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Baker Rescues Elders From Wait List

On October 6th, Governor **Charlie Baker** put his signature on H. 4664, a supplemental funding bill that included section 28, which added $3.78 million to the elder home care services line item. The Governor did not change the line item as he received it from the legislature—thus putting an end to a waiting list for home care that began on September 1st.

According to Mass Home Care President, **Greg Giuliano**, the 36 day wait list was the shortest in history. "We really were able to end the wait list quickly due to extraordinary help from Senate President **Stan Rosenberg** (D-Amherst), House Speaker **Robert DeLeo** (D-Winthrop), and the Governor," Giuliano said. "House Ways and Means Chairman **Brian Dempsey** (D-Haverhill) and Senate Ways and Means Chairwoman **Karen Spilka** (D-Ashland) sped this bill through, because they knew this items in it were all urgent." Giuliano also credited Senate Minority Leader **Bruce Tarr** (R-Gloucsester), and House Minority Leader **Brad Jones** (R-North Reading). "This supplemental appropriation happened during an informal session," Giuliano said, "when any one lawmaker could have derailed it." If the Governor had not signed the measure, the home care wait list would have continued into January or February before the next chance came to end it. "We could have had 2,000 elders in the No Care Zone by the end of June if we had not taken decisive action in October," Giuliano said.

Giuliano credited hundreds of elder advocates across the state who sent emails to their lawmakers and

the Governor to speed this funding through. He noted that AARP Massachusetts also notified thousands of its members in the Commonwealth to speak out on the need for the home care funding.

Section 28 adds $3.78 million of federal "Community First" trust fund to the home care services account. It raised the share of funding for this line item from 1.5% to 5%. Even with this funding, the home care programs are just about level to their appropriation level in FY 2016--so there are still some challenges ahead this fiscal year.

State Issues Bid for Accountable Care Organizations

On the 29th. day of September, MassHealth released its Request for Responses (RFR) for Accountable Care Organizations (ACOs). The document provides the public with an overview of the ACO program, including details on some of the key aspects of the program, such as the structure of ACOs and their provider networks, member experience and rights in ACOs, and payment and quality accountability of ACOs. The 89 page document came with 27 attachments.

An ACO is a group of Primary Care Providers (PCPs) that have partnered with each other and with other providers to deliver care that is integrated, wellness-focused, culturally and linguistically accessible, and member-centered. ACOs will provide the structure for primary care providers to integrate members' care by facilitating providers' communications with each other and investing in necessary primary care infrastructure.

ACOs will establish new affiliations to expand beyond a purely medical model of care, including working with Long Term Support Services (LTSS "Community Partners," which will help members navigate to community resources to address health-related social needs.

The RFR document describes the three ACO models that are part of MassHealth's ACO program: (1) Accountable Care Partnership Plans; (2) Primary Care ACOs; and (3) MCO-Administered ACOs. MassHealth will be selecting ACOs to participate in each of the three ACO models. The ACO model promises to integrate medical care services with behavioral health supports, and long term services and supports (LTSS) into one package of benefits.

MassHealth says it is committed to delivery system reform that is "member-centered" and improves member's care experience and outcomes. MassHealth ACOs must include consumers or consumer advocates as voting members of their governing boards and incorporate Patient and Family Advisory Councils as part of their broader governance structures. Additionally, ACOs' responsibilities for care delivery include requirements to provide member-centered care plans for appropriate members, similar to those present in the One Care program.

The ACO plan will include "staged, thoughtful introduction" of long term services and supports (LTSS) into the MCO and ACO programs. MassHealth intends to transition LTSS into the scope of MCO covered services and include it in the ACO cost of care by Year 3 (FY20) or Year 4 (FY21). MassHealth has also issued a "Request For Information" for entities that want to become LTSS "Community Partners," a new type of entity that will coordinate LTSS under contract with the ACOs/MCOs. As part of the ACO and MCO procurement processes, bidding MCOs and ACOs will be evaluated considering their experience and capabilities around LTSS, including their knowledge of

the population and their competencies with disability culture.

MassHealth will establish requirements governing ACOs' affiliations with Community Partners; these requirements will ensure that ACOs are building linkages to the community, "buying" existing expertise rather than "building" redundant capacity, and not over-medicalizing care. ACOs will provide care coordination and care management activities to certain members; for example, following up with a member after discharge from the hospital.

The ACO program includes three ACO models. An ACO will only be able to participate in one model at a time. Members' benefits and covered services will not differ between models.

•**Accountable Care Partnership Plan** (**Model A** ACO or "Partnership Plan") – An ACO that is partnered with a single managed care organization (MCO). Each Partnership Plan has an exclusive group of primary care physicains (PCPs), and all members enrolled in a Partnership Plan receive primary care from these PCPs. Like a MassHealth MCO, the Partnership Plan is paid a capitated rate for members, and is at risk for losses and savings beyond the capitation rate. Because the Partnership Plan is an MCO, it will perform many of the administrative functions, like paying claims, maintaining the provider network, prior authorization, etc. The Partnership Plan will communicate directly with enrollees what it offers and how to access services. Unlike a MassHealth MCO, Partnership Plans do not have to cover an entire specified geographic region. Partnership Plans will define their service areas, with MassHealth approval, and will need to have network adequacy in those service areas.

• **Primary Care ACO** (**Model B** ACO) – An ACO that contracts directly with MassHealth. Each Primary Care ACO will have an exclusive group of participating Primary Care Clinicians (PCCs), and all members enrolled in a Primary Care ACO receive primary care from these PCCs. Unlike MassHealth MCOs and Accountable Care Partnership Plans, Primary Care ACOs are not paid a capitation to provide services. Instead, their attributed members receive non-behavioral health care from MassHealth's fee-for-service network, which is paid for directly through the MassHealth claims system. Members attributed to Primary Care ACOs are also automatically enrolled in MassHealth's behavioral health plan (the existing contract is with Massachusetts Behavioral Health plan-MBHP). The Primary Care ACO is accountable through shared savings and losses payments based on Total Cost of Care (TCOC) and quality performance for the Primary Care ACO's population of Attributed Members.

• **MCO-Administered ACO** (**Model C** ACO) – An ACO that is part of the primary care provider network(s) for one or more MassHealth MCO(s). An MCO-Administered ACO may contract with multiple MCOs; an MCO may also contract with multiple MCO-Administered ACOs as part of its network. Each MCO-Administered ACO has an exclusive group of Participating PCPs. Members who enroll in an MCO may be attributed to an MCO-Administered ACO. Members attributed to an MCO-Administered ACO receive care from their MCO's network, which is paid for directly by the MCO. MCO-Administered ACOs are accountable to their MCOs through shared savings and losses payments. MassHealth must approve these financial arrangements and the associated requirements in the contracts between an MCO-Administered ACO and its MCOs in order for the MCO-Administered ACO to be eligible for federal Delivery System Reform Incentive Payment Program (DSRIP) funding.

Partnership Plans will receive a prospective, monthly capitation payment, subject to a risk corridor, like MCOs. Primary Care ACOs will receive a Total Cost of Care (TCOC) target, calculated based on the

ACO's population and anticipated costs. After each year, MassHealth will assess the performance of each Primary Care ACO against its TCOC target, and will make a shared savings payment if the ACO has achieved savings, or require the ACO to pay a shared losses payment if the ACO has losses against the target. MCO-Administered ACOs will receive a TCOC target, calculated based on the ACO's population and anticipated costs. MCOs will perform the assessment on TCOC performance and make or receive payments for their MCO-Administered ACOs.

MassHealth will require ACOs to establish agreements with Community Partners. MassHealth ACOs must contract with enough MassHealth-certified CPs to ensure their members with BH or LTSS needs have appropriate access to CPs that the ACO is partnered with. MassHealth believes this requirement will improve care for members in ACOs and will encourage ACOs to be more effective in expanding beyond a medical model of care and in integrating across the physical health, BH, and LTSS delivery systems. Community Partners will provide ACOs with ready linkages to the communities they serve. CPs will bring expertise in BH clinical management (for BH CPs) and coordinating between the physical health and LTSS systems (for LTSS CPs), providing the integration of care necessary to serve these populations more effectively. Community Partners will receive infrastructure funding directly through DSRIP, providing ACOs an opportunity to expand their own capabilities more efficiently than building new capabilities in-house. Non-MCO covered services (e.g., most LTSS) will not be initially included in ACO financial accountability, although LTSS services will be phased in. ACOs will be required to screen all their members to identify their care needs, including unmet needs, such as BH-related needs, functional or LTSS needs, and health-related social needs. They will facilitate access to social services to address health-related social needs, including using flexible services DSRIP funding. ACOs will coordinate care, including establishing discharge protocols to manage transitions of care, and coordinating with agencies or providers involved in members' care, establish wellness initiatives and education programs, and disease management programs for prevalent conditions.

ACOs will identify members who might benefit from care management, including members who are medically complex, have multiple comorbidities, are at risk for readmission, are episodically or chronically homeless, have significant BH care needs, have LTSS needs, or are receiving services from state agencies. They will provide member-centered comprehensive assessment and care planning for certain members, including for members with LTSS or significant behavioral health needs, and including using LTSS CPs to ensure appropriate independence for the functional component of such assessments. ACOs will provide care management activities for certain members, which may include convening integrated care teams and working with CPs to ensure BH and/or LTSS representation, and assigning care coordinators or clinical care managers to oversee member's care. All ACOs will be accountable for a range of quality and member experience measures, including process and outcome measures related to care management, care integration, and member satisfaction.

ACOs must serve a minimum number of members (20,000 for Partnership Plans; 10,000 for Primary Care ACOs; and 5,000 for MCO-Administered ACOs). Accountable Care Partnership Plans and MCOs will be required to provide continuity of care for new enrollees for at least thirty days, or as long as medically necessary or required to ensure a coordinated transition to an in-network provider, including any enrollees with durable medical equipment (DME), prosthetics, orthotics, and supplies (POS), physical therapy (PT), occupational therapy (OT), or speech therapy (ST) that was authorized by the enrollees' previous Partnership Plans or MCOs or by MassHealth directly can continue

to receive those services for at least thirty days after enrollment. Members may be allowed to receive care from providers outside of their ACO's or MCO's network under certain circumstances. ACO and MCOs will have processes to identify and assist members in such circumstances, and may develop single case agreements with these providers. As with MassHealth MCOs today, ACOs and MCOs will not be accountable for the costs of most LTSS for the initial years of their contracts; members in ACOs and MCOs will continue to receive these services from MassHealth, through MassHealth's LTSS network.

ACOs will have exclusive participation from a group of primary care providers, and affiliations with hospitals in order to meet ACOs' responsibilities to manage members' discharges and transitions of care. ACOs must partner with BH and LTSS CPs. Partnership Plans, like MCOs, must also contract with and manage a full, adequate network of providers for all covered services. Primary Care ACOs may have a designated circle of providers for which MassHealth will not require the referrals that would be required in the PCC plan. Each ACO's primary care providers participate exclusively with that ACO, meaning that a member must join the ACO to receive primary care services from that provider. This also means that a member that chooses a primary care provider who is in an ACO will be assigned to that ACO. Primary care providers can still provide specialty services to eligible members outside of their ACO, but cannot have these members assigned to their primary care panels. Accountable Care Partnership Plans, like MassHealth MCOs, will be directly responsible for providing a set of covered services. Members enrolled in Partnership Plans or MassHealth MCOs will receive these services through their Partnership Plan or MCO.

In terms of quality measures, ACOs will be scored on 38 claims, clinical, and member experience measures broken into six quality domains:

•Prevention and Wellness
•Chronic Disease Management
•Behavioral Health/Substance Abuse
•Long Term Services and Supports
•Integration
•Avoidable Utilization

MassHealth will re-procure its MCOs in 2016, and the new MCO contracts will be effective as of October 1, 2017. New ACO options will be offered to members, also starting as of October 1, 2017. Starting October 1, 2017, eligible members will be able to enroll in Partnership Plans or Primary Care ACOs alongside their present-day options of the PCC Plan or available MCOs. All eligible members will have the right and opportunity to enroll in a managed care option and select a primary care provider, as they do today. Eligible members will often have more choices than today, choosing among the following managed care options (as available):

• Available Partnership Plans in their area (new choice)
• Available Primary Care ACOs in their area (new choice)
• Available MCOs in their region, including the option (new choice) to receive care from available MCO-Administered ACOs contracted with these MCOs, based on the member's choice of PCP
• The PCC Plan

As ACOs may have smaller, more closely coordinated primary care networks than MassHealth MCOs, ACOs may not be available everywhere. All eligible members will have an opportunity to choose among the options presented above. If they do not choose within a defined period, MassHealth will assign them. MassHealth will seek to keep members aligned with primary care providers in the assignment process. Members who choose or who are assigned will have further opportunity to change their selection without cause within the first ninety days and for a limited

number of reasons after those first 90 days. Every year, members will have a new enrollment period, including a new opportunity to change plans, without cause, for ninety days.

Heaphy: People Will Have To Fight Ten Times Harder

Dennis Heaphy. Photo: Wren Meyers

On October 13th, disability rights activist **Dennis Heaphy** was invited by Mass Home Care to be the keynote speaker at its 28th Annual Network Conference, which attracted 350 elder care professionals from across the state.

Heaphy is a healthcare analyst with the Massachusetts Disability Policy Consortium. He is a founder and co-chair of Disability Advocates Advancing our Healthcare Rights (DAAHR), a coalition of disability, behavioral health, and elder advocates working on integrated care reform. He also serves as co-chair of the One Care Implementation Council. Prior to working at the DPC, Heaphy served as Americans with Disabilities Act Project Coordinator for the Massachusetts Department of Public Health and as a consultant. He has served on the board of the National and Massachusetts Alliance of HUD tenants.

Heaphy has testified before CMS on the One Care plan, and the new ACO plan. He is an advocate for disability services---but he is also a consumer of those services---so he is living the battle for independence and control every day.

Mass Home Care asked Heaphy to respond to a series of questions about long term services and supports relating to his own lived experience:

MHC: *In your own personal life, what kind of care do you want every day? Explain how your PCA coverage works.*

Heaphy: It is complicated, my schedule, my needs are always in flux and my Personal Care Attendants' schedules change. Their lives can be complicated. I need the ability to adjust my schedule. As I get older, I have more needs. My body does not bounce back the way it used to do. They do my bowel care, range of motion, shower, get me dressed. They do respiratory therapy, especially in the winter. They are my hands doing everything I need from cooking to giving me food. They are my eyes. I cannot feel anything below my shoulders and so they need to check my skin all the time, because my skin can break down fast. It's dangerous and may require long treatment in a hospital. Not everyone knows why examining the skin is so important.

It is not just a job, it is a relationship. It can be really difficult to find people, good people. I am grateful for the people who help me. I want, need, to be able to decide who comes through my door. It is very intimate. I need to train my PCAs to do the things the way I need them done so that I don't get hurt and neither does my PCA. It is more difficult to find PCAs now than it was before. An agency wouldn't help. I used an agency years ago. It was scary. I never knew who was coming to my house or if they would be willing, or even able to do the things I needed done. It's hard to find people willing to work with someone with the complex needs I have. The people who do this work, don't do it for the money, they care. It's about commitment.

MHC: *You said that the One Care program (CCA) saved your life. Explain what happened?*

Heaphy: My bed collapsed right after becoming a member of the CCA One Care program. I developed an infection of the bone that resulted in my spending eight months or so in bed, hoping it would heal. It didn't. I had to have surgery. My PCAs took care of all my

wound dressings before and after my surgery. They administered the antibiotics through a pump before and after the surgery. They did my physical therapy for months until I was able to sit again. If I were not in One Care, I would've had to go to some kind of rehab. I probably would've gotten some kind of opportunistic infection and things could have gotten worse. My PCAs know how to turn me and do everything, people in a SNF would not do that. It was expensive, but it would have been more expensive without my PCAs. I know it costs a lot of money, and I'm grateful.

Al Norman, Dennis Heaphy, Greg Giuliano
October 13, 2016 Mass Home Care Network Conference

MHC: *Why is it important that long term supports not be provided in a medical way?*

Heaphy: The medical system views me as a medical failure, a diagnosis, not a full person and would limit my opportunities. My mother was a healthy woman, but went with an undiagnosed autoimmune disease that left her with kidney failure. She was on dialysis and then broke her hip. She was in the hospital after breaking her hip and she went home with no home assessment or LTSS evaluation. That night she re-fractured her hip. As it turns out, it had never been set in the right place. Insurance plans doctors and hospitals make sure everyone has their prescriptions at the start, but they don't make sure that people have their house assessed to make sure it is safe for them when they get home. Someone should be waiting for the person, or be there that day to evaluate what they need. It's as important as medication.

MHC: *What motivates you to fight for things like social determinants and LTSS in the MassHealth ACO plan?*

Heaphy: I have a big mouth, I can advocate for myself. Other people cannot. These changes are big. I spoke with a legislator at the statehouse--one I respect--who said that she had been told by people in the medical industry that we could not lower cost and improve patient care at the same time. That is scary.

Doctors don't always know what older people and people with disabilities need, but they think they do. There are people who do not self identify as part of the disability community who may not get access to services. Someone in a healthcare clinic told me that upwards of 30% of people going to the clinic had disabilities, but the person was unaware of whether or not the LTSS needs of these individuals would be met. We have to make sure these people get LTSS.

There are people who are not English speakers, elders, who may be embarrassed to ask for help from their children or from the state and so they go without, and they suffer. It should not be this way. I'm also worried about workers. ACOs and hospitals and the state shouldn't get savings by paying a care coordinator in the community less money or give them less benefits than a care coordinator in a hospital with the same job description. It will hurt people. It will hurt the economy. People should be paid a living wage.

MHC: *Are advocates being heard? What do you see that gives you hope about this Accountable Care Organization plan?*

Heaphy: Are advocates being heard? It depends on the day. We have made advances, LTSS community partners for example. But there are concerns. The medical industry provides jobs that are important to our economy. Government leaders are beholden to them as constituents. Corporations, and even nonprofits are beholden to the bottom line. It will be difficult for advocates to have a united voice in this new system that is controlled by large hospital systems. It will be hard to track if, people are getting what they need. People will have to fight 10 times harder to get what

they need. I hate sounding pessimistic. I'm usually an optimist. One Care is not perfect, but it is a model for the country. People are getting coordinated care and LTS coordinators, even if not everybody. The two plans seem to be appreciating the LTS coordinator more. But I'm worried that the ACOs will medicalize services. They think they understand what we need, but they don't, and that's the problem. I'm a person, not a patient or diagnosis, but hospitals don't see me this way. They don't understand that my PCA and LTSS needs are as important as my medical services, or more important.

MHC: *What is the state not doing that it needs to do?*

Heaphy: The state has taken steps lately that raise concerns about whether or not it will support the growth in expenditures on LTSS needed to meet the needs of the aging population. Preventing PCAs from working more than 40 hours a week, even though PCAs have always worked over 40 hours; creating a Third Party Administrator (TPA) that will track PCAs and second-guess what an ASAP or ILC recommends for someone. We are worried the TPA will not be mission-driven or invested in improving the quality of someone's LTSS. They'll just make sure that costs are going down.

We understand the state cannot oversee all the programs it's running, but we are worried that the TPA will not be culturally competent or grow best practices for quality LTSS. We're afraid a national LTSS management company will get the contract and that it will focus only on savings rather than people's needs.

We are praying MassHealth will listen to our concerns and contract with an entity that understands our needs in Massachusetts and will work with advocates to make LTSS more person centered in addition to sustainable. LTSS has to be seen as part of a larger wellness and quality of life system, not a stand alone cost. We hope this plan will also provide ongoing consumer involvement. The TPA might get too focused on short-term money savings rather than investment in LTSS that saves money over time and improves quality of life.

We're really worried there are no goals on rebalancing spending by ACOs; no clear commitment to protecting the LTSS service delivery system from being taken over by large, corporate entities from out-of-state or even from within the state at the end of the five-year DSRIP funding.

It's important that we're at the table to educate policy makers and bring our expertise. There is no protection from ACOs building their own LTSS systems after five years. We need to protect ASAPs, ILCs, RLCs, and ADRCs, because they are mission-driven, and they are here to advocate for people who need services. Their commitment is to consumers and our quality of life, not a hospital or a plan.

The state needs to do more to build quality metrics that are important to us and reflect the priorities of elders and people with disabilities as well as other low income people on MassHealth. There needs to be a commitment to equity and access to services, regardless of payer or plan.

There needs to be consumer oversight. We need a strong advisory council, stronger than what we have for One Care. I am part of One Care, and I worry about other people who will be in ACOs and pay copayments that they cannot afford; even worse is the situation of people in the PCC fee-for-service system who will be paying even higher co-pays because the state wants them to move into ACOs.

But it's not that easy. People are skeptical of managed care and they have relationships with providers that they do not want to lose. They should not be penalized because of this. We hope the state will hear us on this issue as well and change its current plans to charge people co-pays and deductibles.

I do not want to only talk negative stuff, there are a lot of really good people up at MassHealth trying to do the right thing. There are positive things with healthcare reform in ACOs. People need someone to help them coordinate their care clearly if they see lots of specialists.

It can be difficult to keep all the medications and all the doctors' appointments and all the transportation and everything else in order when you're just trying to live your everyday life. Hopefully they will reduce unnecessary emergency room visits and hospitalizations. No one wants to be in a hospital or emergency room.

Hopefully care coordinators will help reduce the stress, reduce the errors and improve your ability to enjoy a healthy life.

Mass Ranks Second Highest In Elder Economic Insecurity

Although they're called the "Golden Years," retirement for many seniors in New England is being tarnished by economic insecurity and an inability to afford basic necessities like food, living in a safe community and affordable health care.

So says a new report on the Elder Economic Security Standard™ Index (Elder Index) and Insecurity in the States 2016 report, which calculates the Elder Economic Insecurity Rate across the country. Developed by the Gerontology Institute at the University of Massachusetts Boston and Wider Opportunities for Women, and maintained in partnership with the National Council on Aging (NCOA), the Elder Index defines economic security as the income level at which older adults are able to cover basic and necessary living expenses and age in their homes, without extra assistance.

When aggregating couples and singles age 65 and older in the six New England states, nearly one in three seniors live in the gap between poverty and economic security. When focusing solely on single people 65 and older, 18% lives below the Federal Poverty Line (FPL), while 41% lives in "the gap" between poverty and economic security.

"Being economically secure means having the financial resources to afford what is needed without forgoing the necessities of life," said **Jan Mutchler**, director of the Center for Social and Demographic Research on Aging at UMass Boston. "The Elder Index can help older adults, policymakers and caregivers understand what income threshold will actually lead to economic security in their communities."

When taking the Elder Index values (estimates of how much it costs to live in various locations) into consideration, four New England states are among the top 10 most expensive:

•#4: Connecticut
•#6: Massachusetts
•#8: New Hampshire
•#9: Vermont

New England is also unfortunately heavily represented on the list of states with the most income insecurity. Among the top ten states with the highest percentage of seniors age 65 and older and living alone who have incomes below the Elder Index for their states, six out of the ten states with the highest level of economic insecurity are in New England:

•#2 in the nation: Massachusetts (61.1%)
•#3 in the nation: New York (60.4%)
•#4 in the nation: Vermont (60.3%)
•#6 in the nation: Rhode Island (57.4%)
•#8 in the nation: New Hampshire (57.2%)
•#10 in the nation: Maine (56.7%)

Nationally, the Insecurity in the States 2016 report also found:

• 53% of older adults living alone, and 26% of older couples, have annual incomes below the Elder Index value
• On average, half of older adults who live below the Elder Index rely on Social Security for at least 90% of their income
• In every state, more than 40% of singles 65 and older are at risk of being unable to afford basic needs
• A majority of couples avoid poverty, but many are unable to afford daily expenses of living as reflected by the Elder Index

The Elder Index is part of the Economic Security Database, which was recently updated to reflect 2016 calculations. The Elder Index is unique in measuring the income that older adults need to achieve economic security by specific cities, counties and states.

Older adults and their loved ones seeking

information about how to get the most out of their money can take a free, confidential EconomicCheckUp® screening at www.EconomicCheckUp.org. The site, managed by the nonprofit National Council on Aging (NCOA), can help visitors set a budget, save money and set financial goals.

Advocates Comment On ACO "Community Partners" Role

In September, MassHealth issued a Request for Information (RFI) asking interested parties to respond tor questions about how to set up "Community Partners" that would work with Accountable Care Organizations in a new managed care plan for people on Medicaid. It is expected by that by February, the state will issue a bid for agencies to apply to MassHealth to become Community Partners.

"As part of MassHealth's efforts related to delivery system reform," the state explained, "MassHealth will be introducing accountable care organizations (ACOs) into the MassHealth delivery system. Under this reformed system, MassHealth expects ACOs to form relationships with certified Behavioral Health (BH) and Long Term Services and Supports (LTSS) Community Partners (CPs) to integrate members' physical, social, behavioral health and long term services and support needs. This reform seeks to move a significant component of the delivery system to one that is person-centered and financially sustainable."

According to MassHealth, CPs "will be an organization that provides deep expertise and support to ACOs and MCOs to support MassHealth members with significant behavioral health or long term services and support needs. MassHealth intends that ACOs and MCOs will partner with CPs support improved care delivery and member experience. MassHealth anticipates that the ACO and MCO, working with the member's primary care physician and the contracted CP(s), will ensure that members will have access to an interdisciplinary care team that includes appropriate representation from community-based BH, LTSS and social service providers to best meet the members' needs."

The group Disability Advocates Advancing Our Health Care Right (DAAHR) responded to MassHealth's Request for Information. Here are excerpts from the DAAHR response to the RFI;

"If there is one thing that will separate MassHealth from other…waiver states, it will be the creation of Community Partners (CPs) as separate and distinct from our medicalized care delivery system in MassHealth. Medicaid programs are struggling to reduce the level of spending in the medical system. CPs will only be as effective as they are free from the hold and financial incentives of this medical system. CPs can promote and develop plans for members to live in the community in ways that are unimaginable to medical systems, systems accustomed to providing care, treatment and services for people within the clinic or the hospital settings…that can only happen by assuring the independence of the CPs.

DAAHR, along with other groups, advocated vigorously to protect people with BH and LTSS needs from being taken over by insurers, the medical system and medical providers. We are grateful that MassHealth has established the community-based "Community Partner" program as a central part of the 1115 waiver to support culturally competent person-centered BH and LTSS care coordination. We are, however, concerned that the CP model may be distorted or undermined by credentialing requirements that contradict the express purpose and vision of CPs, and enable medical entities and/or other entities, including for-profit and/or out-of-state entities, to become CPs.

DAHHR supports integration of BH, LTSS and social services with physical health, not the takeover of these services by medical providers, hospitals,

the nursing home industry or insurance companies. MassHealth should not allow any entity that has direct or indirect financial interest in ACOs or other medical entities to become a CP. The concept of BH and LTSS Community Partners, particularly LTSS CPs, is rooted in the LTSS Coordinator (LTS-C) and Geriatric Social Service Coordinator (GSSC) role in One Care and SCO. As advocated for and understood by DAAHR, Community Partners are the vehicles by which MassHealth and CMS are supporting the development of a robust conflict-free BH and LTSS care coordination system that provides ACO members expertise that counterbalances a medical model framework that too often limits the options available to, or discriminates against, people with BH and LTSS; and Medicaid members more generally.

Having both medical and BH/LTSS CP participation in care teams provides members the opportunity to experience a more integrated physical, BH and LTSS approach to care that has the potential to lead to better health outcomes, increased quality of life and a bend in the cost curve.

To be effective in addressing the needs of underserved populations with high unmet needs, MassHealth should provide increased emphasis on fuller integration of physical, LTSS, BH, oral health, and social determinants interventions within the new ACO system. It is important that MassHealth, in creating the ACO system, look at the intersectionality of coexisting conditions, physical, BH, LTSS needs as well as, economic, ethnic, racial, linguistic, educational, housing and other social determinants when shaping the CP system. CPs should be given the authority to provide members with information about and access to oral health and social services.

MassHealth should consider a social service "hub" to work as a coordinating partner for CPs to collaborate on delivering social services in an integrated manner. As learned from the experience of implementing the Public Health Trust Fund, such an entity is important to achieving public health objectives. CPs serving as "Point of Service" should be able to direct members to the appropriate social service agency. "Point of Service" rather than requiring the referral to go back through ACO prior authorization processes. Research shows that members respond best when appropriate social services are immediately accessible. To provide this immediate access, CPs should be provided some level of independence and access to Flexible Services funding for common/standard referrals – without ACO prior authorization – and refer directly to a menu of appropriate social services.

DAAHR urges MassHealth require all CPs:

• be conflict free, having no financial interest in in ACO, MCO or other entity that might affect decisions made by a care coordinator from a CP;

• be nonprofits that have a demonstrated track record of providing BH, LTSS and social services in Massachusetts;

• be part of the ACO governance structure without any requirement of risk sharing. Beyond creating an environment for conflict of interest to take place, risk sharing requirements would provide undue advantage to larger CPs with the size and liquidity that smaller, specialized and/or consumer member governance run organizations do not have. This would silence the unique voice of CPs that have as their core requirement to work in the best interest of consumers;

• have contractual and/or other arrangements with oral health providers, social service entities and other community services that will benefit members;

• demonstrate that they are paying their staff a living wage in their contracting arrangements with ACOs;

• include in their staff of care coordinators, community

health workers, navigators, etc. adequate representation of people with lived experience of a mental health diagnosis, trauma or substance abuse--this should include, but not be limited to Certified Peer Specialists, Recovery Coaches, and population-based "peer support staff."

• Provide MassHealth with communication access strategies it will use to meet the needs of people who are part of DEAF culture and/or have other communication needs based on visual, mobility, cognitive or other impairments.

MassHealth should be prescriptive by requiring that:

• CPs are nonprofit entities that have a demonstrated history of providing conflict-free LTSS in Massachusetts.

• ACOs, MCOs, hospitals and other entities provide conflict free care and have no direct or indirect financial relationship with coordination and/or provision of LTSS.

• Members in waiver populations have the same choices/access to conflict free care assessment as other members:

• MassHealth should work with stakeholders to establish conflict free care protections and provisions for distribution of functions similar to those being developed in Colorado and Minnesota.

• These protections should include separation of LTSS case management from delivery of LTSS whenever possible and integration of IT solutions to facilitate system wide sharing of information.

• All coordinators providing assessments should use the same assessment tool and receive training on how to conduct assessments using motivational interview techniques that support independent living principles and recovery.

• All ACOs and MCOs should include CPs in their governance structures free from any risk-sharing requirements to prevent financial conflict of interest by LTSS CPs that might result from upside or downside risk sharing arrangements. This includes home health agencies and other community providers that have existing relationships with ACOs.

• Require all ACO/MCO members to receive conflict free assessment for LTSS needs at the initial assessment and/or at the time the care team determines the member needs LTSS.

• MassHealth should work with advocates to build robust quality metrics that are real-time and/or close to real-time. These metrics should include both administrative metrics and quality of service/outcome metrics.

• MassHealth should include formal representation of advocates in the development of the CP credentialing process and RFR procurement

• Entities that engage in activities that would result in a conflict of interest should be disqualified from becoming an LTSS CP. For example, an entity whose primary purpose is the provision of home health services should be precluded from becoming an LTSS CP.

• Entities that are a subsidiary of an ACO, MCO or a provider for, or contractually affiliated with an entity that has any financial incentive that would influence their care management and care coordination of a member should be disqualified.

• The absence of an office or other visible presence located within a geographic service area should be considered as disqualifying criteria.

Lawmakers Ask Governor To Reconsider PCA Overtime

At the end of September, 95 state lawmakers sent the letter below to Governor **Charles Baker** asking him to reconsider his decision to limit Personal Care

Attendant overtime hours. The letter was organized by State Representative **Kate Hogan** (D-Stow), the House Chairwoman of the Joint Committee On Public Health:

Dear Governor Baker,

We have recently become aware that the Executive Office of Health and Human Services (EOHHS) has proposed a change to the reimbursement of services provided by Personal Care Attendants (PCAs)—restricting PCAs to providing no more than 40 hours of care a week per client. It is our concern that this change has the potential to impose serious and unintended consequences on the vulnerable individuals in the Commonwealth who rely on these services.

State Representative Kate Hogan

PCAs provide vital care to approximately 26,000 Massachusetts residents. Often times these attendants have long-term professional and personal relationships with these clients. Limiting the hours that a PCA can assist a client, most of whom are elderly and/or persons with disabilities, could restrict the ability of PCAs to continue providing the necessary level of care.

For some time now, one of our health policy goals has been to ensure that our residents have equal access to cost-effective, high quality care. Restricting the opportunity for PCAs to work the hours necessary to provide such access runs the risk of widening this gap. This restriction will result in diseconomies to the PCAs themselves, because restricting their earning potential will force some current PCAs out of those jobs and discourage others from pursuing them.

Massachusetts has been a leader in ensuring that resources are available for the elderly and/or disabled to live as independently as possible. The proposed change in reimbursement jeopardizes this opportunity; individual clients may be unable to retain the care necessary to remain independent, forcing them into higher-cost, dependent-living environments. This change may also disrupt an already weak labor market for such services.

We are certain that the adoption of the proposed change in reimbursement will expose us to these risks. We do not see the problem that EOHHS is trying to address or the benefits to be obtained by the proposed change. We respectfully urge you to reconsider the proposed change in PCA reimbursement, allowing the thousands of our residents who depend on these services—and the thousands of individuals who provide them—to retain the flexibility to ensure the continuity and stability of care being provided.

Feds Evaluates One Care Plan: Confusion Over LTSS Role

The federal Centers for Medicare and Medicaid Services (CMS) recently published the first annual evaluation report for the One Care managed care program for people 18 to 64. This report evaluates One Care's performance during Demonstration Year 1, from October 1, 2013 through December 31, 2014.

According to the state Executive Office of Health and Human Services (EOHHS), which released the report: "Overall, the report found that more than 80% of One Care enrollees were satisfied with the care and services they received, and care coordination, the hallmark of the One Care model, was cited as one of the Demonstration's greatest successes. The report emphasized that MassHealth officials, One Care plans, and other stakeholders had voiced strong support for One Care and its integrated approach to service delivery, and noted the importance of the successful stakeholder

relationships we have all worked hard together to develop and maintain." EOHHS added: "Ultimately, the report concludes that more time is needed in order to fully evaluate the impact of the One Care model on cost, service utilization, and quality."

The CMS report noted that One Care plans and the LTSS agencies (the ASAPs and Independent Living Centers (ILCs) are referred to in this report as 'Community Based Agencies', or CBOs) "experienced implementation challenges related to the referral process for LTSS. Plans and MassHealth reported concerns that CBOs lacked capacity to meet the referral volume…they reported several difficulties in managing the volume of referrals occurring during phases of high-volume passive enrollment. One CBO described it as 'sheer chaos.'

One Care

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CBOs reported receiving referrals for enrollees they could not locate. As one CBO explained: "The major reason in the beginning plans were trying to deal with us is that a lot of times we were the ones they were asking to find the people…They couldn't find the people and they were asking us to go out and find them." The CBOs reported that they received referrals with just a name and phone number, and the phone number was wrong. When enrollees were located, the LTS Coordinator was sometimes the first person from the One Care plan to meet with them. "In some cases," CMS said, "the enrollee had never head of One Care and had limited if any understanding of why they were being contacted by the CBO."

The One Care plans kept track of how many enrollees with LTSS needs were actually referred to, or met with an LTSS Coordinator. "Based on averages for the demonstration as a whole," CMS found, "the highest percentage [was](21%) of those enrollees who met with their coordinators…"

The ASAP and ILC agencies reported that LTSS Coordinators conducted face to face assessments with enrollees using a needs assessment tool as requires by each plan, and that each One Care plan required using a different assessment tool, with differences in protocols. "In some cases," CMS wrote, "the LTS Coordinator was present at the comprehensive assessment conducted by the One Care plan, but generally LTS Coordinators reported meeting with enrollees separate from that process."

CMS also notes that the LTS Coordinator "is expected to participate as a full member of the Interdisciplinary Care Team for all enrollees with LTSS needs, at the discretion of the enrollee." However, "the extent to which the One Care plans actively engaged the CBOs in the full range of assessment, coordination and monitoring activities varied across plans." ASAPs and ILCs reported "inconsistent practices across plans in term of communication and on-going participation with the enrollee following the completion of the LTSS needs assessments." Several agencies said "they were not always clear on their roles following the assessment, particularly relating to arranging, coordinating and monitoring services." The ASAPs and ILCS reported instances "where they submitted recommendations for LTSS but never received information back from the plan about service authorizations," or whether they were "expected to have an ongoing role…Some CBOs reported that the inclusion of an LTS coordinator as part of the care team as initially envisioned by One Care was more the exception than the rule."

The ASAPs and ILCs noted that procedures across plans were at times opposite from one another, adding to the confusion around roles and responsibilities and practices around information sharing. One of the CBOs said they had "great access" to the central enrollee record at one plan, whereas another plan did not give them access, "hindering their ability to participate as a team member."

To address these challenges, MassHealth convened a work group in the first year of the project "to review the role and expectations for how plans were to be implementing the LTS coordinator role," including

how to describe the service to members, and reasons why enrollees were refusing the LTS Coordinator." MassHealth developed a webinar training for plans about the LTS role, including an enrollee's right to access an LTS coordinator, what an LTS Coordinator is, and how to request an LTS coordinator. "Regardless of the inconsistencies in implementation issues," CMS concluded, "support remains strong for maintaining an LTS Coordinator role as part of the demonstration… The LTS Coordinator role is widely supported by stakeholders, providers, and plans, and is considered to be an important component of the One Care demonstration. Although a number of implementation issues have arisen in connection with the LTS Coordinator role, stakeholders and others remained committed to the concept to ensure that LTSS needs of One Care enrollees receive adequate attention and support."

Among the challenges ahead for the One Care plan, CMS listed "confusion among beneficiaries regarding different care coordination roles." "Many One Care beneficiaries transitioned from having no care coordination at all, to receiving multiple levels of care coordination, including medical, behavioral, and LTSS. Some participants of One Care focus groups reported confusion as to the various people and roles." CMS also concluded that the LTS coordinator role lacked clarity as implemented. "It has been challenging to find the right balance between flexibility and structure for the LTS coordinator role."

As a preliminary finding, CMS said: "Although considered an important service for beneficiaries, the LTS coordinator role has been challenging to implement. The LTS coordinator role was designed to be flexible, person centered, and to meet a broad range of enrollee needs. However, the lack of clearly defined roles and responsibilties led to inconsistencies and confusion in the implementation of the position across plans, and CBOs. Inconsistent practices were reported specific to the assessing, authorizing, implementing, and monitoring processes for delivery of LTSS…. the findings of beneficiary surveys and focus groups generally reflected confusion and lack of understanding by enrollees about the core functions of the LTS coordinator."

To see the full CMS report on the One Care plan, go to:
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html

Mass Home Care Holds 28th Annual Network Conference

Panelists Discuss Future of Post Acute Care at the 28th Annual Mass Home Care Network Conference on Oct. 13th.

On October 13th, roughly 340 participants from across the state gathered in Boxborough for Mass Home Care's 28th Annual Network Conference.

The theme of this year's Network Conference was "Post Acute Care Discovered: New World Beyond Hospitals and Doctors." A total of 20 workshops were presented at the Conference, including Health Care Proxies, Tenant/Landlord Issues, Dementia Friendly Initiatives, Care Transitions, New Technologies in the home, Hoarding, MassHealth Planning, Opiod & Alcohol Misuse Among Elders, SHINE health counseling, Elders With Vision Loss, and Basic Income Support programs.

During the lunch, the Conference featured a special panel presentation: "What Will The Post Acute Care World Look Like in 5 Years?" The panel was moderated by Elder Affairs Secretary **Alice Bonner**, with panelists **Ruth Beckerman-Rodau** of Springwell, **Bernadette Di Re** of United Health Care, **Deb Citrin**, of Philips Health Technology, and **David Morales**, of Steward Health Care.