At Home
With Mass Home Care

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Al Norman, Editor

Beginning To Talk About End of Life Care

Atul Gawande, Alice Bonner, Andrew Dreyfus, Paul Lanzikos, Mary DeRoo. Mass Home Care photo

A new statewide survey of nearly 1,900 people shows that 85% of Massachusetts residents believe that doctors and their patients should talk about end-of-life care – but only 25% of those with serious health conditions have actually had such conversations.

The Massachusetts Coalition for Serious Illness Care conducted the survey this spring. The Coalition, which includes Mass Home Care, is a diverse set of organizations committed to ensuring that health care for everyone in the Commonwealth reflects their goals, values and preferences.

The survey found that:

• 35% of those interviewed did not want to talk about end-of-life issues with their physicians or other health care providers.

• Less than half of participants had completed a health care proxy form, or named an agent to represent their health care wishes if they were unable to do so themselves.

• 45% of those interviewed had named a health care agent---but only half of those (23%) had shared a copy of their proxy form to their doctor.

• Participants who were older and female were significantly more likely to have had a conversation with at least one person about what is important to them if they were facing a serious illness.

• Among people who had had a loved one die in the past year, 20% rated that care as only fair or poor.

"These findings are a wake-up call for all of us, clinicians and patients alike," said **Atul Gawande**, M.D., M.P.H., co-chair of the Coalition, executive director of Ariadne Labs, a joint center of Brigham and Women's Hospital and Harvard T.H. Chan School of Public Health, and author of the *New York Times* bestseller, *Being Mortal: Medicine and What Matters in the End.*

Atul Gawande. Mass Home Care photo

"People have priorities in their lives besides just living longer," said Dr. Gawande. "We have things that we live for that are bigger than just survival. The care that we get can be out of alignment with what we want, and that's when you get suffering." "I interviewed people in their first months of nursing facility care, and they were miserable. They weren't promised a life worth living."

"The goal is not a good death, but a good life to the very end," Gawande said. "If I know what matters to you, I can provide you with care that matches that. What's the minimum quality of life that is acceptable to you? The goal of palliative care is to make your best day possible."

Governor **Charlie Baker** spoke at the Coalition's kick-off event. "This is all about personal control," the Governor said. "You never want to be in a position where your desires and wishes are not known." "I don't want anyone to be without a voice when it comes to their health care. You can't fall behind on this. If you fall behind, your capacity to control your own destiny is in jeopardy."

As part of its membership in the Coalition for Serious Illness Care, Mass Home Care has pledged to ask one-third of its staff and board members—about 1,000 people---to do 4 things: 1) identify a health care agent 2) complete a health care proxy form with that agent 3) get that health care proxy form to your doctor, and 4) have a conversation with your doctor about your wishes and preferences for care.

"Life is a story with a beginning, a middle, and an end," Dr. Gawande noted. One of the goals of the new Coalition is to ensure that health care---at all stages of delivery---is compatible with the individual's wishes and preferences. Mass Home Care notes that this concern is not just for those at the margins of their mortality, but for anyone at any age who wants to be listened to.

"This concept of control over your own care is relevant for anyone at risk of institutional care---regardless of age," explained **Al Norman**, the Executive Director of Mass Home Care. "We need to listen to the thousands of seniors in this state who are nowhere near the end of their life, but who are saying 'I want to live at home---not in an institution.'" Norman said. Massachusetts does not spend its health care dollars in accord with the overwhelming expressed desire of the elderly and the disabled to live in the least restrictive setting. "We need to listen to what people want for care not just at the end of life—but at the beginning and middle of life too. At any age, people want to be treated as persons, not just as patients."

Feds Cut Off Funds for Money Follows the Person Program

On April 19th, the Executive Office of Health and Human Services (EOHHS) notified elder and

disabled groups that a program known as Money Follow the Person (MFP) Rebalancing Demonstration was being abruptly cut short by a year, per order of the federal Centers for Medicare and Medicaid Services (CMS). MFP is a program that helps discharge nursing home residents who have been institutionalized for at least 90 days, to return to the community.

John Garcia, Project Director for the Massachusetts MFP, told program manages in a letter that CMS "recently notified all state grantees that they are cutting MFP budgets covering the remaining period of the Demonstration." According to Garcia the state is now "winding down our MFP Demonstration approximately a year earlier than we had planned." Garcia called the CMS decision "unfortunate."

According to EOHHS, the Massachusetts MFP project achieved great success: through March 2016, 1,680 individuals were de-institutionalized back to the community. In addition, there are many individuals with whom the program continues to work that are currently enrolled in the Demonstration and scheduled for transition.

"Because of these cuts," Garcia noted, "we will need to end transitions from qualified facilities under the MFP Demonstration by December 31, 2016, and would provide associated community services to individuals who transition under the MFP Demonstration by that date through December 31, 2017." The last date for consumers to be enrolled in the program is August 31, 2016. The last day that an individual may transition through the MFP Demonstration will be December 31, 2016, with services provided to these participants for 365 days post-discharge. The majority of MFP Demonstration participation and services therefore should be completed by December 31, 2017.

Under the MFP program, elders could get care management services , Transitional Assistance to move back to the community, assistive technology, and orientation and mobility services. Despite the untimely end of MFP, people on MassHealth in the plan will still be able to access any MassHealth State Plan service or Home and Community Based Waiver services for which they are eligible. "We have taken steps to continue this support after the conclusion of the MFP Demonstration," Garcia noted. "In particular, we will continue the MFP Waivers, ensure that Transitional Assistance is available through those waivers and other existing waivers, and continue efforts on the housing front. The HUD 811 Project Rental Assistance program, which is just beginning to identify developers and housing for transitioning individuals, will continue in Massachusetts, eventually providing up to 197 units of project-based housing as well as an additional 50 units through state provided vouchers." The top priority recipients for this housing are individuals transitioning from long-stay facilities.

Senate Budget: "Seniors Face Stressful Situation"

"Too many of our seniors face stressful situations, from health challenges to financial difficulties to emotional strain." So says the Senate Ways & Means Committee in its FY 17 state budget, which was released by Senate Chairwoman **Karen Spilka** (D-Ashland) on May 17th. "By 2030, 1 in 4 Massachusetts residents will be over the age of 60."

The Committee's budget provides a total of $287.7M for elder affairs, a $4.3M increase over the FY 2016 funding level. But within that total, certain programs, like home care, actually sustained a cut in funding below FY 16 appropriations. Home care

dropped by $771,817 in all three budget proposals issues thus far in the State House: the Governor's budget in January, the House budget in April, and now the Senate budget in May.

The Senate Ways & Means budget acknowledged "demographic shifts in our population," but the senior budget is having its own "stressful situation."

Sen. Karen Spilka mwcil photo

In a joint letter to the Senate Chairwoman, a group of 20 elder agencies, including Mass Home Care, applauded the Senate's messaging about the need for state residents to "continue to care for each other."

"We agree," the advocates said, "that 'demographic shifts in our population' are challenging our families today—and will become more challenging as our elder population rises 46% by the year 2035. We also agree that 'intergenerational support systems' are key to dealing with the social transformations that threaten the ability of older persons to live in the 'least restrictive setting' appropriate to their needs---one of the missions of the MassHealth program (Ch. 118E,s.9)."

"A 'strong and resilient Commonwealth' includes strong and resilient seniors," the letter continued. "Just this past week, two new reports---one from the BCBSMA Foundation on LTSS, and a second from the Elder Economic Security Commission—underscore the growing demand for long term services for seniors, and the financial insecurity that many older households face."

"According to the Medicaid Public Policy Institute, nearly 70% of people turning age 65 will need some level of LTSS in their lifetime, with 40% of people needing services for more than 2 years and 16% of people needing over $100,000 in services. Data from Truven Health Analytics reveals that if Massachusetts spent in FY 13 the same % share of its total LTSS spending as Oregon spent on home and community based services (78.9%) that same year, it would have shifted $850,910,425 into community care."

In response to the Senate budget, Mass Home Care is supporting three budget amendments:

• An amendment filed by **Senator Joan Lovely** (D-Salem) that would equalize the rates between two separate home care management rates (the Enhanced Community Options program and the Community Choices program) that essentially have the same scope of care management services. Care managers who serve elders in one account, also serve elders in the other account interchangeably. The only difference is that ECOP people are not on MassHealth. But the clients in both programs are clinically at the nursing facility level of care. The FY 16 rate for ECOP care management is $215.90. The rate for Community Choices is $275. Every time an ASAP care management goes out on an ECOP visit, the ASAP is paid $59.10 less than a Choices client. The projected cost of this rate equalization for FY 17 is $5.02 million based on projected caseload.

• An amendment filed by **Senator Barbara L'Italien** (D-Andover) This language allows EOEA to write regulations to provide home care services to those "near poor" elders whose annual income does not exceed more than 15% above the current income limits (elders with incomes between $27,015 and $31,066). It allocates a capped pool up to $2.7 million for such applicants. If this 'near poor' fund was split between the basic home care program and the enhanced home care program, EOEA could provide services to 276 elders per month in the basic home care program, and 165 elders per month in the enhanced home care program for the full fiscal 2017 year. This would slow down the progression towards nursing facilities for a total caseload of 441 frail elders per year. This "near poor" fund is capped, and EOEA would report to house and senate ways and means on the caseload attributed to this fund.

• An amendment filed by Senator **Michael Moore** (D-Millbury) which would add $1.75 million to the line item which pays for the operations and staffing at the

26 Aging Services Access Points (ASAPs). The staff in this line item are mostly frontline care managers and RNs. A 2015 independent salary study of 1,305 ASAP care managers and RNs concluded that workers in the home care system are being paid "below market rate salaries." The care management turnover rate is 20% per year. This funding would mitigate the "low salary/ high turnover" syndrome that causes employees to leave the elder services field, and bring this account level with where it stood in FY 16—which is the same as where it stood in FY 11.

Sen. Barbara L'Italien

• An amendment filed by Senator **Barbara L'Italien** that would add spouses to the list of family members who can be paid under MassHealth to provide personal care services. This amendment has been unanimously passed by the Senate twice in the past year, only to die on the budget Conference Committee. The amendment would require the Executive Office of Health and Human Services to file a MassHealth state plan amendment to allow payment to spouses. The federal government has 4 ways to allow this to happen: a 1915c waiver amendment, or a 1915i, 1915j or 1915k state plan amendment---all options under the Affordable Care Act. Research from the California personal assistance services program, where spouses have been paid as caregivers since the mid 1990s, demonstrates that the use of spouses as caregivers has had no adverse financial impact on Medicaid costs. Spouses are cheaper to use than other caregivers, because they do not have to be paid for routine tasks that spouses normally provide for one another, as described below. The Veterans Administration also allows vets to have their spouse as a paid caregiver, including in Massachusetts.

Health Policy Commission ACO Certification Called "Weak"

In January of 2016, Mass Home Care testified before the state's Health Policy Commission that the proposed Accountable Care Organizations (ACOs) should be required to offer enrollees an "independent agent" to arrange for their long term services and supports (LTSS), since ACOs are specialists in health care, but not in LTSS.

"ACOs are likely to be networks of medical care providers, or health insurance entities," Mass Home Care said, "that have little experience with the provision of Long Term Services and Supports (LTSS). These entities have focused on the 'triple aim' of improved patient experience, improved health outcomes, and lowered medical costs. In the LTSS culture, the triple aim is: 1) preserving independence (care in the "least restrictive setting,"2) maintaining control over services (patient-directed care) and 3) choice of care plan services (open network of medical and functional support options)."

"Advocates for LTSS services want ACOs to have the capacity to provide consumers with an integrated care plan of medical and functional LTSS supports that addresses not just medical, acute care needs---but also ADL/IADL/social determinant needs, and to avoid the 'medicalization' of LTSS care," Mass Home Care said. "ACOs should be able to demonstrate the ability to give consumers the care that meets their aspirations and desires. CMS has created the concept of an 'independent agent' on the Interdisciplinary Care Team who performs the assessment and care coordination of the LTSS care needs of the member. This agent helps the member articulate what supports are needed, which the agent can purchase from 3rd parties without any financial conflict of interest."

According to Mass Home Care, the independent agent model has been used for 40 yeaers by the Commonwealth for the elderly home care program (MGL Ch. 19A,4b), as well as the Senior Care Options Plan (MGL Ch. 118E, 9D), and the One Care plan (MGL Ch. 118E, 9F. "ACOs should demonstrate that their members' benefit includes an initial assessment and ongoing LTSS care coordination by an independent conflict free care coordinator." Mass Home Care said.

In Final Rules issued by the Centers for Medicare and Medicaid Services (CMS) for the provision of Home and Community Based Services, there is a section on Independent Assessments (§ 441.720), which requires that states use assessors who "must be independent; that is, free from conflict of interest with regard to providers, to the individual and related parties, and to budgetary concerns." CMS requires the "independence of the assessor in accordance with section 1915(i)(1)(H)(ii) of the Act, and we will apply these also to the evaluator and the person involved with developing the person-centered service plan, where the effects of conflict of interest would be equally deleterious." CMS says that "states have the flexibility to determine the entity that can perform this function, consistent with the requirements at § 441.730 regarding qualifications and § 441.720 regarding the independent assessment."

Mass Home Care said that the function of the conflict free independent agent is critical to the success of the ACO demonstration, and ACO certification standards need to include this design element. In addition, Mass Home Care urged the Health Policy Commission to state that ACOs need to be committed to the cornerstone mission of MassHealth found in MGL Chapter 118E, S. 9 that members should be cared for "in the least restrictive setting," and this principle must be embedded in the HPC Certification standards for ACO.

When the HPC voted on its final certification standards for ACOs on April 27th, neither "least restrictive setting" nor "independent agents" were part of the standards. The new certification criteria includes a "cross-continuum of care" criteria #6, which says that ACOs must collaborate with providers outside the ACO, as necessary, including long term care providers. ACOs would have to produce a narrative regarding how the ACO collaborates with clinical partners like "long term care providers."

Mass Home Care called Criteria #6 on "collaboration" a "largely meaningless metric that measures nothing that matters, and leaves consumers with no protection from ACOs who will self-deal." ACOs will own or control a network of providers, and will refer to those providers as a form of self-referral.

New Overtime Rules Add $52 M to PCA Program

New Federal rules on overtime pay are costing state government an estimated $1 million a week in the Personal Care Attendant program.

On May 6th MassHealth held a ten minute phone call with Personal Care Management (PCM) agencies about a revised "Overtime Management Policy" for the Personal Care Attendant (PCA) program, in response to the new Fair Labor Standards Act rules from the federal government.

On the call, MassHealth stated that they will ask PCMs to "work closely" with PCA clients to inform them that this new policy "will not decrease their authorized PCA hours." MassHealth said within the next 2 weeks they would be getting out details of this new policy to PCAs and PCMs. Four days later, PCA advocates sent the following letter to MassHealth:

"The Statewide Personal Assistance Coalition is writing regarding the use of overtime hours by personal

care attendants since the state began paying OT on January 1 of this year in compliance with the Fair Labor Standards Act. Our understanding is that MassHealth wishes to place controls on its use in order to contain costs. Our hope is that you will continue to work with PCA users, PCAs, and advocates to develop a plan that addresses the needs of all parties involved. We greatly appreciate that the state acted affirmatively to comply with FLSA and did not disrupt the lives of consumers and attendants at the start of this year.

Of primary importance in any effort to change how the PCA program functions is to ensure that the program continues to be a stable, reliable, and effective bedrock of independence for people with disabilities of all ages living in the community. Further, it must continue to embrace the principles of consumer choice and control as it enables consumers to live in the most integrated, least-restrictive environment in compliance with the Supreme Court's Olmstead decision and the Americans with Disabilities Act. Any limits placed on overtime use must consider this as a predominant factor. Serious disruptions in consumers' wellbeing— and that of attendants as well— could otherwise result. No one wants to see anyone have to enter a nursing home or other institutional setting because of service disruptions.

Approximately 70,000 people either receive or provide PCA services, and the care and economics of the program are vital to how people with significant disabilities and attendants— including many single heads of households, ethnic and racial minorities, and immigrants living in some of our poorer communities— live. PCA work is vital, though historically workers have received neither sufficient compensation nor benefits, though we acknowledge there has been movement to change this situation in recent years. That half of the costs of the program are borne by the federal government adds further to the significant value of PCA services to Massachusetts.

As a means to assist us as we consider any plan that you put forth that limits PCAs' use of overtime, we request the data used in determining the expense of OT use. It will be especially important to identify scenarios where harm might accrue to consumers and attendants, and conversely where excessive OT might be an indicator of a PCA working beyond what would be considered safe limits. We also request any transcripts that might be available from the three listening sessions conducted in Boston, Worcester, and Springfield. The many consumers, attendants, union representatives, family members, surrogates, and advocates who attended gave notably strong testament to the value of the program."

Bill Henning, Mass Home Care photo

Several days after this letter was sent, one of its authors, **Bill Henning**, the Executive Director of the Boston Center For Independent Living, sent out this update to advocates:

"In a meeting with MassHealth officials we have learned details of the state's planned management of PCA overtime hours. The basics of their proposal, which will need to go through regulatory approval, are as follows:

- PCA overtime will be permitted for those who are live-in PCAs as the state transitions to overtime controls.
- An exception procedure will be developed to ensure continuity of care where a 40-hour restriction would be harmful, though we believe they wish a minimal number of permanent exceptions.
- The cap for overtime for exceptions will be 60 hours/week.
- Implementation would start September 1, with the steps to begin the regulatory process starting in the next ten days or so. A public hearing will be held on or about

May 31.

• Administrative processes are in development and it is expected community input will be needed.

In discussing these plans, **Dan Tsai,** EOHHS Assistant Secretary for MassHealth, emphasized a commitment to PCA services and no interest in cutting the program. But he equally emphasized steep fiscal challenges faced by MassHealth, citing these numbers:

• Member growth last year was 1.8%.

• In the past two years program expenses have grown from $574 million to $704 million (23% increase).

• Recently implemented sick leave costs $21 million/ year.

• The state's fiscal year 2017 budget, which begins July 1 of this year, adds over $60 million to the program but none for overtime. But in consideration of no new overtime management policies being in place until September and continuing obligations with the proposed exceptions, they anticipate needing to add another $16-20 million to the FY 17 PCA budget.

• $12 million/year is being spent on travel time and there would be no change in reimbursing eligible travel.

• PCA overtime costs for SCO and One Care consumers are being covered by MassHealth (PCA overtime costs were presumably not in the capitation rates established for these plans).

• The approximate weekly costs of PCA overtime are $1 million.

In addition, Assistant Secretary Tsai indicated that 7,300 consumers use PCAs who are working over 40 hours per week, though in many instances these consumers uses multiple PCAs so there is not reliance on just one person.

We will provide information on the hearing and comment process on this plan as soon as we have it. During the meeting, **Paul Spooner** of the MetroWest Center for Independent Living, and **Dennis Heaphy** of the Disability Policy Consortium, who both use PCAs, pointed out that:

• the federal government reimburses MassHealth 50% of PCA costs;

• support of PCAs is a significant economic investment in our communities; and that the PCA program remains critical in keeping people out of nursing homes."

Obama Extends Overtime Pay To Millions of Workers

Getty Images

In a related overtime story, the White House announced on May 17th that it was implementing new rules that expands overtime pay to millions of American workers. Here are excerpts from an email sent by President **Barack Obama** announcing the change:

"I wanted you to be the first to know about some important news on an issue I know you care deeply about: making sure you're paid fairly.

Tomorrow, we're strengthening our overtime pay rules to make sure millions of Americans' hard work is rewarded. If you work more than 40 hours a week, you should get paid for it or get extra time off to spend with your family and loved ones. It's one of most important steps we're taking to help grow middle-class wages and put $12 billion more dollars in the pockets of hardworking Americans over the next 10 years.

The fundamental principle behind overtime pay comes from a Depression-era law called the Fair Labor Standards Act, which helps ensure that workers who put in more than 40 hours per week should generally get paid more for that extra time. I directed Secretary of Labor **Tom Perez** and the Department of Labor to update and modernize the overtime rules and uphold that principle.

After more than a year of listening to workers, employers, and concerned citizens like you, the Department of Labor will issue a new rule tomorrow to

make it clearer to workers and business which workers qualify for overtime pay. It doubles the salary threshold and automatically updates it every three years. The rule takes effect December 1.

Americans have spent too long working long hours and getting less in return. So wherever and whenever I can make sure that our economy rewards hard work and responsibility, that's what I'm going to do. Every hardworking American deserves a paycheck that lets them support their families, gain a little economic security, and pass down some opportunity to their kids. That's always worth fighting for."

The Administration is raising the overtime salary threshold. Nearly all workers earning salaries beneath that threshold are entitled to time-and-a-half pay whenever they work more than 40 hours in a week. The current threshold is just $23,660. The White House is doubling that number, to $47,476, guaranteeing overtime rights for salaried workers earning less than that. The Labor Department will now update the threshold every three years to make sure it keeps pace with inflation.

The White House estimates that the change will bring overtime rights to 4.2 million workers who are currently excluded. It will also clarify eligibility for another 8.9 million workers who may or may not have overtime protections under the current rules, the White House said.

Elder Economic Security Commission Issues Report

In mid-May, the Elder Economic Security Commission, established under the FY 2014 state budget, issued iTs 56 page report to the public, containing 26 recommendations for action ranging from increasing retirement income, and affordable housing, to health care and long term services and supports.

The Commission was tasked with examining the strategies to increase the economic security of older adults, and to help older residents remain living in their communities. The Commission assessed older adult's current level of economic security, identified policies and programs to assist elders, and assessed what additional funding was needed to increase elder economic security. The legislative co-chairs of the Commissoner were Rep. **James O'Day** (D-W.Boylston) and Sen. **Patricia Jehlen** (D-Somerville). Mass Home Care's seat on this Commission was filled by **Linda George**, former CEO of Boston Senior Home Care.

Rep. James O'Day

Sen. Patricia Jehlen

Among the recommendations from this Commission are the following:

• Raise the income eligibility for home care and the Enhanced Community Options Program to 300% of the federal poverty level as a wrap around to the MassHealth program

• Amend MassHealth regulations to allow spouses to be paid caregivers under PCA abd AFC programs.

• Amend the MassHealth regulations to allow PCA consumers to receive care if they require cueing and supervision.

• Expand funding for Options Counselor/Family services Counselors working with the Aging Services Access Point Network.

• Expand funding for Benefit Enrollment Specialists available within the Aging Services Access Point Network.

• Extend the earned income tax credit for working people over age 65 (eliminate the age cap), increase the amount singles without children can receive, and increase the percentage of the federal credit that the state credit is based upon.

• Create a state line item to provide a supplement to the federal Low-Income Heating Program.

• Increase the income limits for MassHealth for people 65 and over from 100% of the federal poverty limit to 135% of the FPL, and raise the MassHealth asset limits

for seniors from current $2,000 for a single person to $13,440 for a single person.

• Create an Elder Affairs line item for the support of a geriatric mental health partnership

• Enable the Secretary of Elder Affairs to implement a universal Community Living Assistance and Supports (CLASS) insurance program for home and community-based long term supports and services.

The Commission's report concludes that "Massachusetts older adults are among the most economically insecure in the nation…63% of the state's retired elder households lacked the income required to meet the costs of their basic daily needs. 81% of African-American senior households and 91% of Hispanic senior households have incomes insufficient to meet their daily needs."

Mass Has Low Rate of Social Service Spending

A new study published recently in *Health Affairs* magazine concludes that spending rates on health care and social services vary substantially across the states, that little is known about the possible association between variation in state-level health outcomes and the allocation of state spending between health care and social services.

Looking at the period 2000–09, researchers found that states with a higher ratio of social to health spending (the sum of social service spending and public health spending divided by the sum of Medicare spending and Medicaid spending) had significantly better subsequent health outcomes for these measures: adult obesity; asthma; mentally unhealthy days; days with activity limitations; mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes. This study suggests that "broadening the debate beyond what should be spent on health care to include what should be invested in health—not only in health care but also in social services and public health—is warranted."

The new study compares state spending on social services to spending on Medicare and Medicaid and to residents' health. For more than two decades,officials in Massachusetts have asserted that Medicaid claims are budget busters, and federal officials have worked to create incentives for providers to cut costs and improve health outcomes.

"We found that the ratio of social to health spending was significantly associated with a range of health outcomes at the state level," the researchers said. "Our results suggest that adequate investment in social services and public health, not just investments in health care, may be key to understanding variations in health outcomes across the states…Our findings suggest broadening the debate beyond health care spending to include investments in social services and public health…The allocation of state-level spending om social services and public health and on health care, not just the total spending, may be key to understanding population health outcomes."

Researchers found that for every dollar of Medicare and Medicaid spending for residents of the average state, an additional $3 was spent on social services and public health between 2000 and 2009. States like Colorado and Nevada had the highest ratios of social service and public health spending relative to medical costs - about $5 for every dollar of medical treatment — and were much healthier.

New York and Massachusetts were listed with traditionally poor-health states, like West Virginia, Kentucky and Louisiana, as states with the lowest ratios of social services to medical spending, averaging about $2.30 on social services for every medical dollar spent. People in these states also tend to have higher rates of heart attacks, lung cancer, mental illness and

obesity, the study showed. The federal government is now testing Medicare reimbursement for social service referrals.

"Accountable care organizations and more recent efforts by the Centers for Medicare and Medicaid Services to create accountable health communities reward providers based on health improvements," researchers wrote. "These efforts could spur experimentation with interventions that address housing, nutrition, transportation, legal and other social services that may improve patients health outcomes."

The head of Aetna told *USA Today* that the time is right for a realignment of health care priorities. Before the recession, people thought of social services as being for "those poor people," the Aetna CEO said, and "a majority of people couldn't afford the basic necessities."

The United States trails behind nearly every other developed country in social service spending, outspending other countrie in medical spending. Yet the U.S. had nearly the sickest citizens.

Researchers at Yale found in the new study that a 20% change in the median ratio of social to health spending would result in there being 85,000 fewer obese adults in a state the following year. Adults with obesity incur about $2,700 more in average annual health care expenses than those who aren't obese.

Medicare's quality initiatives until now have been limited to a handful of medical conditions, including heart disease, pneumonia and hip and knee replacement. Medicaid programs around the United States are increasingly getting federal permission to reimburse health care providers for paying for things like housing assistance, air conditioners and allergy-reducing vacuums that improve people's health.

The Presidential Politics Of Aging

Are **Donald Trump**, **Hillary Clinton, and Bernie Sanders** surfing the Age Wave--or will it catch them by surprise?

According to gerontologist **Ken Dychtwald**, CEO of a company that advises businesses and non-profits worldwide about the opportunities and challenges of an aging population, an "age wave" is coming that will either make or break America. "Anyone seeking to be our next president should indicate their knowledge of and priorities regarding this coming age wave," Dychtwald says.

Two-thirds of all the people who have ever lived past the age of 65 in the entire history of the world are alive today, Dychtwald says. As baby boomers turn 70 at the rate of 10,000 a day, America is becoming a "gerontocracy." 42% of the entire federal budget is spent on Medicare and Social Security, and it will surpass 50% by 2030. In the 2012 election, 72% of men and women age 65+ voted, while only 45% of those 18-29 voted.

Ken Dychtwald

Dychtwald has been warning for years that America is not prepared for the potentially devastating medical, fiscal, and intergenerational crises. He charges that the presidential candidates are not addressing the "age wave" or offering innovative solutions. Dychtwald says there are "five essential transpartisan issues that must be addressed if our newfound longevity is to be a triumph rather than a tragedy." He says he is "outraged that these core issues have not been meaningfully covered (if covered at all) during the presidential debates and interviews."

Here are Dychtwald's 5 issues:

Issue # 1: What is the new age of "old?" When Social Security began, the average American could expect to live only 62 years, and there were 42 workers paying for each "aged" Social Security recipient. Today life expectancy is approaching 79 and there are fewer than

three workers to pay for each recipient.

Questions for candidates:

• If there were breakthroughs that would further elevate life expectancy, would you consider "indexing" entitlements to rising longevity?

• Would you support funding the retraining of older workers for new careers? How should this be done? Would you incentivize employers who hired older workers?

Issue #2: The diseases of aging could be the financial and emotional sinkhole into which the 21st century falls. Until recently, most people died swiftly and relatively young of infectious diseases, accidents, or in childbirth. As a result of modern medical advances and public health infrastructure, we've managed to prolong the lifespan, but we have done far too little to extend the healthspan—as pandemics of heart disease, cancer, stroke, Alzheimer's and diabetes are running rampant. Our healthcare system is incompetent at preventing and treating the complex and intertwined conditions of later life. Our doctors are not aging-ready. We have more than 50,000 pediatricians, but fewer than 5,000 geriatricians. Only eight of the country's 145 academic medical centers have full geriatrics departments, and 97% of U.S. medical students don't take a single course in geriatrics.

Questions for candidates:

• What bold measures would you take to eliminate Alzheimer's before it beats us? Are you willing to make this your "moonshot" and commit whatever resources are necessary to make it happen?

• Considering 34 million people are providing care to an elder loved one, what changes would you make to the tax code and work leave policies to help them out?

• Where do you stand on active euthanasia, passive euthanasia, and assisted suicide.

Issue # 3: Averting a new era of mass elder poverty: Roughly half (52%) of all households near retirement (headed by someone age 55+) have NO retirement savings and about half (51%) of our population have no pensions beyond Social Security. We could be heading to a future in which tens of millions of impoverished aging boomers will place crushing burdens on the U.S. economy and on the generations forced to support them. Questions for candidates:

• Considering the substantial "asset inequality" among older adults, would you affluence test entitlements to give more to those in need and less to those who are not?

• Describe Social Security as you think it should be for the millennial generation.

• How would you avert mass poverty among the aging boomer generation (half of whom are already retired and for whom it may be too late to catch up)?

Issue # 4: Ending ageism. In our youth-focused society, many people of all ages are gerontophobic—uncomfortable both with older adults and their own aging process. And many institutions—from urban planning, to education, to technology, to employment hiring practices, to housing—are both youth-centric and ageist. Less than 2% of our housing stock is built to be safe and accessible for elders (and one third of the elderly fall each year). Similarly, the routes of public transportation were created with young workers, not retirees, in mind.

Questions for candidates:

• Do you believe that ageism exists in America? What would you do as president to wipe it out?

• How should our communities become more "aging friendly?" How would you bring that about?

• Since, as they age, millions of people struggle with mobility and transportation (and corresponding social isolation), what would you do to remedy that?

Issue # 5: The new purpose of maturity. Our 68 million retirees currently spend an average of 49 hours (2,940

minutes) a week watching television. Ultimately, the problem may not be our growing legions of older adults, it may be our absence of imagination, creativity and leadership regarding what to do with all of this maturity and longevity. The unprecedented historical challenge/opportunity of the age wave is how we can unleash our greatest growing natural resources that are hiding in plain sight: experience, skills and wisdom.

Questions for candidates:

• What is your biggest idea for what America's 68 million retirees could be doing to contribute to our society?

• If we could trade two hours per week of retirees' television viewing time for two hours per week of volunteer time, what would you do with those 200+ billion additional public service hours over the next 25 years?

• What would you do as president to elevate the role of elders in our society?

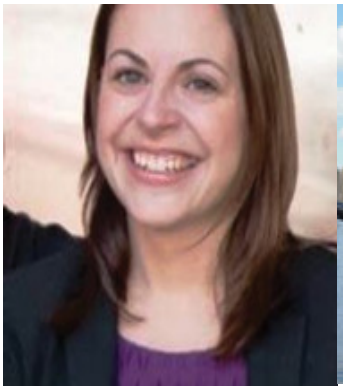
" Just as society's institutions were grossly unprepared for the baby boom, we have done far too little to prepare for the coming 'age wave.'" Dychtwald warns. Do we as a nation have the guts and wisdom to ask – and answer – these questions? The next eight years will be the turning point. I surely hope that our next president is prepared to address these critical issues and boldly make the course-corrections necessary to usher in a healthy and purposeful future of aging."

Minuteman Senior Services Names New Executive Director

Minuteman Senior Services, one of the 29 member agencies of the Mass Home Care Association, based in Bedford, recently announced the appointment of **Kelly Magee Wright** as Executive Director, beginning June 20. She succeeds **Joan Butler**, who has served as Executive Director of the agency since 1984.

Butler, who served for two years as a President of Mass Home Care in the 1990s, is retiring in June, Butler began her tenure as Assistant Director in 1982 and led the agency through periods of major growth.

"We have been extremely fortunate to have had Joan Butler as our Executive Director for the past 32 years. The number of people over the age of 60 in our service area has nearly doubled during her tenure, with the agency serving over 27,000 people through 20 different programs last year" said **Margaret Hoag**, Board President. She added, "This is an exciting time for Minuteman Senior Services, and I am confident that Kelly Magee Wright is the right person to lead this quality organization".



Kelly Magee Wright

Joan Butler

Originally from Acton, Magee-Wright has extensive executive healthcare leadership experience, most recently as the Director of National Development and State Support at Caregiver Homes, where she held numerous management roles. She holds a Masters of Social Work from Simmons College School of Social Work and a BA in Psychology from University of Massachusetts at Amherst. She currently sits on the Board of Directors of the Massachusetts Council for Adult Foster Care.

Mass Home Care Executive Director **Al Norman** called Butler "one of the most innovative thinkers in the aging network."

Mass Home Care's 33rd Annual Meeting

Monday June 20, 2016

11 AM at the Burlington Marriott

Andrew Dreyfus, Blue Cross Blue Shield; Alice Bonner, EOEA; Representative Denise Garlick, Senator Patricia Jehlen, Senator Barbara L'Italien.

For reservations call: 978-502-3794