At Home
With Mass Home Care

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Al Norman, Editor

Revenue Cuts Hit Adult Foster Care

On December 7th, the state's "soft revenues" resulted in some hard cuts to programs in Massachusetts that help the elderly and disabled to live at home. Governor **Charlie Baker** released cuts amounting to $98 million from the state budget to bring it into projected balance. Some of the largest cuts came from MassHealth programs for poor people. A total of $52.2 million was cut from the Executive Office of Health and Human Services, including $5.6 million from the Adult Foster Care program, one of the Commonwealth's key residential programs for keeping people out of nursing homes.

Five days after the cuts were announced, a coalition of groups, including Mass Home Care, sent a letter to House leaders urging them to restore the lost funding, which in FY 2018 will annualize to $22.6 million in reduced funds. Total appropriations this year for the AFC program in FY 16 are around $240 million. Here are excerpts from the letter sent to House Speaker **Robert DeLeo** (D-Winthrop) and House Ways and Means Chairman **Brian Dempsey** (D-Haverhill):

"We are writing to urge the House to restore funding caused by recent 9c cuts made to the Adult Care (AFC) program, one of the state's premier "community first" programs. We share the position of the General Court that these cuts are untimely with respect to the overall status of the Commonwealth's fiscal condition.

We also wish to share with you our concern that the cuts targeted within Mass Health, which reduce $5.6 million for the Adult Foster Care program in FY 16,

and $22.6 million annualized in FY 17, are unwise and likely to cause instability and quality erosion within a program that has saved the Commonwealth millions of dollars in savings that otherwise would have resulted in nursing home placements or other out-of-home placements.

As you know, the Adult Foster Care program is an innovative and highly effective cost alternative to out- of-home placements that currently supports more than 10,000 elders and people with disabilities to live in their own homes or the homes of individual caregivers at a tremendous cost savings to the overall budget of Mass Health and the Commonwealth. Between the years 2000 and 2015, nursing facility patient days paid for by Mass Health have fallen -37%, in part because of community-based alternatives like AFC. It gives elders and people with disabilities an inclusive opportunity to continue to live in a home setting and be part of a family. It is a program beloved by the participants and the wonderful caregivers who open their homes and hearts to others. AFC is one of the few 24/7 residential support programs that uses volunteer caregivers on a stipend, and keeps members living in the least restrictive setting, which is the mission of Mass Health.

We have spoken with and met with the leaders of Mass Health and continue to share our concerns with them. They believe that a reduction in requirements on provider agencies to employ nurses and care managers to conduct home visits justifies a 10% rate reduction to agencies. We believe that a substantial and unprecedented rate reduction for this program will:

• Undermine the ability of quality agencies to provide the level of clinical and social support that lay caregivers need to take on caregiving responsibilities for individuals with complex health and behavioral conditions.

• Negatively impact the ability of provider agencies to recruit individual caregivers willing to share their homes and the capacity of those agencies to train and provide quality assurance to individual caregivers.

• Erode the confidence of families to take on around-the-clock commitment to caregiving at home and thereby the utilization of more costly alternatives.

• Place some provider programs into a fiscal deficit for the current year and going forward, having built programs, staffing, training and administration based upon their contract assurance of funding with the Commonwealth, the needs of Mass Health members and the Commonwealth's current regulatory requirements.

We will continue to meet with Mass Health leaders to convince them this rate reduction is untimely and unwarranted. We believe that these cutbacks will result in program damage and negative impact upon the lives of people served within the AFC program.

If the General Court chooses to reverse the AFC 9C reductions, we request that there be inserted into line item 4000-0600 language that requires Mass Health to maintain the rate for Adult Foster Care in force at the level it was at as of July 1, 2016."

According to legislative sources, a supplemental budget to restore the lost AFC funding could happen in January, which could prevent the cutbacks, which the Baker Administration has said will begin March 1st.

Governor Signs AARP CARE Act

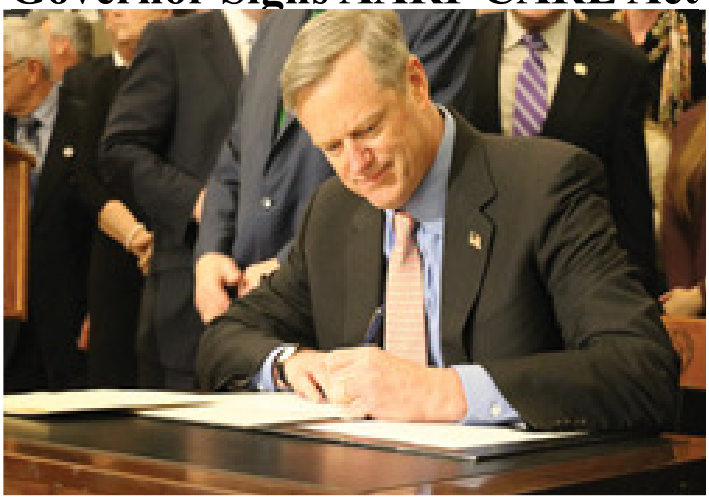


photo: Boston Magazine

On December 9th, Massachusetts became the 34th state to pass a version of the CARE Act, drafted by AARP Massachusetts. The Caregiver Advise, Record, Enable (CARE) Act known in the Massachusetts Legislature as H.3911, recognizes the critical role family caregivers play in keeping their loved ones at home, and out of costly institutions.

According to AARP Massachusetts, there are more than 844,000 Bay State residents who are caring for an aging parent or loved one, helping them to live

independently in their own home. In 2015 family caregivers in Massachusetts provided 786 million hours of unpaid care valued at approximately $11.6 billion annually.

The CARE Act features three important provisions related to the family caregiver's role when their loved one is hospitalized:

• The hospital patient is provided with an opportunity to designate a family caregiver;

• The family caregiver is notified if the patient is to be discharged to another facility or back home; and

• The facility must provide an explanation and live instruction of the medical tasks – such as medication management, injections, wound care, and transfers – that the family caregiver will perform at home.

"On behalf of our 800,000 members in Massachusetts, we thank sponsors Senator **Linda Dorcena Forry** (D- Dorchester) and Representative **Chris Walsh** (D – Framingham) for their leadership and tenacious advocacy on behalf of all family caregivers," said **Mike Festa**, AARP Massachusetts State Director. "This law provides essential support to unpaid caregivers who are often called on to provide complex medical care for which they receive little or no instruction. Additionally, we thank the 16 partner organizations that supported this bill and our tireless band of volunteer advocates who stood with us and supported the CARE Act through this legislative session."

"I am proud to have worked with the AARP in Massachusetts on the CARE Act, and commend the leaders in our state Senate President **Stan Rosenberg**, Speaker **Robert DeLeo** and Governor **Charlie Baker** on signing this critical bill into law," said State Senator Linda Dorcena Forry (D-Dorchester). "This new law is an important step in helping family caregivers undertake the enormous responsibility of caring for loved ones. The CARE Act is an example of the commitment we have in our state in keeping our seniors healthy and happy in their homes, while alleviating burdens on hospitals and nursing facilities."

"Today many family members or family friends are charged with caring for a person when they are released from the hospital without adequate instructions. The CARE Act ensures that caretakers will be provided with appropriate training and education in what they will need to do for the patient upon release," said Representative Chris Walsh (D-Framingham.) "When AARP came to me in 2013 they were aware that I was caring for my elderly father, and had cared for my mother at home. I was more than familiar with the challenges of dealing with post-hospitalization care for them without ever actually being trained in areas such as giving medications or changing dressings."

Senator Linda Dorcena Forry, AICUM photo

Lynn Nicholas, President & CEO, Massachusetts Health & Hospital Association (MHA) added, "MHA thanks AARP for working so closely with us on the development of this language. The hospital community is closely focused on keeping people healthy - both within and outside of their walls. This bill will help ensure that designated caregivers have the information they need to best support their family members and friends once they have left the hospital."

MassHealth Loosens Its PCA Overtime Rules

On the afternoon of November 22nd, MassHealth announced "important changes" to its overtime rules governing the Personal Care Attendant (PCA) program.

The Administration had been under pressure from disability rights advocates to improve on its first set of regulations, which came out in September of

2016. The need for OT regulation changes were due to federal changes in the Fair Labor Standards Act (FLSA) requiring workers to receive overtime pay in excess of 40 hours per week. MassHealth was spending millions of dollars in overtime costs unless the existing rules were changed. But once the first set of OT regulations were issues, disability advocates felt they were too restrictive, and would force most PCA workers to lose overtime pay. This, in turn, would result in workers leaving the PCA field entirely.

Overtime Rally, State House. Mass Home Cae photo

According to a Disabilty Policy Consortium press release in September, "The Baker Administration is imposing significant restrictions on overtime for ,Massachusetts' Personal Care Attendants (PCAs) – capping the number of hours that PCAs can work at 40 hours a week, with some exceptions up to 60 hours/ week…The new regulations will place a significant burden on thousands of Massachusetts'most vulnerable residents, including elders and individuals with disabilities who rely on the PCA program to live at home independently, safely and with dignity. Many people with disabilities and elders, who require 60 or even 80 hours of care each week and have utilized the same PCA for a decades, are struggling to find replacement services to cover the extra hours."

The DPC said that the first regulations issues were "draconian regulations that could force thousands of Massachusetts residents to leave independent lifestyles at home and move into more expensive care at institutions."

Several State House rallies were held by disability rights groups, both inside and outside of the building. MassHealth created a small workgroup of advocates and Personal Care Management agencies to continue refining the regulations. Here is an excerpt from the November 22nd notification from MassHealth: "Dear Colleagues,

On September 1, 2016, MassHealth put in place new rules to manage PCA overtime. MassHealth has been working with PCA consumers and other stakeholders since then about managing PCA overtime. Based on the feedback we received, MassHealth has made important changes to the PCA Overtime Management rules including increasing the number of hours a PCA can work before an overtime approval is required to 50 hours per week as well as updating the overtime approval criteria along with other initiatives."

The new PCA overtime provisions included the following:

A 4-part approach to ensure continuity of care, budget sustainability, and integrity of the program:

1. Establishes an overtime cap at 50 hours per week. Establishes both Temporary Approvals and Continuity of Care (COC) criteria to begin in the week of January 16th.

• Temporary Approvals apply when a consumer has a temporary need to schedule one PCA to work overtime in excess of 10 hours (e.g., post-acute hospitalization).

• Continuity of Care (COC) approvals last for the duration of the consumer's PCA prior authorization period (includes complex medical needs that require specialized skills, length of consumer-PCA relationship >5 years, and other criteria)

• Amends PCA regulation to provide for 50 hour cap (which covers ~66% of OT hours)

• Applies a consistent health and safety cap of 66 hours on COC approvals

2. Creates a compliance policy for unauthorized PCA overtime.

• The current proposed framework provides for 3 warning letters to PCAs with opportunities of 30 days each to correct the overuse of overtime unless the consumer employer has received authorization to schedule overtime.

• After the 3rd warning and opportunity to correct overuse: PCAs who continue to work overtime per

week without authorization would be issued a notice of proposed sanction. The proposed sanction would be termination as a MassHealth provider.

• Consumers who continue to schedule overtime without authorization would, at minimum, be required to receive additional skills training.

3. Strengthens consumer/ PCA protection and program integrity by implementing Electronic Visit Verification (EVV) by January 2018

• Ensures resources go to individuals who need services vs. fraud and abuse

• Supports identification and closing of care gaps (e.g., PCA does not show up, need back-up triggered)

• Maintains consumer direction and promotes accountability

• Implementation of EVV will involve stakeholder engagement

4. Recruits PCAs and supports consumers in finding available PCAs who are not working overtime

• Enhances the Rewarding Work website by re-launching on 11/10/16 enhanced Job Posting Board + simplified PCA application

• Assures more PCAs are registered on the Rewarding Work directory by 12/31/16

• 5,000 new PCAs registered by 12/31/16

• Personal Care Management agencies will provide Functional Skills Training to consumers on using the directory to hire PCAs

• Consumers must be signed up on the directory in order to a receive an approval. 1,000 new consumers registered by 12/31/16

According to MassHealth, a consumer may request authorization to schedule a PCA to work in excess of 10 hours of overtime in a single week under certain circumstances. When authorizing a consumer to schedule a PCA to work overtime in excess of 10 hours, MassHealth will review the consumer's request and, if approved, will provide either a temporary authorization of up to 12 weeks or a continuity of care authorization for the duration of the consumer's prior authorization period. MassHealth will use health and safety guidelines in making approval determinations.

MassHealth will approve overtime in excess of 10 hours in a single week under certain circumstances:

• TEMPORARY APPROVAL

A consumer may request a Temporary approval to schedule a PCA to work overtime when:

• The consumer has a temporary need to schedule one PCA to work overtime hours, including:

• The consumer has planned travel, and it would not be feasible to bring multiple PCAs to provide the consumer's PCAs services.

• The consumer's PCAs is temporary unavailable (e.g. vacation, winter break, family leave).

• The consumer has a temporary need to schedule their PCA to work additional approved PA hours. (e.g. post-acute hospitalization)

• The consumer's PCA works greater than 66 hours per week and the Consumer needs time to hire additional PCAs.

Overtime Rally, State House. Mass Home Care photo.

A request for a temporary approval must include the specific reason(s) for such request. Temporary approvals will be granted when one or more of the following circumstances are present:

• Approvals will be granted when the consumer provides evidence that the request is time limited (for example, that the PCA is going on maternity leave and expected delivery date).

• Planned Travel: The consumer will be traveling, and it is not feasible to bring multiple PCAs to provide PCA Services during planned travel.

• Increased Need For Personal Care Service: The consumer has a temporary need to schedule their PCA to work additional approved PA hours (e.g. post-acute

needs).

• Significant challenges in hiring/retaining additional PCAs. The PCA placed multiple ads/used multiple resources for seeking PCAs, but received no responses, including evidence that the consumer registered on the rewarding work website and is using that website to try to recruit PCAs. The PCA interviewed multiple PCAs but no PCAs would accept the position. The PCA did not remain in employment because PCA could not attain basic knowledge to safely carry out the PCA assigned tasks. The PCA left employment suddenly.

• PCA short term leaves or short term fluctuations in schedule (PCA will return to work): Is in school and absent due to school breaks; has child care needs; family leave; sick leave; maternity leave. The consumer's PCA works greater than 66 hours per week and the consumer needs time to hire additional PCAs.

Paul Spooner at Overtime rally. Mass Home Care photo'

• CONTINUITY OF CARE APPROVAL

A consumer may request a continuity of care approval to schedule a PCA to work overtime when:

• The consumer has complex medical needs that require the specialized skills of the experienced PCA.

• The consumer has communication barriers that require the specialized skills of the experienced PCA.

• The consumer has specialized medical conditions that necessitate fewer PCAs. Examples might include circumstances in which additional PCAs in the consumer's home would compromise the consumer's health due to a highly compromised immune system, or a circumstance in which a consumer has significant cognitive impairments or behaviors that impact safety, and that the hiring additional PCAs would cause disruption in security, health and/or safety to the consumer.

• The consumer receives Hospice care.

• The consumer's PCA has worked with the consumer for 5 or more years.

Continuity of care Approvals are for the duration of the consumer's Prior Authorization, and must be resubmitted for subsequent Prior Authorization periods. Requests for continuity of care Approvals must include the specific reason(s) for such request. If a PCA works greater than 66 hours per week, the consumer must apply for a Temporary Authorization.

Continuity of Care Approvals:

1. The consumer has Intensive ADL and health care needs that require the specialized skills of a specific PCA. Training levels exceed basic ADL/IADL tasks. Hiring additional PCAs will cause a disruption in security and increased vulnerability to secondary, co-morbid, and age-related conditions. Physical, mental, and behavioral impairments have a significant impact on ADL and IADL performance status. Consumers approved for moderate to dependent level of physical assist with ADLS (from PCA evaluation) require 50% to 100% physical assist with ADLs. (Defined on Time for Task tool).

Procedures performed and equipment utilized are factors for consideration of complex care needs. (Time for Task tool): Tube feedings; Tracheostomy care; Vent and respiratory treatments; Ostomy care; Bowel regimes; Catheter care; Subcutaneous injections; Transfer and mobility aids (mechanical and manual); G-tube equipment; Urological equipment and drainage systems; Respiratory equipment/oxygen; Assistive devices for Communication; and the consumer provides evidence that they have complex medical needs.

2. Complex Medical Needs Include: Hospitalization admission (over the past year reports acute hospitalization requiring SNF admission); Skilled nursing facility admissions (over past two years; reports 1 or more SNF admission > 90 days); Behavioral health impairments which result in difficulty engaging with new people,

impacting daily function. (Examples includes: Social anxiety disorder or Post-traumatic stress disorder and Autism Spectrum, Schizo-affective disorder); 3 or more ADL impairments; Community Case Management-consumer using the PCA under the nurse/ PCA option; Length of Service: the PCA has worked for the consumer on an ongoing basis for 5 or more years; One On One Relationship: the consumer is approved for 50 to, up to 66 hours of PCA services; consumer has one PCA who provides all of the consumer's PCA services; consumer and PCA reside together (confirmed via 3rd party documentation).

After the second set of regulations were issued, disability activists were generally pleased with the progress that had been made. "These new regulations cover a lot of important ground," said **Al Norman**, Executive Director of Mass Home Care. "The Baker Administration is to be commended for listening to advocates, and responding to calls for more supportive regulations."

For more overtime information, go to: http://www.mass.gov/eohhs/consumer/insurance/masshealth-member-info/pca.

The Interview: Charlie Carr On PCA Overtime

One of the coordinators of the effort that changed the state's rules regarding PCA overtime, was **Charlie Carr**. Carr served as the Commissioner of the Massachusetts Rehabilitation Commission (MRC) for 8 years under Governor **Deval Patrick**. In 1974 he co-founded the Boston Center for Independent Living, and six years later he founded the Northeast Independent Living Program in Lawrence, Massachusetts. Carr was a founding member of the National Council of Independent Living (NCIL). He credits the independent living movement for his "escape" from 8 years of institutionalization. Carr is now the principal owner of Charlie Carr Consulting, a business that provides management consultation, executive coaching, strategic planning and Board and staff training for private and public entities. Here is our At Home Interview with disability rights advocate, Charlie Carr:

Q: When the Baker Administration issued its first set of regulations regarding overtime pay for Personal Care Attendants, what were your concerns?

Carr: Like most others, I was completely caught off guard because prior to the regulation the administration told advocates and service providers that there would be "no change" in the program after the Fair Labor Standards Act overtime requirements. In July the state regulation was released that capped PCA hours at 40 per week and had poorly defined exemptions along with an impossible implementation date of September 1. It was a complete bombshell with very real and dangerous implications. I realized that many people with significant disabilities on the program have PCAs that work in excess of 40 hours per week and the kind of chaos and complete disruption of their lives that this regulation would impose. When pressed for details, EOHHS reported that approximately 7,000 PCA users have PCAs that work in excess of 40 hours per week. It was obvious to me that they didn't understand the program and had no real grasp of what the human impact would be. I was beyond concerned; outraged is more like it.

Charlie Carr. Mass Home Care Photo

Q: You and others began a concerted campaign to change the overtime regulations. Describe some of the tactics of that campaign.

Carr: I was asked by the Disability Policy Consortium

to coordinate the PCA Overtime (OT) campaign in July when the regulation was released. I've been a coalition builder all of my life and quickly realized that there were several strong entities in the state that would be negatively impacted by this new regulation and were natural allies in an effort to defeat it. A steering group met in August that was comprised of the DPC, Mass Home Care, SEIU 1199, ADAPT, Personal Care Mangement agencies, Greater Boston Legal Services, and PCA users. After a lengthy group discussion, we framed a consensus plan to have the regulation rescinded and establish a stakeholder involvement process to negotiate with EOHHS for an acceptable solution. We agreed that the first thing we'd do was to outreach to Gov. Baker for a meeting to explain what our fears were with the regulation, and hope to educate him enough to change it. After the founding meeting, a smaller working group was established and laid out a blueprint; it had an escalating series of meetings/occupation of the Governor's office, a "People's regulation that laid out our OT demands," a large statewide rally, and legislative visits and support from ADAPT. The Governor never met with us and continually deflected us back to EOHHS. From the very beginning, we imagined that this would be a long-term battle and focused on holding our coalition together and communicating on a regular basis. There was a lot of work that went into each of the tactical components of the campaign but each member played a key role(s). In addition, there was a lot of work done in the legislature to educate them and garner their support. In late September a letter was written to Gov. Baker by 95 House and Senate members asking him to reconsider the regulation. Leadership in both branches prioritized PCA OT on their personal agendas and in meetings with the Governor. All of these things, combined with negative media exposure, led the Governor and Secretary Marylou Sudders to negotiate a favorable solution.

Q: What were the results? How are the new rules better?

Carr: EOHHS reached out and hosted 3 by-invitation-only workgroups and then issued an announcement in mid-November further revising the regulation that increases the 40 hour per week cap on PCA hours to 50 and specified in detail an exemption process that allows for increases to reach 66 hours per week. The exemption must be submitted and approved annually. Although this is better, it still doesn't go all the way for a fair amount of people who have PCAs that work more than 66 hours. We claim it as a victory and point out that only California has a better PCA OT policy. These changes will prevent unnecessary institutionalization and the inevitable erosion of health status when not enough hours are available to live independently.

Overtime Rally, State House. Mass Home Care photo

Q: Do your think the advocacy campaign made a difference in the outcome?

Carr: Without the advocacy campaign, the regulation would still be standing. There is no question that the coalition did an effective job in articulating the frightening negatives of this misguided regulation and fighting to defeat it.

Q: Did you learn any lessons for advocates from this campaign?

Carr: As in any battle, you learn a lot about the opposition and what they can and will do to advance their agenda. We are under no illusion that the Baker administration will do anything less than go full throttle in their quest to rein in Medicaid spending. We now know what to expect and what we need to do to keep vital programs like PCA viable and available to grow community-based LTSS. We also learned that our work must be intersectional and that disability and age cut across all of the Medicaid funded populations.

Q: If the Trump administration tries to cap Medicaid funds to our state, are advocates going to be facing even bigger battles over the future of services for individuals with disabilities?

Carr: Giving states block grant authority with their Medicaid programs presents significant challenges for poor people in general. The allocation for each state will be capped and eventually reduced which forces MassHealth to make very difficult decisions about funding a broad spectrum of programs each with their own advocacy groups. People with disabilities and elders need to pull together now more than ever to not only hold onto vital programs we fought so hard for over the years but also to enter into the managed healthcare arena to ensure that LTSS reflects our values and leaves us with a robust system to continue to reduce the institutional bias.

Governor Signs Malnutrition Prevention Commission Bill

On November 30th,. Governor **Charlie Baker** signed the Malnutrition Prevention Commission bill (S.2499: An Act Establishing a Malnutrition Commission among Older Adults)

Estimates of the annual state-specific economic burden of direct medical spending on disease-associated malnutrition is $322 million in Massachusetts. Seven days before the Governor signed this bill into law, Mass Home Care sent the following letter to the Governor:

"Dear Governor Baker,

Please support S.2499: An Act Establishing a Malnutrition Commission among Older Adults.

Today, one in three elderly patients arrive at our hospitals malnourished. An additional one in three become malnourished while in the hospital. Up to one in ten of the elders in our community is at risk for malnutrition.

This matters because patients without proper nutrition will have longer hospital stays, more complications, be at greater risk for falls, and are more likely to be re-hospitalized.

The economic burden of disease-associated malnutrition in the US is estimated to be $156.7 billion per year—and for those aged 65+ it is estimated to be $51.3 billion per year.

Today's healthcare system is being refocused to help our citizens more successfully "age in place." Quite simply, we can't achieve this without attention to malnutrition prevention.

By establishing a Malnutrition Commission we have the opportunity to make a change for the better. Malnutrition prevention and treatment should become the standard that supports the healthy aging of all senior citizens across our communities in Massachusetts."

The new law amends Chapter 19A of the General Laws by adding a new Section 42 to create with the Executive Office of Elder Affairs a commission on malnutrition prevention among older adults. The commission will have 17 members, including the secretary of elder affairs or a designee, who shall serve as chair; the commissioner of public health or a designee; the commissioner of transitional assistance or a designee; the commissioner of agricultural resources or a designee; 2 members of the house of representatives or their designees, 1 of whom shall be appointed by the speaker of the house and 1 of whom shall be appointed by the minority leader of the house; 2 members of the senate or their designees, 1 of whom shall be appointed by the senate president and 1 of whom shall be appointed by the minority leader of the senate; and 9 persons to be appointed by the governor, 1 of whom shall be a physician, 1 of whom shall be a university researcher, 1 of whom shall be a community-based registered dietitian or nutritionist

working with a program funded pursuant to the Older Americans Act, 1 of whom shall be a representative of a hospital or integrated health system, 2 of whom shall be nurses working in home care, 1 of whom shall be a registered dietitian or nutritionist working with a long-term care or assisted living facility, 1 of whom shall be a registered dietitian or nutritionist representing the Massachusetts Dietetic Association and 1 of whom shall be a representative from the Massachusetts Association of Councils on Aging.

The commission will produce a comprehensive study of the effects of malnutrition on older adults and of the most effective strategies for reducing it. The commission will monitor the effects that malnutrition has on health care costs and outcomes, quality indicators and quality of life measures on older adults, and (i) consider strategies to improve data collection and analysis to identify malnutrition risk, health care cost data and protective factors for older adults; (ii) assess the risk

and measure the incidence of malnutrition occurring in various settings across the continuum of care and the impact of care transitions; (iii) identify evidence-based strategies that raise public awareness of older adult malnutrition including, but not limited to, educational materials, social marketing, statewide campaigns and public health events; (iv) identify evidence-based strategies, including community nutrition programs, used to reduce the rate of malnutrition among older adults and reduce the rate of rehospitalizations and health care acquired infections related to malnutrition; (v) consider strategies to maximize the dissemination of proven, effective malnutrition prevention interventions, including community nutrition programs, medical nutrition therapy and oral nutrition supplements, and identify barriers to those interventions; and (vi) develop strategies for pilot testing, implementation and evaluation.

The commission will file a report annually to the House and Senate chairs of the joint committee on elder affairs and chairs of the House and Senate committees on ways and means not later than December 31.

Advocates Give MassHealth"Community Partner" Standards

On December 5, 2016, a group of 10 elder and disabled rights groups sent a letter to **Dan Tsai,** the Assistant Secretary for MassHealth, suggesting certification standards for the state to use in a procurement being issued in February, 2017 to pick "Community Partner" agencies that will provide Long Term Services and Supports (LTSS) to low income people who are enrolled in Accountable Care Organizations (ACOs) or Managed Care Organizatoins (MCOs).

MassHealth has received federal approval from the Center for Medicare and Medicaid Services (CMS) to implement a 5 year waiver demonstration to reform MassHealth to integrate acute care with behavioral health care and long term supports and services. One of the innovative proposals in this ACO plan is the use of independent LTSS Community Partners to work with the medical ACO and MCO entities. The LTSS Community Partner (CP) is a community-based entity which collaborates with ACOs/MCOs to assess and coordinate the LTSS functional component of the interdisciplinary care team's assessment. The CPs will improve member experience and quality of care, and help the managed care medical entities to leverage the expertise of existing community-based services.

Advocates wrote to MassHealth to delineate the "certification standards" needed to evaluate groups that will apply to become LTSS Community Partners. Here is the letter that was sent to Assistant Secretary Tsai,

along with the recommended list of CP certification standards:

"Dear Assistant Secretary Tsai,

We are writing to share with you an outline of recommended LTSS Community Partner (CP) certification standards. We strongly support LTSS CPs, because they are an innovative entity with the potential to improve the integration of LTSS with medical and other services in the Accountable Care Organization (ACO) plan.

To be successful, CP standards must move the needle in how coordination of LTSS takes place. It is therefore essential that CP care coordinators function in a fashion similar to LTS coordinators in One Care. As in one care, they should have as part of their core functions the role of reframing LTSS away from a medical model to an independent living, recovery model and shifting the care team approach from a medically centric model to a model that integrates member goals inclusive of ADL/ADL needs.

For this to take place it is vital that the CP governance structures and composition that foster a paradigm shift in how ACOs and medical teams function. CP certification standards should incentivize the growth of entities with expertise in the assessment and management of LTSS within the state. In particular, MassHealth should ensure its commitment to encouraging ACOs to partner with the existing LTSS community management infrastructure, and ensure the certification standards maximize member access to community-based entities that have been doing LTSS coordination for years, such as the Independent Living Centers and ASAPs.

MassHealth will need transparent, consistent certification standards for selecting CPs. The standards recommended here ensure a consistent, clear path to designation of CPs. CPs must have independence from self-dealing, and the cultural competence to assess the functional and social determinant needs of MassHealth members. The outcomes that result from CP involvement on the care team include broad consumer choice, integration of independent living and recovery principles, balance of LTSS and medical care, engagement of the enrollee in their own care planning, and care in the least restrictive, cost-effective settings.

We would like to discuss the draft standard highlighted in this letter as well as other potential standards. There is some level of urgency to our request, since MassHealth has stated its intention to issue a request for proposals for CPs in February of 2017. We urge MassHealth to provide sufficient time for the public to comment on any proposed certification standards for CPs."

The letter was signed by **Bill Henning**, Boston Center for Independent Living, **Brian Rosman,** Health Care For All, **Michael Festa**, AARP Massachusetts, **Dennis G. Heaphy,** Disability Policy Consortium, **Charles Carr**, Charles Carr Consulting, **Carolyn Villers,** Mass Senior Action Council, **Al Norman**, Mass Home Care, **Jim Kruidenier**, Stavros, **Paul Spooner,** MetroWest Center for Independent Living, and **David P. Stevens**, Mass Councils on Aging.

Attached to the letter was a list of The LTSS Community Partners Certification Standards, which included the following:

"The LTSS CP certification process should have clear standards and indicators, and an evaluation process that allows EOHHS to review applicants on a consistent basis. The list below of certification standards is designed to allow Community Partners to demonstrate the extent to which they meet each standard. Establishing a scoring or ranking process should be considered, with weighting for some core standards. Each CP applicant might receive a final numerical ranking based on its responsiveness to the following LTSS CP certification standards and others that may be added:

GOVERNANCE/CORPORATE STRUCTURE

Community Partners shall demonstrate the extent to

which they have:

• MassHealth members, family relatives, or other potential consumers sitting on the governing board of the CP.

• no financial, legal, contractual or other business interest in any ACO or MCO doing business with EOHHS, and no ACO or MCO representative sitting on the CP's board of directors.

• a mission statement regarding provision of LTSS to residents of Massachusetts

• status as a public entity, or are approved as a 501c3 organization by the IRS and are registered with the Secretary of State and Attorney General's office.

• designation from, or contractual relationship with, a state agency to work with individuals in need of LTSS.

• an ADA-accessible physical office space located in its service area.

• written policies regarding enrollee rights, which shall comply with applicable federal and state laws that pertain to such rights, including the right to be treated with respect, dignity and privacy, the right to receive information on available service options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand, the right to participate in decisions regarding his or her LTSS care, including the right to refuse services, etc.

ORGANIZATIONAL INFRASTRUCTURE

Community Partners shall demonstrate the extent to which they have:

• provided LTSS assessments and care coordination in Massachusetts for a minimum two years.

• an existing network of contracted LTSS provider agencies, MOUs, or working agreements with entities included in their CP consortium.

• the capacity to assess and manage LTSS to serve enrollees in any city or town in an ACO/MCO's service area, either directly, or through subcontracts with other Community Partners or LTSS assessment agencies.

• the capacity to conduct independent LTSS needs assessments, care management. and monitoring of care plans. Providers of facility- or community-based LTSS shall not conduct LTSS needs assessments unless the provider has select expertise or is the only qualified and willing entity available. A CP may conduct evaluation, assessment, coordination, skills training, peer supports, and Fiscal Intermediary services.

• the operational structure to manage direct service funds on a pass-through basis only, and any direct service funds firewalled from any assessment and care coordination funds.

• contractual relationships, MOUs, or demonstrable working relationships in force with service providers who can deliver to multiple subpopulations state plan LTSS, social services, and flexible services required of an ACO, and contracts, MOUs, or demonstrable working relationships in place to connect enrollees with a full range of behavioral health services, and to maintain care coordination for enrollees who present both LTSS and behavioral health needs.

• collaborative working partnerships with hospitals, primary care physician practices, rehabilitation and nursing facilities, rest homes and assisted living facilities, in the ACO/MCO service area, regarding coordination of care, inclusion of non-medical goals, patient referral and data sharing protocols.

• care management and RN staff under supervision available to respond to ACO/MCO requests for assessment consultations needed during standard business hours.

• existing infrastructure for personnel, local facilities in the service area, an IT system for capturing electronic LTSS encounter data/billing and reporting, for maintaining enrollee LTSS records with full clinical records and treatment plans, treatment goals and outcomes, and for which encounter data and records can be provided on a monthly basis.

• connectivity with the MassHiWay, and a secure, HIPAA-compliant interoperable exchange of enrollee

information between the CP and any ACO/MCO and subcontracted entities with which it contracts for assessments. The CP shall conform to HIPAA-compliant standards for data management and information exchange.

• a website that is accurate and up-to-date, and that enables enrollees and providers to quickly and easily locate all relevant information, as specified by EOHHS.

• enrollee record review procedures to eliminate unnecessary duplication of LTSS services.

• protocols in place for conducting an annual member satisfaction survey, and a process to assess the care provided to enrollees with LTSS needs.

• an independent financial audit performed annually, which is conducted in accordance with generally accepted principles and generally accepted auditing standards.

• no significant outstanding audit notes in at least their last three annual audits, and have no significant debt.

• sufficient cash flow and liquidity to meet obligations as they become due

• designation or certification by the state agency which oversees their agency over a period of at least the last three years.

• the quality assurance capacity to measure process and outcomes goals, and conduct member experience surveys as established by MassHealth for an LTSS CP.

• provide care management that is linguistically and culturally competent, including to a range of disabilities and people of differing ages, and has protocols to evaluates its enrollee population to identify language and health literacy needs, and the needs of a range of persons with disabilities, including, though not exclusively, those who are blind, deaf or hard of hearing or who have intellectual, behavioral health, physical, or multiple disabilities. protocols to assist members who are chronically or episodically homeless or housing insecure.

• the capacity to link enrollees to chronic disease self-management programs, and evidence-based wellness programs.

• a care management program designed to assist enrollees in care transitions, such as discharges from hospitals, rehabs, or nursing facilities, and capable of processing event notification protocols as a member of the MassHiWay.

CORE COMPETENCIES

Community Partners shall demonstrate the extent to which they have experience providing core competencies for community-based LTSS service delivery, social support services, and relevant flexible services. Demonstrated core competencies shall include:

• staff capacity to speak languages prevalent in their service areas, and the background to understand and be sensitive to cultural issues in minority communities.

• staff capacity to assist members in applying for and obtaining key social support services that are related to their health plan, such as housing stabilization and support services, housing search and placement, utility assistance, physical activity and nutrition, medical transportation, income security, money management, medical escort, home repair and weatherization, home modification, evidence-based health and wellness services, protective services and experience of violence supports, peer mentoring and skills training, etc.

• staff trained in person centered assessment and consumer control of services to address the goals and preferences of the enrollee, and motivational interviewing, to ensure the appropriate and least restrictive care setting as a care planning goal,

• staff trained to provide care coordination and supports during transitions of care, providing expertise to facilitate discharge to the community from hospitals,

rehabilitation centers, nursing facilities, and from other LTSS settings.

• staff trained to provide literacy level/culturally appropriate information on advance directives policies.

• staff (assessors and care managers) with the subject matter expertise to meet the needs of any subpopulation they have chosen to serve (e.g. adults with disabilities, ABI, DD, ID. etc.)

• an information and referral department with trained staff that meet the standards of its designating state agency, or other professional I&R standards.

• a detailed staffing chart.

• staff trained in self-directed care options, and protocols in place that give members a choice of at least three providers of any LTSS state plan or flexible service offered by the ACO.

ACO Plan Calls for "Conflict Free" Assessments

The CMS approval letter for the Accountable Care Organization (ACO) 1115 waiver requires the state to ensure that when MassHealth members are assessed for the LTSS needs, that the assessment is not conducted by an entity that owns services, which would be a form of self-dealing conflict of interest.

To prevent this, CMS approved the following rules:

"Assessments: The state will develop policies and procedures to ensure comprehensive assessments are completed for members enrolled in MCO-based delivery systems and Primary Care ACOs with identified LTSS needs. MassHealth MCOs, Partnership Plans, and Primary Care ACOs will be responsible for comprehensively assessing each enrollee with LTSS needs, consistent with the requirements at 42 CFR 438.208(c)(2). MassHealth will develop and set standards to ensure assessments of LTSS needs are independent, as described in STC 61(c) below

Avoiding Conflict of Interest for LTSS: EOHHS will establish policies and procedures to ensure that individuals with LTSS needs enrolled in MassHealth MCOs, Partnership Plans, and Primary Care ACOs receive independent LTSS assessments. Providers of facility- or community-based LTSS may not conduct LTSS needs assessments, except as explicitly permitted and monitored by the state (e.g. because a provider has select expertise, or is the only qualified and willing entity available). In such circumstances, the state will require that the provider entity establish a firewall or other appropriate controls in order to mitigate conflict of interest. An organization providing only evaluation, assessment, coordination, skills training, peer supports, and Fiscal Intermediary services will not be considered a provider of LTSS."

An LTSS CP will perform the following functions:

• LTSS assessments and counseling on available options

• Support for person-centered care management, care plan support and care coordination activities, including but not limited to:

1.Screening to identify current or unmet LTSS needs

2. Review of members' existing LTSS assessment and current LTSS services

3. Independent assessment for LTSS functional and clinical needs

4. Choice counseling including navigation on LTSS service options and member education on range of LTSS providers

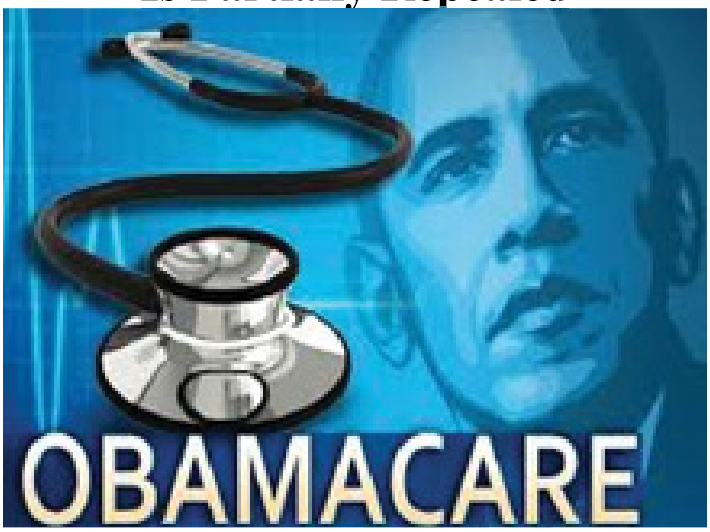
5. Care transition assistance

6. Provide LTSS-specific input to the member care plan and care team

7. Coordination (e.g., scheduling) across multiple LTSS providers; coordination of LTSS with medical and BH providers/services as appropriate

8. Member engagement regarding LTSS
9. Health promotion
10. Other activities to help promote integration across physical health, behavioral health, LTSS and health-related social needs for LTSS CP members, as agreed upon by the care team

If Obamacare Is Partially Repealed



A new analysis by the Urban Institute projects what will happen if Congress takes up a partial repeal of the Affordable Care Act (ACA) through the budget reconciliation process. The only components of the law with federal budget implications can be changed through reconciliation, which would permit elimination of the Medicaid expansion, the federal financial assistance for Marketplace coverage (premium tax credits and cost-sharing reductions), and the individual and employer mandates.

The Urban Institute compares future health care coverage and government health care spending under the ACA versus passage of a reconciliation bill similar to one vetoed in January 2016.

The key effects of passage of the anticipated reconciliation bill are as follows:

• The number of uninsured people would rise from 28.9 million to 58.7 million in 2019, an increase of 29.8 million people (103%). The share of nonelderly people without insurance would increase from 11% to 21%, a higher rate of uninsurance than before the ACA because of the disruption to the nongroup insurance market.

• Of the 29.8 million newly uninsured, 22.5 million people would become uninsured as a result of eliminating the premium tax credits, the Medicaid expansion, and the individual mandate. 82% of the people becoming uninsured would be in working families. 80% of adults becoming uninsured would not have college degrees.

• There would be 12.9 million fewer people with Medicaid or CHIP coverage in 2019.

• State spending on Medicaid and CHIP would fall by $76 billion between 2019 and 2028. In addition, because of the larger number of uninsured, financial pressures on state and local governments and health care providers (hospitals, physicians, pharmaceutical manufacturers, etc.) would increase dramatically. This financial pressure would result from the newly uninsured seeking an additional $1.1 trillion in uncompensated care between 2019 and 2028.

• The 2016 reconciliation bill did not increase funding for uncompensated care beyond current levels. Unless a different action is taken, this approach would place very large increases in demand for uncompensated care on state and local governments and providers.

• Some people would stop paying premiums, and insurers would suffer substantial financial losses (about $3 billion); the number of uninsured would increase right away (by 4.3 million people); at least some insurers would leave the nongroup market midyear; and consumers would be harmed financially.

• Many, if not most, insurers are unlikely to participate in Marketplaces in 2018—even with tax credits and cost-sharing reductions still in place—if the individual mandate is not enforced starting in 2017. A precipitous drop in insurer participation is even more likely if the cost-sharing assistance is discontinued, or if some additional financial support to the insurers to offset their increased risk is not provided.

"This scenario," the Urban Institute concludes, "does not just move the country back to the situation before the ACA. It moves the country to a situation with higher uninsurance rates than before the ACA. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit."