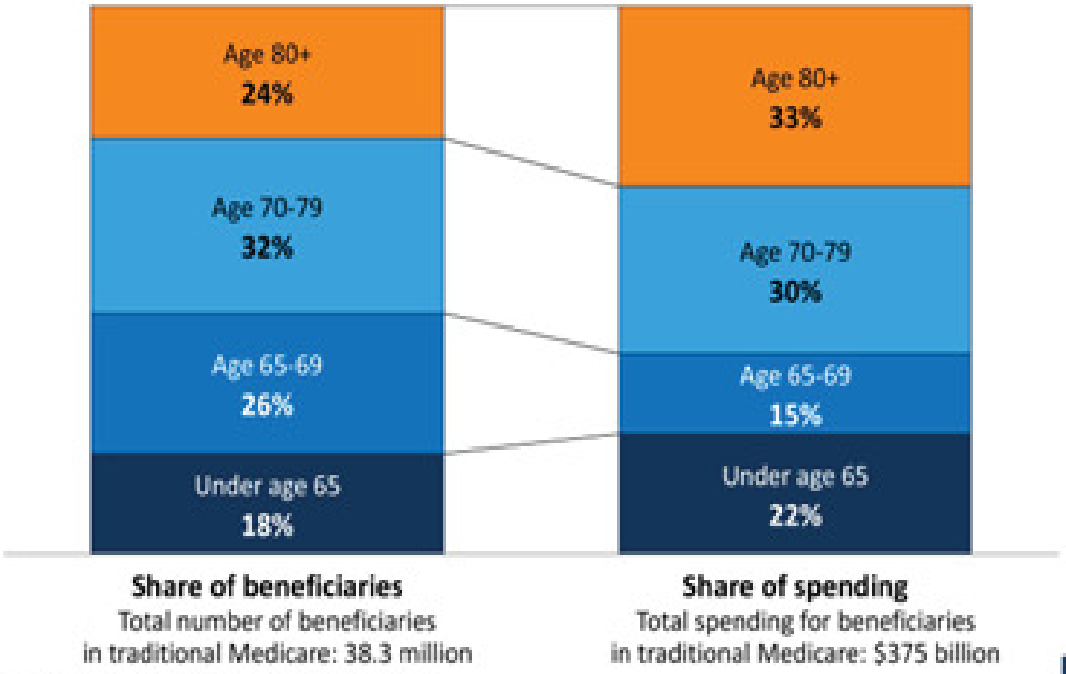
ing hospitalizations, and improve care management for beneficiaries who are dually eligible for Medicare and Medicaid. Recently, the Centers for Medicare & Medicaid Services (CMS) announced it would provide payments to physicians who manage care for beneficiaries with two or more chronic conditions. These efforts potentially could lower costs and improve care for Medicare patients, including the oldest old.

The analysis shows that patients, families, and providers may be opting for less intensive and less costly end-of-life interventions for beneficiaries as they grow older. This possibility is consistent with the finding that average per capita spending on hospice services among beneficiaries in traditional Medicare increases with age, due to both a larger share of beneficiaries electing hospice at older ages and higher per capita hospice costs for older than younger Medicare beneficiaries who elect hospice area. As the U.S. population ages, the increase in the number of people on Medicare and the aging of the Medicare population are expected to increase both total and per capita Medicare spending. The increase in per capita spending by age not only affects Medicare, but other payers as well. In fact, other studies have documented increases in both Medicaid and out-of-pocket spending by age, primarily attributable to the cost of long-term services and supports that are not covered by Medicare. Kaiser says further work is needed to better understand the social, medical, and long-term care needs of older Americans and how best to address those needs. Focusing on ways to improve the management and coordination of care for high-need, high-cost patients, many of whom are among Medicare's oldest beneficiaries, will be essential to meet the needs of an aging population.

Exhibit I.1

People ages 80 and older accounted for 24 percent of the Medicare population and 33 percent of Medicare spending in 2011

Distribution of traditional Medicare beneficiaries and Medicare spending, 2011



NOTE: Analysis excludes beneficiaries with Medicare Advantage.
SOURCE: Kaiser Family Foundation analysis of a 5 percent sample of Medicare claims from the Chronic Conditions Data Warehouse, 2011.