# At Home
## *With Mass Home Care*

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**Al Norman, Editor**


# Historic Women's March In Boston

***Photo Credit: Meg Hogan***

An energized crowd estimated by official sources at 175,000 spread out across the Boston Common on a balmy Saturday, January 21st with thousands of hand-made signs expressing a wide range of opinions about the future course of American policy both domestically and abroad.

The crowd was so large that the actual marching route was a wall of people that curled slowly along Charles Street, onto Beacon Street, Arlington Street, and back down Boylston Street to the Common., while church bells pealed out the notes to "We Shall Overcome.

"At one point, members in the crowd who had been standing shoulder-to -shoulder for half an hour, began chanting "Start the march! Start the march."

Thousands of women wearing pink hand-knitted and crocheted 'pussy hats' carried banners on reproductive freedom, Planned Parenthood, and other women's rights issues. With them were thousands of men, holding signs which read, "I'm with Her," "Class warfare hurts everybody," and "Equal Pay and Affordable Health Care." Ethnic diversity, immigrant rights and "Black Lives Matter," were scrawled on hundreds of magic-marker posterboards.

Boston Mayor **Marty Walsh** welcomed the marchers, and promised them, "We will take this fight from Boston Common to the Mall in Washington to let the President know he is supposed to represent all of us. He doesn't have to make America great again! America

is great; it's the greatest country in the world!"

Keynote speaker U.S. Senator **Elizabeth Warren** added: "We can whimper. We can whine. Or we can fight back. We come here to stand shoulder to shoulder to make clear: We are here! We will not be silent! We will not play dead! We will fight for what we believe in!"

Mass Home Care Executive Director **Al Norman**, who marched in the event, along with dozens of home care workers, carried a sign which read, "Hands Off Social Security, Medicare and Medicaid." "Any elected official—regardless of party affiliation or district—who tries to lower the economic or health security of low income or middle class citizens, is going to feel the pushback. These Great Society programs have eased the financial burden of those on the bottom of the ladder," Norman said. "If these people are pushed down, they will rise back up in protest."

Norman said threats to turn Medicare into a "premium support/voucher" program, or to block grant Medicaid to the states, will lead to hundreds of thousands of Baystate residents losing critical health and income supports."


*Mass Home Care photo*

**Meg Hogan**, the CEO of Boston Senior Home Care, and one of the Women's March event organizers, said :"Boston was one of 600 marches across the country and the world to show that women will not sit quietly as their healthcare access is taken away. Senator Elizabeth Warren, Mayor Marty Walsh, Attorney General **Maura Healy** and men and women of the House and Senate lent their voices of solidarity and support."

## Tufts Health Plan Foundation Funds "Same Day" Home Care

On December 19th, the Tufts Health Plan Foundation announced a series of new community investments of more than $1.1 million in the areas of policy and advocacy. These grants reflect the Foundation's commitment to advancing age-friendly policies and practices that are relevant, focus on older adults, and include them in community solutions. The Foundation is also providing year-two support for seven multi-year initiatives. In 2016, the Foundation invested more than $2.9 million in community.

"The momentum is building around age-friendly communities, and we are excited to partner with state and local leaders in their work to consider and include older adults," said **Nora Moreno Cargie**, vice president, corporate citizenship for Tufts Health Plan and President of its Foundation. "We are proud collaborators on initiatives that promote cross-sector conversations, address challenges and inequities facing communities, and advance policies and practices that support all ages."

The new investments include initiatives to improve access to affordable housing and supportive services for older adults; address gaps that limit access to services and healthy, nutritious food; and engage more seniors as advocates for their communities. They are aligned with the Foundation's support for age-friendly communities. Mass Home Care received an award of $75,000 for The RIGHT Program: Rapid Integration for Good Health Transitions—to tackle barriers that limit care in community after a hospital discharge and advocate for improved policies and best practices that support healthy aging in community.

According to the grant proposal, nursing facility care can be accessed with one phone call, in one day, but home care is often not available on a

same day basis. The "Rapid Interventions for Good Health Transitions" (RIGHT) Program will eliminate the barriers that make community care difficult to use. The RIGHT program improves quality of life for individuals with disabilities across the lifespan, by making community care accessible on a rapid, or same day basis, to disrupt the default mode that leads to unnecessary placements in institutions. Care in the community today is too complex and fragmented to easily implement. This proposal brings together diverse stakeholders to plan and implement more age-friendly public policy around the issue of accessible community care. The project seeks to create system change that will expand access to community-based care and services, improve the quality of life for elderly and individuals with disabilities, and make care in the "least restrictive setting" a reality in Massachusetts.


Under the RIGHT program model, an interdisciplinary team is formed, consisting of the Aging Services Access Points (ASAP) agency, home care/ home health workers, discharge planners at hospitals and nursing facilities, physicians, consumers and caregivers. A community care plan is quickly assembled to serve as an alternative to institutional placement based on consumer preferences. Existing ASAP assessment and care planning resources are triaged to create a same day response. Service providers, such as personal care attendants, home care aides, home health aides, and adult family care homes are available on quick turn around basis. In-home supports on the day of discharge are available to activate the care plan and supports. On-going in home supports by many members of the RIGHT Team will be required for a short, transitional period of time, on a decreasing hourly basis over time as the consumer returns to independence.

The frame of reference of our communities when it comes to post-acute discharge for elderly, almost always involves a nursing home placement. This needs to change if we are to consider any of our communities "age friendly." The RIGHT Program can start the transformation to a successful aging model that emphasizes community and human interaction and deemphasizes the institution.

In all, Tufts Health Plan Foundation announced 13 new grants engaging nearly 150 community organizations in Massachusetts and Rhode Island for a total community investment of $1.1 million. The Foundation is also providing year-two support for an additional seven multi-year initiatives. In 2016, the Foundation invested more than $2.9 million in community.

Established in 2008, Tufts Health Plan Foundation supports the health and wellness of the diverse communities it serves. The Foundation has given more than $24 million to Massachusetts and Rhode Island nonprofits that promote healthy living with an emphasis on older adults. This year, the Foundation began funding in New Hampshire.

The Tufts Health Plan Foundation funds programs that move communities toward achieving age-friendly policies and practices that are relevant, focus on seniors, and include them in community solutions. Visit www.tuftshealthplanfoundation.org or follow us on Twitter, Facebook, and YouTube.

## Home Health Rates Slated For Cutbacks

Home Health agencies will face a major loss of funding under new rates released today by the Baker Administration. MassHealth has released proposed changes to home health rates, calling for the rate to drop from the highest rate in the first 30 days, to a lower rate from day 31 to day 180, and the lowest rate for visits after 180 days. Under this proposed plan, the rate for

the longer term chronic rate is 42% lower than the first 30 days of post acute care.

In total, Home health Agencies will lose $13.7 million in FY 18, as these rates are slated to start July 1, 2017. An announcement cutting Adult Foster Care rates by $22.6 million in FY 18 was made recently as well.

These changes are being made in accordance with M.G.L. c. 118E, sections 13C and 13D, which requires the Secretary of the Executive Office of Health Human Services to establish, by regulation, rates for health care services, including home health services.

The following rate changes are effective January 1, 2017:

• A 6.75% reduction in the rate for skilled nursing services provided on or after 61 calendar days to reflect decreased acuity of services provided after 61 days.

• A 2.6% increase in the rates for continuous skilled nursing (CSN) services pursuant to Chapter 46 of the Acts of 2015, line item 4000-0300 which required MassHealth to "review the reimbursement rates for independent home care nurses and consider restructuring the rate."

The following rate changes are effective July 1, 2017:

• A change from the current two-tiered rate structure for skilled nursing visits to a three-tiered rate structure. The purpose of this change is to better align payment rates for home health skilled nursing visits with the efficient delivery of these services. The three-tier rate structure reflects the higher intensity of skilled nursing services provided in the first 30 days of skilled nursing visits, and the reduced intensity of skilled nursing that occurs during visits occurring after a member has been routinely receiving skilled nursing services for an extended period of time (i.e. greater than six months), EOHHS says.

The three-tier rate structure for skilled nursing visits includes the following three rate tiers:

1) a higher post-acute rate of $89.21 for the first 30 days of service;

2) a short-term chronic rate of $69.59 from 31 days to 180 days; and

3) a lower long-term chronic rate of $52.19 for visits after 180 days.

Under the proposed three-tier rate structure, the higher 'post-acute' rate for skilled nursing services provided in the first 30 days reflects a 2.6% Cost Adjustment Factor (CAF) increase over the current 1-60 day nursing visit rate to reflect that visits in the first 30 days tend to be more complex and time-sensitive than visits to established patients. The 'short term chronic' rate of $69.59 represents the current rate for visits on or after 61 calendar days, being applied to visits on or after 31 calendar days. And the lowest rate, the 'long-term chronic' rate for skilled nursing visits after 180 calendar days, reflects a 25% reduction from the current nursing visit rate of $69.59 for visits on or after 61 calendar days. The 25% reduction is based on MassHealth audits of home health agencies, which showed reduced intensity of nursing care and the time required for skilled nursing visits after a member has been routinely receiving skilled nursing services for an extended period of time.

It is estimated that annual aggregate state expenditures will decrease by $13.7 million as a result of these changes. The actual change in annualized expenditures may vary depending on actual utilization of services.

On January 20th, Mass Home Care submitted testimony against the 3 tiered rate plan for home health. Here are excerpts from the Mass Home Care statement: "Assuming that the cost of producing a RN visit per hour is the same---regardless of whether the client has been seen for two weeks or two months---the effect of this declining rate structure for longer term patients means that an agency will be paid $22.30 per 15 minutes for a

visit to a post acute care patient, but the same RN who visits a patient who is in the long term chronic care stage (day 181+) will have to spend only 35 minutes in the home to earn that same rate of reimbursement that a post acute care case generates at $22.30 per 15 minutes, because the long term rate only pays $13.04 per 15 minutes.

This rate design will force RNs to spend considerably less time with people who have chronic care needs, creating the possibility that the visit will be less thorough, cut corners, be less attentive to the ongoing needs of the patient---who may appear "established"---but in fact may be at risk for medical supports at any time. There is an assumption, based on EOHHS audits of HHAs, that the longer you need care, the more stable you become. The "established," or "stabilized" patient gets less time, attention and care.

A similar approach has happened on the Medicare home health program side. For years, Medicare home health patients suffered from what was known as the 'improvement standard," by which home health agencies would stop visiting patients who failed to show further improvement in their status. This led to the view that home health services under Medicare were only meant to be short-term in nature.

We worry that the link between long-term patients and lowered reimbursement will foster the notion that MassHealth home health services are "short term and intermittent," and induce HHA's to see people with chronic care needs as less of a priority. We do not want to see these patients triaged. People stable today, can be unstable tomorrow. The cost of sending an RN out to a patient's home does not change—so clearly the visit has to be shorter to prevent the agency from losing money on the visit—which is not in the best interests of the agency, MassHealth, or the patient...The fact that skilled care has stabilized a person's health does not render that level of care unnecessary. A MassHealth patient need not risk a deterioration of her fragile health to validate the continuing requirement for skilled care: "skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable."

We would prefer to see MassHealth use its "Individual Consideration" approach to patients, which is used only for continuous skilled nursing care. Under individual consideration, MassHealth looks at the "unique condition of the patient, and rates of payment to an eligible provider are determined on an Individual Consideration basis using the following criteria:

(a) The length of time required to perform the service;
(b) Degree of skill required for the service rendered;
(c) Severity and complexity of the patient's disorder or disability;
(d) Policies, procedures and practices of other third party purchasers of care, governmental and private;
(e) Prevailing continuous skilled nursing ethics and accepted customs;
(f) Such other standards and criteria as may be adopted by other governmental purchasing agencies.

Patients' needs for home health care should not be measured based on their longevity in the system, but based on their individualized care plan at any point in time, and the time required to meet that need. Nursing facilities are paid on a "resource utilization" basis, not on how long they have been in the facility. In our state home care system, per member per month payments do not shrink over time. Service plans change based on changing member needs.

Finally, we wish to note that the rates for home health aide services as of July, 2017, which is $24.40 an hour (including agency overhead costs), will not increase at all over the rates as of January, 2017. These home health aides should receive biennial rate hikes, based on an analysis of the actual cost of delivering these services, not on a simple cost of living adjustment."

## The At Home Interview: Linda Andrade

*For the past two years, Linda Andrade has served as the President of the Massachusetts Council for Adult Foster (MCAFC), a statewide AFC provider agency membership organization with the goal of leadership, knowledge and advocacy.*

*Linda's primary job is Program Director for Cerebral Palsy of Massachusetts/ Options Programs. She has an extensive background in developing, implementing and directing a variety of community based programs that include a person centered, consumer empowered approach to promote opportunities for independence. She is a native of Taunton where she lives with her husband and two children. She is a retired Medical Service Corp Major from the US Army Reserves, having served over 21 years.*

At Home interviewed Linda regarding the recent cutbacks in AFC funding.

**Q: MassHealth announced recently that cuts totaling $5.6 million would be made to the Adult Foster Care program in the last 4 months of this year, and more than $22 million next year. Explain what AFC does, and how the specific changes proposed will impact the people in this program?**

**Andrade:** Adult Foster Care is a MassHealth program service that enables over 10,000 elders and individuals with disabilities to live at home in the community with full time live in caregivers across the Commonwealth. Eligible MassHealth members and their caregivers are supported by professional staff, including registered nurses and care managers employed by AFC agency providers. AFC agency providers support MassHealth members and their caregivers in the management of care at the qualified home.

By design, the AFC program provides value to the Commonwealth as it serves a broad range of individuals who otherwise fall through the gap of services in MassHealth. These members don't meet strict eligibility criteria for DDS, DMH or Elder Affairs. This program is unique in that it provides intense support to caregivers of all qualifications and backgrounds.

The Commonwealth of Massachusetts is proposing to withdraw certain caregiver supports by reducing the AFC program's visit and staffing requirements. MCAFC anticipates major quality compromise to the support and training relationship to these homes if the cuts are realized.

**Q: What is the Mass Adult Foster Care Coalition doing to stop these cuts?**

**Andrade:** MCAFC heard the news of the 9C cuts and reacted in a way that brought our sister associations to the table. MCAFC confirmed the message with MassHealth and made sure that our sister associations also heard the same message. This was the beginning of major discussion and planning around educating lawmakers, regulators and the public about the negative impacts that will result from the cuts. MCAFC during this time flagged the cuts as a major program concern to all legislators and our sister associations did the same. There continues to be engagement with MassHealth around the potential consequences of lowering AFC program standards. MCAFC will continue to work with its sister associations, legislators, MassHealth, the Administration and stakeholders to stop cuts that could harm the AFC program and members served by it.

**Q: Why is AFC a valuable program to protect?**

**Andrade:** The Adult Foster Care program is valuable to many who may be otherwise in a more restrictive environment. Adult Foster Care is a program that happens in a home in the community. AFC program staff consisting of a registered nurse and college degreed care manager provide resources, training and

support to these homes. AFC members have choices of caregivers and they are involved with their plans of care. AFC professional staff have provided in home services and supports that have prevented costly inpatient or emergency room visits. AFC professional staff train and support caregivers and members who may have little to no experience with medical treatment and care. This valuable support keeps information current, relevant and focused on care of the AFC member. Each AFC program has 24/7 on call resources which has helped prevent emergency room visits or offered support any time of the day or night. This model serves many people in the community who may otherwise be institutionalized or needing group homes with 24/7 staff. This 24/7 community model is part of the attraction of this program which serves those who fall through the gap of services.

**Q: Are there any changes that you would like to see to AFC?**

**Andrade:** The Adult Foster Care regulations were published in February, 2007. Since then, there have been a great increase in the number of AFC provider agencies offering this valuable service. MCAFC has concern about the variety of interpretations of the AFC regulations and especially around eligibility of members. MCAFC has also expressed concerns about Provider Eligibility. In response to MCAFC's strong desire to keep Program Integrity at the head of the table, MCAFC has submitted to MassHealth recommendations of regulation changes---including strengthening provider and member eligibility to ensure that those definitions are clear across the provider community.

**Q: This is the second time the BakerAdministration has proposed cuts to AFC. Does it really make sense financially to cut these programs?**

**Andrade:** This program is a per diem model which does have predictability, unlike some other models. Providers get paid the same amount if a person has 3 Activity of Daily Living (ADL) needs or 5 ADL needs. AFC is a valuable model that is most cost effective. AFC caregivers are paid a daily stipend which in no way compares to the more restrictive and more costly alternatives of group home or nursing home placement. Programs like AFC should be reinforced and expanded rather than cut, as they provide the Commonwealth with savings that can be achieved in a manner that also meets another goal — provision of care in the least restrictive setting.

Massachusetts Council for Adult Foster Care

**Q: If you could get an audience with the Governor directly, what would you tell him about AFC?**

**Andrade:** AFC saves the Commonwealth money as it is a viable solution to saving long term services and supports cost by maintaining the least restrictive environment for those people in the community who are in need. AFC is not a model that the Commonwealth has to worry about added administrative burden when someone's condition changes, or approving minutes or units. Adult Foster Care is not the same as Home Health or Group Adult Foster Care. This AFC model stands alone. Recommendations that were submitted to MassHealth to enhance AFC program integrity through provider eligibility and clarification of the AFC regulations will automatically bring costs down, but only if the program is not prematurely cut in the midst of these important program integrity and care initiatives, as is currently proposed by the 9C reductions.

## MassHealth Releases Community Partners Plan for LTSS

On December 16th the Massachusetts Executive Office of Health and Human Services (EOHHS) Office of Medicaid ("MassHealth") announced it plans to put out a bid in February or March for a new entities called the **Long-Term Services and Supports Community Partners (LTSS CPs)** to perform care coordination and other administrative support activities for identified

members with LTSS needs, as part of its new 5 year plan for Accountable Care Organizations (ACOs) for integraed managed care. The bidders ae expected to be selected by EOHHS in April of 2017.

The ACO plan as proposed will give hospital and physician networks total control over the access and use of LTSS—raising concerns that medical organizations for the first time will be controlling access to non-medical supports like help with activities of daily living—eating, bathing, dressing, walking, toileting. Health care companies have never managed or provided such functional supports.

According to MassHealth, the new LTSS CPs will perform six core functions:

1. Provide disability expertise consultation as requested by MassHealth, the member's MassHealth managed care entity, or the member on the comprehensive assessment;
2. Provide LTSS care planning using a person-centered approach and choice counseling;
3. Participate on the member's care management team to support LTSS care needs decisions and LTSS integration, as directed by the member;
4. Provide LTSS care coordination and support during transitions of care;
5. Provide health and wellness coaching; and
6. Connect the member to social services and community resources.

MassHealth anticipates that the LTSS CP program will target members age 3 to 64 (but people as they turn 65 will likely remain in the program) with complex LTSS needs. MassHealth will define the categories of members that LTSS CPs may support. MassHealth anticipates that out of roughly 1.2 million eligible MassHealth members, only 20,000-25,000 members will be identified or referred for LTSS CP support. This means that 98% of the members in the plan will not get LTSS.

EOHHS intends to allow LTSS CPs to provide optional "enhanced" LTSS CP functions for members with complex LTSS needs who would benefit from comprehensive care management provided by a LTSS CP. Managed care entities will delegate responsibility for these functions to the LTSS CP. In the first couple of years, ACOs and MCOs will be accountable for the total medical cost of care for their enrolled members--but they will not be responsible initially for LTSS costs, which MassHealth will continue to pay for directly to these new LTSS Community Partners.

## Community PARTNERS

MassHealth will select roughly four LTSS CPs in 5 regions across the state through a competitive procurement. The state says it will only require ACOs to partner with two of the four LTSS CPs in each of the regions. The community-based organizations or consortiums that bid on becoming an LTSS CP must serve people who need LTSS services in all of the following categories:

- Individuals with complex LTSS and BH needs;
- Individuals with brain injury or cognitive impairments;
- Individuals with physical disabilities;
- Individuals with Intellectual Disabilities and Developmental Disabilities (I/DD), including Autism;
- Older adults (up to age 65) with LTSS needs; and • •
- Children and youth (ages 3 - 21) with LTSS needs;

Bidders can be a partnership or consortium if it is a legal entity capable of entering into a contract with EOHHS, or the consortium must identify a lead entity "with the power to bind constituent entities" to the terms of the LTSS CP contract. The bidders will have to demonstrate the capacity to meet the following ten criteria:

**1. Experience working with members with complex LTSS needs.** Demonstrated experience working with each disability population listed above; knowledge of current trends in services and supports to individuals with disabilities; knowledge of federal rules and statutes, and knowledge of person-centered planning principles and practices. The bidder must also describe organization's contributions to date toward helping the state rebalance its LTSS system from institutional to home- and community-based settings.

**2. Experience working with diverse member**

**populations in a culturally and linguistically appropriate manner**, including serving individuals from diverse populations such as individuals who identify as LGBTQ and individuals with diverse linguistic, racial, ethnic, and religious backgrounds with local entities providing culturally and linguistically appropriate support.

**3. Financial stability.** Certification, disclosure of any financial audit ongoing or concluded within the past two years (and copy of the audit report), and certificate of good standing from taxing authority of the bidder's principal office.

**4. Management stability/infrastructure**. Management credentials and experience, organizational chart, description of organizational infrastructure.

**5. Governance.** Input from adult consumers with LTSS needs to the board or governing committee about the bidder's policies, processes and services.

**6. Staffing plans and training processes**. Current and future capacity to hire and appropriately supervise managers, and care coordinators and examples of qualifications and job descriptions; training plans for all employed and contract staff that address cultural and linguistic competence, person-centered planning, and independent living philosophy.)

**7. Care coordination requirements, mechanisms, processes, and experience.** Capabilities to perform screenings and assessments, provide choice counseling, develop care plans using a person-centered approach, coordinate services, and perform routine outreach and monitoring.

**8. Community partnerships.** Demonstrates working relationships and agreements with LTSS and social services providers, and other community-based resources and the capacity to assist members in applying for and obtaining key support services that are related to their overall health and well-being.

9. Data management, Analytics, Information systems, and Reporting. Existing or planned future use of health information technology (HIT) system, electronic health records.

**10. Quality management and quality improvement**. Evidence of quality measurement systems, improvement plans, outcomes and member experience evaluation.

Members who have co-occurring Behavioral Health (BH) and LTSS needs who meet the eligibility criteria for a Behavioral Health Community Partner (BH CP) will be offered support from a BH CP. Members with behavioral health needs will be automatically "attributed" to a BH CP in the member's region that also provides LTSS CP functions. So MassHealth is encouraging BH CPs to also become LTSS CPs—even if they have never done so before. Members may only be assigned to a single CP at any time and payments for CP functions will only be made to that CP. People with BH and LTSS needs will not be allowed to have a LTSS CP collaborating with a BH CP.

Additionally, MassHealth and/or the member's MCE, as appropriate, and LTSS CP may collaborate to identify a cohort of individuals who would benefit from receiving enhanced LTSS CP supports. In addition to the functions described above, the enhanced LTSS CP supports would include coordination of all services across the care continuum (e.g. medical, behavioral health and LTSS), and management of the member's overall care plan. The member's MCE, if any, and LTSS CP may make a proposal to MassHealth requesting a supplemental per member per month payment for the LTSS CP to provide these enhanced functions. MassHealth will consider each proposal and, if approved, will pay a supplemental PMPM payment to the LTSS CP for each member receiving the enhanced functions. Additional qualifying criteria, reporting requirements and quality measures will apply.

MassHealth anticipates paying LTSS CPs a per member, per month (PMPM) payment of $80 for

each member assigned to the LTSS CP for each month the LTSS CP supports the member. MassHealth will define the additional PMPM and qualifying services for enhanced LTSS CP functions.

LTSS CPs may also receive federal funding to make investments to advance the LTSS CP's overall capabilities to serve its member population and form partnerships with MassHealth-contracted ACOs and MCOs. Such investments may include workforce development, Health Information Technology (HIT) and care management software, performance management capabilities, and data analytics capabilities.

## Mass Home Care Responds to LTSS CP Plan

On December 30th, Mass Home care submitted 11 pages of comments, concerns and questions about the upcoming Community Partners procurement. Here are some of the key points raised in Mass Home Care's comments:

• "The assessment and care management of non-medical services should not be a walk-on or cameo role if the Commonwealth seeks to have a comprehensive integrated care plan. Since the beginning of the ACO 1115 plan, Mass Home Care has urged MassHealth to build on the major investment that the Commonwealth has created by designating agencies to serve as independent agents for the assessment and care management of individuals with long term support needs. This capacity should be the platform for any expansion of home and community based care. Previous integrated care plans in Massachusetts, like the SCO and One Care plans, have required integrated care entities to partner with existing independent, community-based long term supports coordinators.

• The ACO/MCO plan is an opportunity to broaden this LTSS infrastructure, not work around it. For example, MassHealth has the option to use the ASAPs or the Aging and Disability Resource Consortiums (ADRCs), which it helped create, to serve as a platform for the provision of LTSS CPs to medical providers, like ACO/MCOs. As a logical extension of the investments made to date, MassHealth could use the ACO plan as an opportunity to invest in enhanced infrastructure for the ASAPs or the ADRCs as a main partner for the medical providers who will be ACOs. Because of existing statute (19A, 4B) regarding the role of ASAPs to provide assessments and care management for MassHealth members age 60 and over, MassHealth should respect this existing relationship, and require ACOs/MCOs to refer members age 60 and over to ASAPs for assessment and care coordination.

• When new initiatives like ACOs are developed, there is a tendency to 'start from new cloth,' rather than to understand the garment that exists. The SCO and One Care plans began in this fashion, but as the plans developed, they were connected with what existed in the field for LTSS assessment and care coordination. This is what MassHealth can do now: incorporate the LTSS entities that you have invested in, designate the LTSS CPs that you want the ACOs to work with, and invest in the infrastructure to have a seamless, coordinated system.

• The LTSS CP Notice of Upcoming Procurement is unfocused, and should be more directive and prescriptive regarding the integration of what exists on the medical side, with what exists on the functional, social determinant side.

• The role of the LTSS CP has been narrowing in scope as additional details of the ACO plan emerge. In its September 2016 overview of the LTSS CP program, MassHealth wrote, "the role of the LTSS CP will include providing the LTSS functional component of comprehensive assessments…" In its slide on "what LTSS CPs do," MassHealth stated: "LTSS-specific member engagement including the LTSS component

of comprehensive assessment." MassHealth said LTSS CPs would "review member's LTSS information", (e.g. LTSS history, current LTSS utilization, and existing assessments); and conduct LTSS functional and social components of comprehensive assessments." The approved CMS waiver list for the ACO plan states that "The state will develop policies and procedures to ensure comprehensive assessments are completed for members…with identified LTSS needs,..." Under 42 CFR 438.208(c)(2) the assessment mechanisms must use "appropriate providers or individuals meeting LTSS service coordination requirements of the State or the MCO…as appropriate." The state has not defined what the requirements are for individuals meeting LTSS service coordination requirements. In addition, reducing the LTSS CP role as just providing "expertise consultation" means that the ASAPs current statutory role to conduct assessments under Chapter 19A, 4B for people age 60 and 64 affected by the ACO plan, are being 'substantially changed,' and require written findings in accordance with 19A, 4B.

• Finally, LTSS CPs are being given a substantially smaller role than the BH CPs, which under their NOI are responsible for "facilitating a care team…leading the person-centered treatment planning for every engaged member…coordinating services across the care continuum…facilitating access and referral to social services." The role of the LTSS CP, which is predominately by request of the MCE, is much more circumscribed and ancillary to the care team functions. Our concern is that LTSS will be a minor player in the member's assessment and care planning.

• Care coordination must be an on-going process, not just at points of transition, which is a fragmented form of care management. In its September, 2016 slides, MassHealth said that LTSS CPs would "support implementation of LTSS components of the person-centered care plan (e.g. through scheduling, communication), coordinate across multiple LTSS providers, and identify LTSS resources and complementary community based resources not funded by MassHealth." This is care management before, during and after transitions in care. Only members with "complex LTSS needs" will have access to comprehensive care management by an LTSS CP. The CFR cited above says that ACOs "will be responsible for comprehensively assessing each enrollee with LTSS needs." One of the lessons from the CMS evaluation of the One Care demonstration is that many members with LTSS needs were not being connected to the Independent Long Term Supports Coordinator and not getting an LTSS care plan at all.


• Without providing any rationale, MassHealth tells ACOs in the BH CP NOI that "MassHealth intends for MCEs to partner with all BH CPs within the region and/or service areas in which the MCE operates" but only half of the LTSS CPs. LTSS CPs should receive the same treatment as the BH CPs. If the state certifies an entity as an LTSS CP, the ACO should be required to contract with the LTSS CP on the same footing as with a BH CP. LTSS are equally critical to maintaining the health and well being of this population; numerous studies have borne this out. As such, they must be given the same weighting in the contractual requirements as behavioral health providers. Failure to do so will result in significant gaps in service delivery and resulting costs to the individual and the overall health care system. In addition, members should have as broad a choice of LTSS CPs as they have of BH CPs. If there are entities approved by MassHealth to be LTSS CPs, and who have been used by members in the past, but who are not chosen by an ACO, then members of that ACO have had their range of LTSS CPs narrowed by the ACO's decision not to contract with approved LTSS CPs.

• It is extremely wasteful to ask all LTSS CP applicants to serve as a "one stop shop" for all subpopulations. LTSS CPs should be encouraged to form consortiums that have the capacity to serve more than one subpopulation.

But it is at the ACO/MCO level that one should expect to find a network of LTSS CPs that cover all the LTSS subpopulations. What is critical is that the ACO, at its level, has sufficient BH and LTSS CPs to meet the needs of its members. The number of CPs should be left flexible, so that ACOs can integrate the current array of LTSS CPs serving the communities the ACO chooses to serve." If a LTSS CP has had no previous experience with "Children and youth (ages 3 - 21) with LTSS needs," it should not have to respond to that population. A LTSS CP that focuses on children should not have to provide services to seniors. ACOs should contract with LTSS CPs that can demonstrate subject matter expertise. It is duplicative to ask all LTSS CPs to serve all populations. If an LTSS CP does not, or cannot serve children, for example, it should not be disqualified as a CP. Similarly a LTSS CP with focused expertise on seniors should not be disqualified as a CP. The ultimate goal here is to provide the appropriate care, at the appropriate time and the appropriate place. The service delivery should be consistent with already developed community expertise with specific populations. In the medical field, we do not expect all pediatricians to double as geriatricians. But a health plan covering people of all ages should have both. Members will not be inconvenienced by having an LTSS CP that has expertise in children's services, and another in elder services.

• MassHealth has not yet clearly defined the quality metrics by which LTSS CPs will be measured. There are some process outcomes, some medical metrics, and some member experience metrics, but only "community tenure" has been listed as a true LTSS quality outcomes measure. (Of all the quality metrics being presented by MassHealth, only one is LTSS related. The one metric is a process measure, not an outcome: has a member been "assessed for LTSS." As the ACO plan gets ready to launch, it has no meaningful LTSS outcomes, other than a member was offered a LTSS assessment.)

• The "claims-based" approach to population management reduces the number of members with LTSS needs only to those who have historically been high users of LTSS supports. When you separate out the children and those with BH needs, MassHealth projects that only 13,000 out of 1.2 million eligible members will need LTSS services. This is just over 1% of the population. 99% of the members in this plan will not be considered to be in need of LTSS. The One Care program also substantially underestimated the need for LTSS in the eligible population. Very few of the enrollees who needed LTSS ever saw an ILTSC, and fewer ever had an LTSS care plan developed.

• Many members with complex care needs will present with both BH and LTSS needs. The expertise needed to work on these co-existing conditions may best come from two entities working in coordination, as might be expected in dealing with medical comorbidities. Members should be able to receive services from one or more CPs at the same time, subject to their needs. A BH CP that is also an LTSS CP will presumably be eligible to receive two capitations. There is no difference if the BH and LTSS CPs are not one in the same. MassHealth could have resolved this situation by creating one classification of CP that has the capacity to perform BH and LTSS functions, instead of creating CP siloes. However, as long as the BH and LTSS have the ability to coordinate their services, it is better for the member to give the plan more options than a "single CP at any time" approach. In a provider-centered plan, it might be easier to have fewer CP entities to contract with, but it is not that complex to have more than 4 LTSS CPs per region. If ACO's rule out 2 LTSS CPs, members will have a narrower choice of LTSS CPs than in any other care discipline. Members with combined BH and LTSS needs should not be "attributed" to either a BH

or an LTSS CP based solely on their clinical condition, but more importantly to what degree the member has existing relationships with BH or LTSS providers in their community, so as not to disrupt continuity of care. Each member needs a flexible system to assign the main care coordination responsibility.

• Over time, the role of the LTSS CP has diminished in scope and practice. MassHealth has repeatedly stated that LTSS CPs would have a role in the comprehensive assessment process, as well as an important care management role. As recently as September 16, 2016, in its LTSS RFI, MassHealth said: "As part of the overall member support, ACOs/MCOs and CPs will collaborate to provide comprehensive care management, care planning, assessments, care coordination, care transition, and health promotion for identified members." In slides from September of 2016, MassHealth stated that "the role of the LTSS CP will include providing the LTSS functional component of comprehensive assessments." The LTSS CP was also expected to provide "LTSS-specific input into an integrated, person-centered care plan, and support its implementation." MassHealth said the LTSS CP would provide "the LTSS expertise to complement the medical or behavioral health member engagement provided by other entities." Unless the MCE seeks the "disability expertise consultation," the LTSS CP is not likely to work with ACO/MCO members' assessment—unless the member asks for their help—which is unlikely, given the low visibility of the LTSS benefit in the plan.

• Despite CMS's requirement that "Massachusetts will develop and set standards to ensure assessments of LTSS needs are independent," MassHealth has included no reference at all in the Notice of Procurement that independent LTSS assessments will be required. In its September, 2016 slides, MassHealth said one design element to be finalized was "How to leverage community based population expertise while maintaining independent assessments and choice counseling." Mass Home Care has proposed that LTSS providers with subject matter expertise can be retained during the assessment process to participate in the assessment process, because the care plan recommendations are then sent to the ACO/MCO for final integration. The ACO makes the final decision to approve the care plan. The LTSS care plan then should return to the LTSS CP for implementation and care management. The LTSS provider was used for its subject matter expertise, but the LTSS CP gives the member the choice of at least 3 LTSS providers---one of which can be the LTSS provider that sat in on their assessment. This process creates a firewall between the assessment role and the final care plan.


• Members with LTSS needs will need on-going supports, not just during "transitions of care." Such transition periods are a critical time of need for LTSS supports, but help with activities of daily living and IADLs are daily living skills, and are needed before and after transitions. The language in the NOI which is the key CP role here is "Ongoing maintenance and implementation of LTSS component of the member's care plan." The BH CPs, by contrast, support members during transitions, but also work with members at other times: "including crisis and emergency events… provide follow up and transitional care support… conduct medication reconciliation, and to coordinate any clinical and support services needed." Many LTSS CPs have nursing staff who are capable of providing similar follow up and transitional care supports.

• Comparing the scope of BH CP functions and activities with LTSS CPs illustrates how much broader the BH CP functions are than the LTSS CP functions. Again, it appears that there is a lack of understanding as to the evidence-based research on the efficacy of LTSS supports to individuals in this population.

• LTSS CPs and BH CPs are both capable of "Assessing member for social support needs and identifying community and social supports and resources." BH CPs are also given the same mandate to "identify community and social supports and resources." A CP working with a member with BH and LTSS needs could find it confusing regarding who will be contacting the social support services unless the two CPs have decided which entity will do which social determinant work. Social services benefits are a non-medical area in which LTSS CPs and BH CPs have extensive expertise, and with proper coordination can seamlessly provided.

• MassHealth has provided no basis for how the proposed rate for LTSS care management has been calculated. It does not appear to be based on the current costs or LTSS experience. Our LTSS assessment team requires both nursing and social work care management. The LTSS CP rate of $80 is 61% of the lowest home care management per member per month rate that ASAPs are paid for basic home care clients ($131.45); it is 34% of the EHS ECOP care management rate ($233.37) and only 29% of the EHS Choices rate ($275). A Care manager at $35,000 plus 27% fringe = $44,450 cost per year. Hourly rate= $21.29. If a home visit assessment, write up and initial care plan development took 4 hours per client, that is $85 per month, not counting any RN time with clients or collateral contacts with LTSS providers or ACOs, training, etc. MassHealth has not provided the basis for the rate BH CPs are receiving of $180 per member per month, which is 2.25 times higher than the LTSS CP rate. MassHealth clearly sees the BH CP rate as worth significantly more than the LTSS CP rate...The $80 rate is woefully inadequate for the scope of services required and historical costs for a pmpm service. We recommend that MassHealth create a 'blended' rate for individuals who require BH and LTSS supports, and that in such cases a BH and a LTSS CP would be eligible for a blended rate that recognizes that there is both BH and LTSS content in the care plan.

• All LTSS CPs should be operating under the same quality and member experience measures. Any tool chosen for member satisfaction should be uniform across ACO plans. As far as progress towards integration, the One Care program has demonstrated that when the One Care plans are the filter for who gets LTSS, then the referrals number are low, and the numbers of people who actually got LTSS care plans even lower. If LTSS CPs are not doing baseline assessment for all new enrollees, if LTSS CPs are playing a minor role of "expertise consultation," then it is the ACO/MCO which should be held accountable for these integration measures, not the LTSS CP. At a minimum, LTSS CPs should be given responsibility for engaging through outreach members who from an initial screening are deemed to be likely in need of LTSS and social determinant supports. Efficiency measures should not all be medical in nature, such as hospital readmissions, ER visits, and total cost of medical care. Mass Home Care has suggested to EHS a list of LTSS outcome measures that could be useful metrics in the ACO plan, including community tenure as one example. There should be more than member satisfaction and process measures for LTSS supports."

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