

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**COMMUNITY LIVING
ASSISTANCE SERVICES AND
SUPPORTS PROGRAM: 2011
REPORT TO CONGRESS**



Daniel R. Levinson
Inspector General

December 2011
OEI-04-11-00450

THE CLASS PROGRAM: 2011 REPORT TO CONGRESS

OEI-04-11-00450

CLASS PROGRAM STATUS

On October 14, 2011, the Secretary of Health and Human Services (HHS) informed Congress that HHS had not identified a Community Living Assistance Services and Supports (CLASS) program benefit plan that is both actuarially sound for the next 75 years and consistent with the requirements of Title VIII of the Patient Protection and Affordable Care Act of 2010 (the CLASS Act). Following this announcement, HHS suspended program implementation activities.

WHY WE DID THIS STUDY

Effective January 1, 2011, the CLASS Act established the CLASS program as a federally administered, voluntary insurance program to help working adults cover some costs of long-term-care services and supports. The CLASS Act requires the HHS Office of Inspector General (OIG) to submit an annual report to the Secretary and Congress on the overall progress of the CLASS program and the existence of waste, fraud, and abuse in the program. Each report must include findings in four areas: providing cash benefits; determining eligibility; providing quality assurance and protecting against waste, fraud, and abuse; and recouping unpaid and accrued benefits.

HOW WE DID THIS STUDY

We reviewed progress in the development of the CLASS program from March 23, 2010, when the CLASS Act was enacted, through October 14, 2011, when program activities were suspended. This review focuses primarily on the Administration on Aging's (AoA) activities in the four areas specified in the CLASS Act's OIG annual reporting requirement after January 2011, when AoA became responsible for developing the program. We obtained data about AoA's progress from interviews with AoA senior management, a questionnaire completed by AoA staff, and documents provided by AoA to support interview and questionnaire responses.

WHAT WE FOUND

AoA focused most of its efforts on developing at least three actuarially sound benefit plan alternatives, as required by the CLASS Act. The CLASS Act requires the Secretary to designate one of these benefit plan alternatives as the CLASS Independence Benefit Plan by October 1, 2012. As stated above, the Secretary informed Congress of the status of the benefit plan on October 14, 2011.

WHAT WE RECOMMEND

The Secretary has not designated a viable benefit plan. Therefore, we have no recommendations regarding program progress or the existence of waste, fraud, and abuse. OIG will determine the most appropriate way to meet OIG's CLASS Act reporting requirements in future years based on the program's status. AoA had no comments on the report.

TABLE OF CONTENTS

Objective	1
Status of the CLASS Program	1
Background	1
Methodology	12
Findings.....	14
I. Providing cash benefits.....	14
II. Determining eligibility	17
III. Providing quality assurance and protecting against waste, fraud, and abuse	18
IV. Recouping unpaid and accrued benefits.....	19
Conclusion	19
Agency Comments and Office of Inspector General Response.....	19
Appendixes	20
A: OIG Reporting Requirement in the CLASS Act.....	20
B: Agency Comments	21
Acknowledgments.....	22

OBJECTIVE

To report progress in the development of the Community Living Assistance Services and Supports (CLASS) program.

STATUS OF THE CLASS PROGRAM

On October 14, 2011, the Secretary of Health and Human Services (HHS) informed Congress that she does not see a viable path for implementing the CLASS program.¹ This decision was based on results presented in the HHS report on the actuarial, marketing, and legal analyses of the CLASS program.² Following this announcement, HHS suspended program implementation activities.³

Title VIII of the Patient Protection and Affordable Care Act of 2010 (the CLASS Act) requires the HHS Office of Inspector General (OIG) to submit an annual report to the Secretary and Congress on the overall progress of the CLASS program and the existence of waste, fraud, and abuse in the program. Each report must include findings in four areas: providing cash benefits; determining eligibility; providing quality assurance and protecting against waste, fraud, and abuse; and recouping unpaid and accrued benefits.⁴

This report describes the Administration on Aging's (AoA) activities prior to program suspension. OIG will determine the most appropriate way to meet OIG's CLASS Act reporting requirements in future years based on the program's status.

BACKGROUND

Effective January 1, 2011, the CLASS Act established the CLASS program as a federally administered, voluntary insurance program to help working adults cover some costs of their long-term-care (LTC) services and supports. LTC services assist primarily individuals with chronic illness or disabilities in their daily activities.⁵ Nearly 70 percent of

¹ Kathleen Sebelius, *Letter to Congress*, October 14, 2011. Accessed at <http://www.hhs.gov/secretary/letter10142011.html> on October 15, 2011.

² HHS, *A Report on the Actuarial, Marketing, and Legal Analyses of the CLASS Program*. Accessed at <http://aspe.hhs.gov/daltcp/reports/2011/class/index.pdf> on October 15, 2011.

³ Kathleen Sebelius, *HealthCare Blog: The CLASS Program*, October 14, 2011. Accessed at <http://www.healthcare.gov/blog/2011/10/class10142011.html> on October 18, 2011.

⁴ Public Health Service Act (PHSA) § 3209.

⁵ Centers for Medicare & Medicaid Services (CMS), *What is Long-Term Care?* Accessed at <http://www.medicare.gov/LongTermCare/Static/Home.asp> on October 4, 2011.

Americans over age 65 will require LTC services at some point in their life.⁶

The CLASS program is intended to allow working individuals age 18 and older to purchase insurance that can help pay for future LTC services if they meet all eligibility requirements, including having qualifying functional limitations.⁷ Individuals with qualifying functional limitations:

- are unable to perform at least two or three activities of daily living (ADLs) without substantial assistance,^{8, 9}
- require substantial supervision to protect against threats to their health and safety because of substantial cognitive impairment, or
- have a level of functional limitation that is determined under regulations prescribed by the Secretary to be similar to the levels described above.¹⁰

The purpose of the CLASS program is to:

- provide tools to allow individuals to maintain their personal and financial independence while living in the community,
- establish infrastructure to help address the Nation's community living assistance needs,
- alleviate burdens on family caregivers, and
- address the tendency to place individuals with functional limitations in institutional settings by providing a financial mechanism to support community living.¹¹

The CLASS program should increase access to in-home and community LTC services through a cash benefit that may enable eligible beneficiaries to avoid nursing homes and other more expensive care options for as long as possible. This may reduce reliance on Medicaid, which is jointly

⁶ Prudential Research Report, *Long-Term Care Cost Study*, 2010. Accessed at <http://www.hcbs.org/files/198/9879/LTCCostStudy.pdf> on September 6, 2011.

⁷ PHSA §§ 3201 and 3204(c) (describing individuals eligible to enroll); 3205(b) and 3202(6) (defining eligible beneficiary).

⁸ The CLASS Act states that the minimum number of ADLs may be two or three. The Secretary will determine the minimum number and define the term "substantial assistance." PHSA § 3203(a)(1)(C)(i).

⁹ ADLs include bathing, dressing, using the toilet, transferring (e.g., to or from a bed or chair), caring for incontinence, and eating. PHSA § 3202(3).

¹⁰ PHSA § 3203(a)(1)(C).

¹¹ PHSA § 3201.

financed by the Federal and State governments, to pay for LTC services.¹² The Congressional Budget Office (CBO) estimated that the CLASS program would result in \$2 billion in savings to the Medicaid program by 2019. This estimate was based on the assumption that the program would collect premiums in 2011 and pay benefits in 2016.¹³

Overview of LTC Services

LTC Services. LTC services include a variety of health and social services (e.g., assistive technology, meal delivery), but do not include medical treatments for acute and chronic conditions.^{14, 15} LTC services often involve nonskilled assistance with ADLs but can also involve skilled assistance (e.g., providing physical therapy or monitoring a serious illness). LTC services can be offered in institutional settings (e.g., nursing homes) or in the home by hired attendants (e.g., home health aides) or family members.¹⁶ LTC services are also provided in community settings (e.g., community centers offering adult day services).¹⁷

The annual costs of LTC services vary depending on the type and amount of care, the service provider, and the location. For example, care at home provided by a home health aide can cost \$21 an hour.¹⁸ The national median yearly rate for a room at an assisted living facility is

¹² The Federal Government paid 66 percent and State governments paid 34 percent of total Medicaid expenditures in 2009. National Health Policy Forum, *The Basics: Medicaid Financing*, February 4, 2011. Accessed at http://www.nhpf.org/library/the-basics/Basics_MedicaidFinancing_02-04-11.pdf on August 29, 2011.

¹³ This estimate was based on the assumption that 3.5 percent of the adult population would participate in the program. CBO, *Letter to the Honorable George Miller, Chairman of the Committee on Education and Labor*, November 25, 2009. Accessed at http://www.cbo.gov/ftpdocs/107xx/doc10769/CLASS_Additional_Information_Miller_letter.pdf on August 29, 2011.

¹⁴ National Clearinghouse for Long-Term Care Information, *Definitions & Need for LTC*. Accessed at http://www.longtermcare.gov/LTC/Main_Site/Understanding/Definition/Index.aspx on October 4, 2011.

¹⁵ Assistive technology is any product or equipment used to increase, maintain, or improve the functional capabilities of individuals with disabilities. National Institutes of Standards and Technology, *What is Assistive Technology?* Accessed at http://standards.gov/standards_gov/assistiveTechnology.cfm on August 5, 2011.

¹⁶ Home health aides provide nonmedical care in the home for individuals who need assistance with ADLs and supervision for individuals with cognitive impairments. They may be licensed but do not provide medical care. Bureau of Labor Statistics, *Home Health Aides and Personal and Home Care Aides*. Accessed at <http://www.bls.gov/oco/ocos326.htm> on October 3, 2011.

¹⁷ Adult day services are structured, comprehensive programs provided for less than 24 hours at a community-based center to care for functionally impaired adults. National Clearinghouse for Long-Term Care Information, *Glossary*. Accessed at http://www.longtermcare.gov/ltc/Main_Site/Site_Uutilities/Glossary.aspx#l on October 4, 2011.

¹⁸ National Clearinghouse for Long-Term Care Information, *Costs of Care*. Accessed at http://www.longtermcare.gov/LTC/Main_Site/Paying/Costs/Index.aspx on September 30, 2011.

approximately \$39,000.¹⁹ The national median rate for a semiprivate room in a nursing home or skilled nursing facility is approximately \$70,000 a year.²⁰

Medicare Pays for Limited LTC Services. Four out of five Americans incorrectly believe that Medicare provides extensive coverage for LTC services.²¹ However, Medicare accounts for only 23 percent of total LTC spending.²² Medicare coverage of LTC services includes only select home health care services and limited time in a skilled nursing facility.^{23, 24} Medicare coverage of home health services is limited to individuals who require part-time skilled nursing care or certain skilled therapy services.²⁵ The home health benefit also includes services such as home health aide services and medical social services.²⁶

Medicare Part A pays in full for up to 20 days in a skilled nursing facility directly following a 3-day hospital stay.²⁷ Beneficiaries must pay coinsurance for days 21–100.²⁸ Medicare does not cover care in skilled nursing facilities after 100 days.²⁹

¹⁹ Assisted living facilities provide personal and medical care for those who are not able to live by themselves but do not require the constant care provided by nursing homes. This figure is based on a one-bedroom, single-occupancy rate. Genworth Financial, *Executive Summary: Genworth 2011 Cost of Care Survey*. Accessed at http://www.genworth.com/content/etc/medialib/genworth_v2/pdf/ltc_cost_of_care.Par.85518.File.dat/Executive%20Summary_gnw.pdf on August 4, 2011.

²⁰ Nursing homes and skilled nursing facilities provide skilled nursing care 24 hours a day. Ibid.

²¹ Kathy Greenlee, *Statement before the House Committee on Energy and Commerce Subcommittee on Health*, March 17, 2011. Accessed at <http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/031711/Greenlee.pdf> on August 5, 2011.

²² For this calculation, total LTC spending includes spending on nursing home and home health services. It does not include community-based services, which are financed primarily through Medicaid home- and community-based waivers. Kaiser Commission on Medicaid Facts, *Medicaid and Long-Term Care Services and Supports*, February 2009. Accessed at http://www.kff.org/medicaid/upload/2186_06.pdf on August 5, 2011.

²³ Home health care is a range of skilled and unskilled health care services provided in the home. CMS, *What is Home Health Care?* Accessed at <http://www.medicare.gov/homehealthcompare/About/GettingCare/WhatIsHomeHealthCare.aspx> on September 6, 2011.

²⁴ CMS, *Medicare Benefit Policy Manual*. Pub. No. 100-02, ch. 7, §10.1. Accessed at <https://www.cms.gov/manuals/downloads/bp102c07.pdf> on September 30, 2011. Social Security Act §§ 1812(a)(2)(A).

²⁵ 42 CFR § 409.42(c).

²⁶ 42 CFR § 409.45.

²⁷ 42 CFR § 409.61(b). CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 8, § 20.1.

²⁸ 42 CFR § 409.61(b). The Medicare Part A beneficiary copayment is \$141.50 per day for days 21–100 in a skilled nursing facility. HHS, *Medicare Premiums and Coinsurance Rates for 2011*. Accessed at https://questions.medicare.gov/app/answers/detail/a_id/2305/~medicare-premiums-and-coinsurance-rates-for-2011 on August 29, 2011.

²⁹ Social Security Act §§ 1812(a)(2)(A).

Medicare also does not pay for assisted living facilities, retirement communities, or adult day services. Additionally, the Medicare home health benefit does not cover transportation services or services with the sole purpose of enabling an individual to continue living at home.³⁰

Medicaid Pays for 40 Percent of All LTC Services. In 2009, Medicaid spent \$111.2 billion on LTC services, and this spending is expected to increase as the U.S. population ages.³¹ Medicaid accounts for 40 percent of total LTC spending.³²

Medicaid coverage of LTC services varies by State. Medicaid pays for care in nursing facilities if recipients meet financial and functional eligibility requirements.³³ However, many Americans must first exhaust their resources to qualify financially for Medicaid LTC coverage.³⁴ Medicaid covers adult day services in some States. Generally, Medicaid coverage of home health services includes nursing; home health aides; and medical equipment, supplies, and appliances used in the home.³⁵ Medicaid may also pay for some home modifications.³⁶

Medicaid waiver programs cover some care-related costs in assisted living facilities in some States but do not cover room and board.

Few People Have Private LTC Insurance. Only 8 to 10 percent of Americans have private LTC insurance coverage.³⁷ Private insurance accounts for 9 percent of total LTC spending.³⁸ Age or health status can affect the cost of private LTC insurance policies, which often require medical underwriting or a review of an applicant's health status to

³⁰ CMS, *Medicare Benefit Policy Manual*. Pub. No. 100-02, ch. 7 §§ 80.2 and 80.4. Accessed at <https://www.cms.gov/manuals/downloads/bp102c07.pdf> on September 30, 2011.

³¹ Greenlee, op. cit.

³² For this calculation, total LTC spending includes only spending on nursing home and home health services. It does not include spending on community-based services, which are financed primarily through Medicaid home- and community-based waivers. Kaiser Commission on Medicaid Facts, op. cit.

³³ Financial and functional eligibility requirements vary by State. For individuals enrolled in Medicaid and Medicare, Medicaid pays for nursing facilities after Medicare coverage is exhausted. HHS, *Understanding Medicaid Home and Community Services: A Primer*. Accessed at <http://aspe.hhs.gov/daltcp/reports/primer.pdf> on August 25, 2011.

³⁴ National Clearinghouse for Long-Term Care Information, *Who Pays for LTC Services?* Accessed at http://www.longtermcare.gov/LTC/Main_Site/Paying/Costs/Who_Pays.aspx on August 5, 2011.

³⁵ 42 CFR §§ 440.70(b) and 440.180(b).

³⁶ Social Security Act § 915(c) and CMS, *HCBS Waivers Section 915(c)*. Accessed at [https://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915\(c\).asp](https://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp) on October 5, 2011.

³⁷ Greenlee, op. cit.

³⁸ For this calculation, total LTC spending only includes spending on nursing home and home health services. It does not include spending on community-based services, which are financed primarily through Medicaid home- and community-based waivers. Kaiser Commission on Medicaid Facts, op. cit.

determine whether he or she is eligible for coverage.³⁹ Private insurance companies use this process to exclude or set higher premiums for individuals at the highest risk of needing future LTC services, making it difficult for individuals with certain preexisting medical conditions to purchase such policies.

CLASS Program Structure

The CLASS Act tasks the Secretary with developing, overseeing, and administering the CLASS program. On January 28, 2011, the Assistant Secretary for Aging established a CLASS Office responsible for developing, overseeing, and administering the CLASS program.⁴⁰

The CLASS Office is to coordinate with other Federal departments and agencies (e.g., the Department of the Treasury, the Social Security Administration, ASPE) to develop and implement the CLASS program.⁴¹ To implement the program, AoA must determine details about enrollment; the benefit plan; premiums; cash and service benefits; funding; and protections from waste, fraud, and abuse.

Enrollment. Actively employed individuals age 18 and older who earn wages or income taxable under the Old-Age, Survivors, and Disability Insurance Program or the Railroad Retirement Tax Act are eligible to enroll in the CLASS program.⁴² The CLASS Act describes two processes for enrollment: (1) a process for participating employers to automatically enroll eligible employees and withhold CLASS premiums through payroll deductions; and (2) an alternative process for individuals who are self-employed, have more than one employer, or have an employer that does not participate in automatic enrollment.^{43, 44} Individuals must have the option to waive enrollment at any time.⁴⁵

The CLASS Act prohibits medical underwriting of enrollees, allowing individuals with preexisting medical conditions to participate.⁴⁶

³⁹ HHS, *Glossary*. Accessed at <http://www.healthcare.gov/glossary/M/medicalunderwriting.html> on October 5, 2011.

⁴⁰ 76 Fed. Reg. 5178 (Jan. 28, 2011).

⁴¹ Between the enactment of the CLASS Act in March 2010 and January 2011, HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE) led the work on CLASS.

⁴² PHSA § 3204(c)(1)–(3). “Actively employed” is defined at PHSA Sec. 3202(2). Certain individuals (e.g., prison inmates and Medicaid recipients who are patients in a hospital or nursing facility) are prohibited from enrolling in the CLASS program. PHSA Sec. 3204(c)(4).

⁴³ PHSA §§ 3204(a)(1) and (e)(1).

⁴⁴ PHSA § 3204(a)(2).

⁴⁵ PHSA § 3204(b).

⁴⁶ PHSA § 3203(b)(3).

The Benefit Plan. AoA must develop at least three actuarially sound benefit plan alternatives.⁴⁷ Each alternative must include details about premiums, benefit amounts, benefit eligibility, and access to advocacy services and advice and counseling.⁴⁸

The CLASS Act established the CLASS Independence Advisory Council.⁴⁹ The council must evaluate the benefit plan alternatives and recommend to the Secretary the plan that “best balances price and benefits to meet enrollees’ needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the program.”⁵⁰ The President appoints members of the council. Upon receiving the council’s recommendation, the Secretary must designate one actuarially sound benefit plan to serve as the CLASS Independence Benefit Plan by October 1, 2012.⁵¹

Premiums. Premiums must be based on an actuarial analysis of the 75-year costs of the program and must ensure program solvency in this period.⁵² The CLASS Act requires that the monthly premium at enrollment generally not change as long as the individual is an active enrollee (i.e., is enrolled in the CLASS program and has paid premiums to maintain enrollment).^{53, 54}

The CLASS Act establishes a monthly premium of \$5 for actively employed full-time students under the age of 22 and individuals with incomes that do not exceed the Federal poverty line.⁵⁵ The CLASS Act allows the Secretary to increase premiums if required to maintain program solvency.⁵⁶ However, those premium increases do not apply to active enrollees who are 65 and older, have paid premiums for at least 20 years, and are not actively employed.⁵⁷

Benefit Eligibility. The CLASS Act requires the Secretary to establish an Eligibility Assessment System by January 1, 2012, to provide eligibility

⁴⁷ PHSA § 3203(a)(1).

⁴⁸ Ibid.

⁴⁹ PHSA § 3207(a).

⁵⁰ PHSA § 3203(a)(2).

⁵¹ PHSA § 3203(a)(3).

⁵² PHSA § 3203(a)(1)(A)(i).

⁵³ PHSA § 3203(b)(1)(A).

⁵⁴ PHSA § 3202(1).

⁵⁵ PHSA § 3203(a)(1)(A)(ii)(I). The \$5 premium will be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) each year after 2009. PHSA § 3203(a)(1)(A)(ii)(II).

⁵⁶ PHSA § 3203(b)(1)(B)(i). However, the Secretary must maintain a nominal premium.

⁵⁷ PHSA § 3203(b)(1)(B)(ii).

assessments of active enrollees applying for benefits.⁵⁸ AoA is responsible for assisting the Secretary in meeting this requirement.

AoA must develop processes to determine benefit eligibility, to appeal benefit eligibility denials, and to redetermine benefit eligibility. Benefit eligibility determination and redetermination processes must include certification by a licensed health care practitioner.⁵⁹

AoA must determine the intervals at which eligible beneficiaries are required to submit medical evidence to recertify their eligibility and to submit records of benefit expenditures.⁶⁰

To become an eligible beneficiary, an active enrollee must have:

- paid CLASS premiums for at least 60 months;⁶¹
- paid CLASS premiums for at least 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred;⁶²
- met certain minimum earning requirements for a specified time during the period he/she is enrolled in the CLASS program;⁶³ and
- been determined to have a qualifying functional limitation, as certified by a licensed health care practitioner, that is expected to last more than 90 consecutive days.⁶⁴

Cash Benefits. The CLASS Act requires a cash benefit averaging at least \$50 per day. That amount varies by benefit levels, which are based on a scale of functional ability.⁶⁵ Eligible beneficiaries may use the cash benefit to pay for various nonmedical services and supports needed to maintain independence, including:

- home modifications,
- assistive technology,
- accessible transportation,
- home care aides, and

⁵⁸ PHSA § 3205(a)(2)(A)(i).

⁵⁹ PHSA § 3205(a)(2)(B).

⁶⁰ PHSA § 3205(c)(6).

⁶¹ PHSA § 3202(6)(A)(i).

⁶² PHSA § 3202(6)(A)(iii).

⁶³ PHSA § 3202(6)(A)(ii). An eligible beneficiary must have earned at least enough money to earn a credit toward eligibility for future Social Security benefits (under section 213(d) of the Social Security Act) for at least 3 calendar years of the first 60 months for which the individual has paid premiums. The Commissioner of Social Security sets this amount each year. The law does not establish maximum earnings requirements.

⁶⁴ PHSA §§ 3202(6)(B) and 3203(a)(1)(C).

⁶⁵ PHSA § 3203(a)(1)(D). There must be at least two, and no more than six, benefit levels. PHSA § 3203(a)(1)(D)(ii).

- personal assistance services.⁶⁶

The CLASS Act also allows eligible beneficiaries to use the cash benefit to obtain decisionmaking assistance concerning medical care (e.g., forming advance directives and accepting or receiving medical treatment).^{67, 68}

Cash benefits must be paid into each eligible beneficiary's account, referred to as the Life Independence Account, on a daily or weekly basis.^{69, 70} AoA must establish procedures to credit beneficiaries' Life Independence Accounts and to allow them to access their accounts using debit cards.⁷¹ AoA must also develop procedures to allow an eligible beneficiary's authorized representatives to access his or her Life Independence Account.⁷²

Beneficiaries can defer daily or weekly benefits and receive a lump-sum payment. Deferred benefits may roll over from month to month but not from year to year.⁷³ AoA, in conjunction with the Secretary of the Treasury, must recoup any accrued benefits if a beneficiary dies or fails to collect deferred payments after 12 months.⁷⁴ All recouped benefits must be returned to the CLASS Independence Fund.⁷⁵

The CLASS Act includes special provisions for providing cash benefits to eligible beneficiaries enrolled in Medicaid (Medicaid beneficiaries). Medicaid beneficiaries in an institutional setting (i.e., a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental diseases) retain 5 percent of their cash benefit while 95 percent must be applied to the facility's cost of providing the beneficiary's care.⁷⁶ In some States, Medicaid beneficiaries receiving home- and community-based services or Program of All-Inclusive Care for the Elderly services

⁶⁶ PHSA § 3205(c)(1)(B).

⁶⁷ PHSA § 3205(c)(1)(B).

⁶⁸ Advance directives are written instructions regarding health care decisions to be used if an individual is no longer able to make these decisions. HHS, *Literature Review on Advance Directives*, June 2007. Accessed at <http://aspe.hhs.gov/daltcp/reports/2007/advdir/r.htm#term> on August 31, 2011.

⁶⁹ PHSA § 3205(c)(1)(A).

⁷⁰ PHSA § 3203(a)(1)(D)(iii).

⁷¹ PHSA § 3205(c)(1)(C)(i) and (ii).

⁷² PHSA § 3205(c)(2)(A).

⁷³ PHSA § 3205(c)(4)(A) and (B).

⁷⁴ PHSA § 3205(c)(5)(C)(i).

⁷⁵ PHSA § 3205(c)(5)(C)(ii).

⁷⁶ PHSA § 3205(c)(1)(D)(i).

retain 50 percent of their cash benefit.⁷⁷ The remaining 50 percent must be applied to the State's cost of providing assistance.⁷⁸

Advocacy Services and Advice and Counseling Services. Advocacy services and advice and counseling services are included in the program's administrative costs.⁷⁹

Eligible beneficiaries must be assigned, as needed, an advocacy counselor under an agreement with their State Protection and Advocacy System to provide:

- information regarding how to access the appeals process established for the program,
- assistance with the benefit eligibility recertification process, and
- other assistance with obtaining services the Secretary will require by regulation.^{80, 81}

Upon their request, eligible beneficiaries must be assigned an advice and assistance counselor to provide information about:

- accessing and coordinating LTC services and supports in the most integrated setting,
- possible eligibility for other benefits and services,
- developing a service and support plan,
- available assistance with decisionmaking concerning medical care, including the right to accept or refuse medical or surgical treatment and to formulate advance directives or other written instructions recognized by State law (e.g., a living will or a durable power of attorney for health care),

⁷⁷ PHSA § 3205(c)(1)(D)(ii)(I) and (iii)(I).

⁷⁸ PHSA § 3205(c)(1)(D)(ii)(I) and (iii)(I). A State will be paid the remaining cash benefit for eligible beneficiaries receiving home- and community-based services only if: (1) the State does not waive the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) or of section 1902(a)(10)(B) of the Social Security Act (relating to comparability); and (2) the State offers, at a minimum, case management services, personal care services, habilitation services, and respite care. PHSA § 3205(c)(1)(D)(ii)(II).

⁷⁹ PHSA § 3205(b)(4).

⁸⁰ State Protection and Advocacy Systems empower, protect, and advocate on behalf of individuals with developmental disabilities. HHS, *State Protection and Advocacy Services*. Accessed at <http://www.acf.hhs.gov/programs/add/states/pnafactsheet.html> on September 7, 2011.

⁸¹ PHSA § 3205(d)(1).

- programs established and services offered under the Assistive Technology Act of 1998,⁸² and
- other services the Secretary may require by regulation.⁸³

Not later than January 1, 2012, the Secretary must enter into an agreement with each State's Protection and Advocacy System to provide advocacy services and with public and private entities to provide advice and assistance counseling.⁸⁴

Funding. All CLASS premiums must be transferred to a trust fund called the CLASS Independence Fund.⁸⁵ The Secretary of the Treasury is responsible for managing this fund, which must be invested and used to pay CLASS administrative expenses and cash benefits.⁸⁶ The CLASS Act prohibits the use of taxpayer funds to pay for cash benefits.⁸⁷

Providing Quality Assurance and Protecting Against Waste, Fraud, and Abuse. AoA must include provisions in the CLASS program to prevent fraud and abuse.⁸⁸ To protect against conflicts of interest, AoA must establish procedures to ensure that all entities that provide services (e.g., the Eligibility Assessment System, State Protection and Advocacy Systems, and advocacy counselors) to active enrollees and eligible beneficiaries:

- have operating procedures to minimize conflicts of interest between the entity and active enrollees or beneficiaries;
- provide information about all services and options available to active enrollees or beneficiaries, including services available through other entities;
- assist active enrollees or beneficiaries in accessing desired services, regardless of the provider;
- report the number of active enrollees and beneficiaries assisted by age, disability, and whether the active enrollees and beneficiaries received services from the entity or another entity;⁸⁹

⁸² The Assistive Technology Act of 1998 provides grants to States to address the assistive technology needs of individuals with disabilities. States have used grants to provide screen readers, computer programs, mechanical lifts, and other devices and services to individuals with disabilities. Association of Assistive Technology Act Programs, *State AT Programs*. Accessed at <http://www.ataporg.org/atap/projects.php> on August 5, 2011.

⁸³ PHSA § 3205(e).

⁸⁴ PHSA § 3205(a)(2)(A)(ii) and (iii).

⁸⁵ PHSA § 3204(f)(1).

⁸⁶ PHSA § 3206(a).

⁸⁷ PHSA § 3208(b).

⁸⁸ PHSA § 3208(c).

⁸⁹ PHSA does not indicate to whom, or how frequently, entities will report this information.

- provide active enrollees and beneficiaries with a list of available service providers that can meet their needs;⁹⁰
- provide services in the best interests of active enrollees or beneficiaries, if the entity provides counseling or planning services; and
- ensure that active enrollees or beneficiaries are informed of any financial interest the entity has in another service provider, if the entity provides counseling or planning services.⁹¹

AoA must also establish standards of conduct for authorized representatives of eligible beneficiaries. These standards must require that authorized representatives provide quality services, do not have conflicts of interest, and do not misuse benefit payments or otherwise engage in fraud or abuse.⁹²

METHODOLOGY

Scope

We reviewed progress in the development of the CLASS program from March 23, 2010, when the CLASS Act was enacted, through October 14, 2011, when program implementation was suspended.⁹³ This review focuses primarily on AoA's activities in the four areas specified in the CLASS Act's OIG annual reporting requirement after January 2011, when AoA became responsible for developing the program.

Data Sources

We obtained data about AoA's progress in developing the CLASS program from interviews with AoA senior management responsible for implementation. We interviewed the Chief Operating Officer of the CLASS Office, the special advisor to the Chief Operating Officer, and two other members of the CLASS Office. AoA also responded to a questionnaire and submitted documents to support its interview and questionnaire responses. The questionnaire asked AoA to describe its progress and challenges in developing the CLASS program. AoA staff collaborated to provide one response. It also provided internal documents (e.g., meeting agendas, a logistics contract) and public documents (e.g.,

⁹⁰ Entities that provide services to CLASS beneficiaries may include the Eligibility Assessment System, State Protection and Advocacy Systems, and advocacy counselors. PHSA § 3205(h).

⁹¹ PHSA § 3205(h).

⁹² PHSA § 3205(c)(2)(B).

⁹³ Prior to the establishment of the CLASS Office within AoA in January 2011, ASPE led the work on the CLASS program.

Federal Register notice soliciting nominations for the CLASS Independence Advisory Council) to demonstrate its progress.

Data Analysis

We analyzed information from interviews and AoA's responses to the questionnaire. We also analyzed the supporting documentation submitted by AoA. We used this information to describe the progress AoA reported in developing the CLASS program.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

On October 14, 2011, the Secretary informed Congress that, based on the results of the Department's analysis, she does not see a viable path for implementing the CLASS program.⁹⁴ Following this announcement, HHS suspended program implementation activities.⁹⁵

This report describes AoA's activities prior to suspension of program activities. OIG will determine the most appropriate way to meet OIG's CLASS Act reporting requirements in future years based on the program's status.

During our review period, AoA was in the early stages of planning and developing the CLASS program. Its priority was to develop benefit plan alternatives that would enable the program to be solvent for the required 75 years. AoA cannot implement the program if the Secretary does not designate a benefit plan. The Secretary is not required to designate a benefit plan until October 1, 2012. Before program activities were suspended, AoA did not expect to collect premiums until 2013 or pay benefits until 2018.

Consistent with the CLASS Act's OIG reporting requirements, our report describes AoA's activities in developing the program with respect to:

- I. providing cash benefits;
- II. determining eligibility;
- III. providing quality assurance and protecting against waste, fraud, and abuse; and
- IV. recouping unpaid and accrued benefits.

I. Providing cash benefits

To provide cash benefits, AoA must first develop at least three actuarially sound benefit plan alternatives to present to the CLASS Independence Advisory Council. The Secretary must designate one of the alternatives as the CLASS Independence Benefit Plan, which must include details about premiums, cash benefit amounts, benefit eligibility, and access to advocacy services and advice and counseling services. AoA must

⁹⁴ Kathleen Sebelius, *Letter to Congress*, October 14, 2011. Accessed at <http://www.hhs.gov/secretary/letter10142011.html> on October 15, 2011.

⁹⁵ Kathleen Sebelius, *HealthCare Blog: The CLASS Program*, October 14, 2011. Accessed at <http://www.healthcare.gov/blog/2011/10/class10142011.html> on October 18, 2011.

establish procedures for active enrollees to apply for benefits and procedures to pay benefits.

AoA focused on developing actuarially sound benefit plans

AoA made progress in attempting to develop at least three actuarially sound benefit plan alternatives.⁹⁶ Because program implementation depends on completing this requirement, AoA focused its efforts on developing alternatives for the CLASS Independence Benefit Plan. To develop benefit plans, AoA assessed program models, collaborated with other agencies and experts, and prepared for the appointment of the CLASS Independence Advisory Council.

AoA expected to provide cash benefits in 2018 at the earliest, pending the designation of a benefit plan by October 1, 2012.⁹⁷ However, HHS reported in October 2011 that it was unable to identify an actuarially sound benefit plan within the legal requirements of the CLASS Act.⁹⁸

AoA must complete the following requirements pertaining to providing cash benefits if the Secretary designates a benefit plan at a later time:

- establish procedures for active enrollees to apply for benefits,
- establish procedures for crediting beneficiaries' Life Independence Accounts and allowing beneficiaries to access accounts using a debit card,
- establish procedures for crediting institutions caring for Medicaid beneficiaries and States providing Medicaid coverage, and
- establish procedures for authorized representatives to access eligible beneficiaries' Life Independence Accounts.

AoA Developed and Assessed Program Models. AoA hired a Director of Actuarial Integrity and Benefit Design (i.e., Chief Actuary) in January 2011 to lead AoA in the actuarial modeling and market research activities necessary to develop actuarially sound benefit plan alternatives. In June 2011, the Chief Actuary developed a CLASS Enhancement Plan outlining the features that the program should include to be actuarially sound.

To develop actuarially sound benefit plan alternatives, AoA worked with ASPE to assess different program models based on a wide range of

⁹⁶ For a detailed analysis of the benefit plan alternatives, see HHS, *A Report on the Actuarial, Marketing, and Legal Analyses of the CLASS Program*. Accessed at <http://aspe.hhs.gov/daltcp/reports/2011/class/index.pdf> on October 15, 2011.

⁹⁷ AoA expected enrollment to begin in 2013 at the earliest. Enrollees must pay premiums for 60 months before they are eligible to receive benefits, making 2018 the earliest date for benefit payments.

⁹⁸ Kathleen Sebelius, *Letter to Congress*, October 14, 2011. Accessed at <http://www.hhs.gov/secretary/letter10142011.html> on October 15, 2011.

scenarios (e.g., various participation rates and rates of benefit claims) and alternative program features (e.g., various eligibility requirements, enrollment procedures, and premium levels). AoA worked with the HHS Office of the General Counsel to ensure that the program features under consideration met the requirements of the CLASS Act.

AoA worked to determine potential premiums by estimating enrollment rates, enrollment demographics, and the number of active enrollees who would collect benefits immediately following the required 5-year vesting period. AoA estimated the proportion of direct enrollees likely to become eligible for benefits.⁹⁹

Because the expected number of enrollees would affect the benefit plan, AoA considered potential marketing strategies for the program to maximize enrollment. A larger enrollment would reduce the risk of having a disproportionate number of unhealthy enrollees, which could result in higher benefit costs or cause the program to be actuarially unsound.

AoA Collaborated With Other Agencies and Experts. AoA worked with Federal actuaries and experts in the LTC insurance field to develop the CLASS program. AoA incorporated the information it gathered from meetings with experts and actuaries into ongoing benefit plan modeling efforts.

In June 2011, AoA hosted a technical expert meeting on the actuarial modeling of the benefit plan alternatives. This meeting included actuaries, economists, demographers, sociologists, ASPE staff, and AoA staff. The meeting addressed six major issues:

- characteristics of likely program enrollees,
- future LTC utilization by enrollees,
- reasonableness of key assumptions used in potential benefit plans (e.g., assumptions regarding interest rates, progression of disabilities, and morbidity),
- expected participation levels,
- alternative benefit plan designs to increase financial stability, and
- strategies to improve the program beyond changes to the benefit plan.

In June 2011, AoA held a meeting with actuaries from CMS, the Social Security Administration, and the Office of Personnel Management.

⁹⁹ Direct enrollees are individuals who enroll through the method designed for those who are self-employed, have more than one employer, or have an employer that does not participate in automatic enrollment. Because these individuals are not automatically enrolled and must opt into the program, AoA expects them to generally be less healthy than those who are automatically enrolled.

Participants discussed various benefit plan alternatives, actuarial models for the program, and the actuarial certification of the program.

AoA Prepared for the Appointment of the CLASS Independence Advisory Council. AoA is not directly responsible for establishing the CLASS Independence Advisory Council but worked with the Secretary to prepare for the council's appointment. The President is responsible for appointing members of the council. The Secretary signed a charter for the council on November 9, 2010. On November 16, 2010, AoA issued a Federal Register Notice soliciting nominees for the council by December 1, 2010, and sent the names to the White House.¹⁰⁰ AoA hired a logistics contractor in June 2011 to organize 2- to 3-day public meetings for council members to attend after their appointment.

II. Determining eligibility

The CLASS Act requires the Secretary to establish an Eligibility Assessment System by January 1, 2012, to provide eligibility assessments of active enrollees applying for benefits. AoA must establish procedures for determining benefit eligibility, appealing benefit eligibility denials, and redetermining benefit eligibility. AoA must also determine intervals at which beneficiaries must recertify their eligibility.

AoA examined legal issues related to establishing an Eligibility Assessment System

The CLASS Act requires the Secretary to establish an Eligibility Assessment System by January 1, 2012. However, the Secretary may wait until October 1, 2012, to designate a benefit plan. Because the benefit plan must contain details about benefit eligibility, AoA reported that establishing an Eligibility Assessment System should be contingent upon designating a benefit plan. Therefore, AoA worked with the HHS Office of the General Counsel on the legal issues surrounding this requirement. Because of the 5-year vesting period, AoA reported that 2018 is the earliest year active enrollees will be able to submit a claim for benefits and have their eligibility assessed.

AoA must complete the following requirements pertaining to determining eligibility if the Secretary designates a benefit plan at a later time:

¹⁰⁰ 75 Fed. Reg. 70005 (Nov. 16, 2010).

- to establish procedures for benefit eligibility determination, appeals to benefit eligibility denials, and benefit eligibility redeterminations;¹⁰¹ and
- to determine intervals at which beneficiaries must recertify their eligibility.

III. Providing quality assurance and protecting against waste, fraud, and abuse

The CLASS Act requires AoA to include provisions in the CLASS program to protect against fraud and abuse. Specifically, AoA must establish procedures to ensure that entities providing services to active enrollees and eligible beneficiaries comply with conflict-of-interest requirements in the law, as well as standards of conduct for authorized representatives of beneficiaries.

AoA developed provisions to protect against waste, fraud, and abuse

AoA developed provisions in benefit plan alternatives intended to protect against waste, fraud, and abuse after program implementation. The CLASS Enhancement Plan, developed by the Chief Actuary, describes a potential list of excluded services and supports that beneficiaries cannot purchase with the cash benefit (e.g., food, liquor, housing, luxury items). The Enhancement Plan also describes potential reenrollment rules not included in the CLASS Act to prevent enrollees from repeatedly lapsing in premium payments and then reenrolling permanently when their health deteriorates.¹⁰² AoA also established and selected a head of the Office of Program Integrity and Compliance within the CLASS Office.

AoA must complete the following requirements pertaining to providing quality assurance and protecting against waste, fraud, and abuse if the Secretary designates a benefit plan at a later time:

- to establish procedures to ensure that entities providing services (e.g., advocacy, counseling, and planning services) to active enrollees and beneficiaries comply with the requirements of the law; and
- to establish standards of conduct for authorized representatives of eligible beneficiaries.

¹⁰¹ Benefit eligibility determination and redetermination processes must require certification by a licensed health care practitioner. PHSA § 3205(a)(2)(B).

¹⁰² If reenrollment occurs after a lapse in premium payments of between 90 days and 5 years (beginning with the first month of the lapse), enrollees will receive credit for paid premiums prior to the lapse. PHSA § 3203(b)(1)(C). According to AoA, enrollees could continuously allow premium payments to lapse throughout the 5-year vesting period and begin steadily paying premiums only when they need to receive benefits.

IV. Recouping unpaid and accrued benefits

In conjunction with the Secretary of the Treasury, AoA must establish a mechanism to recoup benefits if a beneficiary dies or fails to collect deferred benefits after 12 months. Recouped benefits must be returned to the CLASS Independence Fund.

AoA will establish a mechanism to recoup unpaid and accrued benefits if the Secretary designates a benefit plan at a later time

AoA reported that it planned to establish a mechanism to recoup unpaid and accrued benefits later in the program development process. If the Secretary designated a benefit plan by October 1, 2012, AoA did not expect to recoup benefits in the event of a beneficiary death until 2018, the earliest year for benefit payments. Because deferred benefits can roll over from month to month, but not from year to year, AoA expected to recoup deferred benefits in 2019 at the earliest.

CONCLUSION

At the time of our review, AoA was in the early stage of CLASS program planning and development and focused most of its efforts on developing at least three actuarially sound benefit plan alternatives. However, on October 14, 2011, the Secretary informed Congress that HHS cannot identify a benefit plan that is both actuarially sound for the next 75 years and consistent with the requirements of the CLASS Act. Following this announcement, HHS suspended program implementation. OIG will determine the most appropriate way to meet OIG's CLASS Act reporting requirements in future years based on the program's status.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

AoA reviewed a draft of this report and had no comments. They noted that the report did not contain any recommendations and that HHS has suspended work on the program. For the full text of AoA's comments, see Appendix B. AoA provided clarifying and technical comments, which were incorporated into the final report.

APPENDIX A

OIG Reporting Requirement in the CLASS Act

PHSA Sec. 3209, 42 USC § 30011-8

SEC. 3209. INSPECTOR GENERAL'S REPORT.

The Inspector General of the Department of Health and Human Services shall submit an annual report to the Secretary and Congress relating to the overall progress of the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

- (1) The eligibility determination process.
- (2) The provision of cash benefits.
- (3) Quality assurance and protection against waste, fraud, and abuse.
- (4) Recouping of unpaid and accrued benefits.

APPENDIX B

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
Administration on Aging

Washington D.C. 20201

NOV 2 2011

TO: Daniel R. Levinson
Inspector General

FROM: Kathy Greenlee */SI/*
Assistant Secretary for Aging

SUBJECT: OIG Draft Report: *Community Living Assistance Services and Supports Program:
2011 Report to Congress*, OEI-04-11-00450

Thank you for the opportunity to comment on the subject OIG draft report. We appreciate your staff's professionalism and collegiality in conducting this review and preparing this report. As stated in the report, on October 14, 2011, the Secretary informed Congress that she does not see a viable path for implementing the CLASS program, and we have suspended work on the program.

The draft OIG report does not contain any recommendation, and we do not have any comments on the report.

The Administration on Aging would again like to thank the OIG for their work in conducting this review. If we can be of further assistance, please let me know.

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Jaime R. Durley, Deputy Regional Inspector General.

Sarah Langford served as the lead analyst for this study. Other principal Office of Evaluation and Inspections staff from the Atlanta regional office who contributed to the report include Starr Kidda and Janna Sayer; central office staff who contributed include Heather Barton.

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.