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Al Norman, Editor

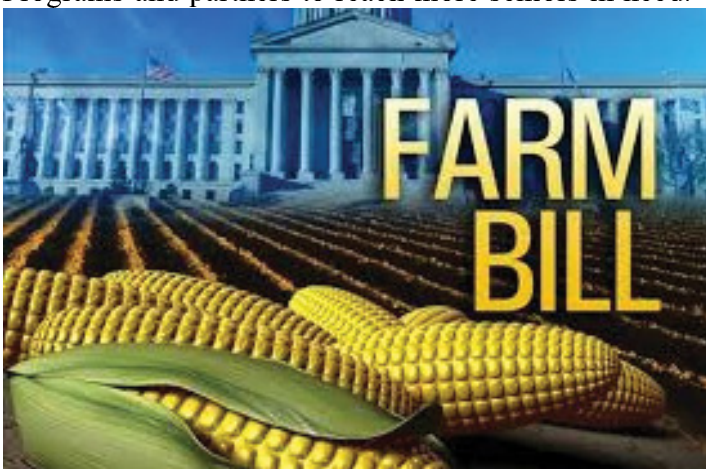
Farm Law Slices $8.6 Billion From Food Stamps

After more than two years of debate, Congress produced a bipartisan bill to reauthorize key national agriculture and nutrition programs. This $956 billion legislation, the Agricultural Act of 2014 – most commonly referred to as the "Farm Bill" was signed by President **Barack Obama** on February 7th in a horse barn at Michigan State University in East Lansing, Michigan. Standing in front of a tractor, the President said the legislation "lifts up our rural communities" and would give more Americans "a shot at opportunity" in the years ahead.

The final bill replaces direct crop payments to farmers with an insurance program and trims more than $8 billion from food stamps over the next decade — far less than the $40 billion cut some Republicans had called for. The President said the legislation would provide the money for the nation's food stamp program, which helps poor families buy groceries even as it provides an important market for the nation's farmers. "More than half of all Americans will experience poverty at some point during their adult lives," Mr. Obama said. "For more than half a century, this country has helped Americans put food on the table when they hit a rough

patch or when they're working hard but aren't making enough money to feed their kids. They're not looking for a handout, these folks, they're looking for a hand up."

But advocates for the poor criticized the new farm law, noting that spending cuts in the food stamp program will reduce the amount of money that poor families receive for food. Meals on Wheels America, for example, said the Farm Law will set the agricultural and nutrition policy for the next five years – including policies impacting America's hungry seniors. Although the Farm Law makes significant cuts in the nation's largest nutrition safety net program, MOWA said it "remains optimistic about other elements of the bill that could enable Senior Nutrition Programs and partners to reach more seniors in need."



The new law cuts the Supplemental Nutrition Assistance Program (SNAP) by $8.6 billion over 10 years. This is more than the Senate's earlier proposal of $4.1 billion in cuts, but dramatically less than the House's version of nearly $40 billion. "While the Association does not support these harmful cuts," MOWA said, "we do believe it represents the best compromise achievable compared with the earlier options offered. The impact these cuts could have on some of our nation's most vulnerable remains to be seen; however, some estimates suggest that the average household will lose $90 a month in benefits. Given that the average SNAP benefit for a senior living alone is already less than $122 a month, a cut of any size would be devastating.

A provision spearheaded by Senator **Al Franken** (D-MN) and Senator **Roy Blunt** (R-MO) in the Senate, and Congressman **Erik Paulsen** (R-MN) in the House, will benefit low-income individuals who are homebound and currently unable to easily utilize SNAP. The language included in the law allows the U.S. Department of Agriculture (USDA) to establish pilot programs to deliver groceries to homebound seniors and disabled individuals participating in SNAP.

The two other programs that affect seniors most are the Commodity Supplemental Food Program and Senior Farmers' Market Nutrition Program. The Commodity Supplemental Food Program (CSFP), which currently delivers nutritious food boxes to low-income seniors, women and children, would have the authorization to expand services in six additional states, including Connecticut, Massachusetts and Rhode Island, bringing the total states to 45. Given that 97% of program participants are seniors, the Agricultural Act of 2014 clarifies that the program be only for seniors over the age of 60, while allowing all other households to remain on the program for as long as they meet current eligibility requirements.

No changes were made to the Senior Farmers' Market Nutrition Program (SFMNP), which provides benefits to be used specifically at farmers markets for seniors. According to the latest data from USDA, SFMNP distributed $22.2 million in vouchers to over 885,000 seniors in the 2012 fiscal year. This translated into more sales for over 19,000 farmers markets, over 3,000 roadside stands and 154 community-supported agriculture (CSA) operations, as well as healthier food for America's seniors.

The Agricultural Act also increases the authorization of funding for The Emergency Food Assistance Program (TEFAP) by $205 million over the next ten years. It encourages the Secretary of Agriculture to find ways to deliver bonus commodities to emergency feeding organizations, some of whom also provide Meals on Wheels and congregate meals more efficiently, and to explore how to eliminate the regulatory and administrative barriers to accessing these programs.

According to the National Council on Aging (NCOA) the change in the Standard Utility Allowance, which boosts benefit levels based on household utility costs is estimated to affect only people in 16 states and the District of Columbia and 4% of beneficiaries over-

all, as many as 850,000 households could lose up to $90 per month in assistance. This cut comes on top of an $11 billion cut that affected all beneficiaries in November.

"Throughout the debate, food assistance for the most vulnerable Americans continued to be in the crosshairs," NCOA said. "This is despite the fact that SNAP spending will naturally decrease as the economy improves and people find jobs, and that the program had its lowest error rate ever in 2012."

NCOA notes that the new law places additional restrictions on SNAP outreach. Given that only one-third of seniors eligible for the program actually participate, NCOA and other advocates plan to address this in the coming weeks as the new provisions are put into effect.

On the positive side, the legislation includes a proposal to enhance services for elderly and disabled SNAP participants, particularly those who are homebound. Benefits can now be used to pay for nonprofit grocery delivery services, as long as certain standards are met, such as excluding the delivery fee. Rules for this program have not yet been issued.. Although SNAP cannot be used to purchase prepared food, a few states have elected to waive this rule for certain vulnerable participants who lack the means to prepare and store food—including seniors, persons with disabilities, and the homeless—allowing them to use benefits at certain restaurants. The new law retains this provision and strengthens the reporting requirements to ensure that this limited exception is used properly.

Markey: "We Have A Dire Hunger Problem"

On February 4th, Senator Edward J. Markey (D-Mass.) released the following statement after voting against passage of the Agricultural Act. In Massachusetts, 125,000 households may lose $70 per month in food assistance:

"Instead of stopping wasteful aid to the wealthiest farmers, the Farm Bill slashes SNAP benefits for the poorest Americans, the elderly and disabled. We have a dire hunger problem in this country, and cuts to the SNAP program will only make it worse. Nearly 50 million people across the country do not have enough food to eat. During this frigid winter, vulnerable families shouldn't have to choose between heating their home or putting food on the table. SNAP is the most effective anti-hunger program we have. Cuts to the SNAP program mean more Massachusetts families will go hungry, more children will go without nutritious meals, and millions of America's households will not be able to make ends meet. As our economy continues to recover, we need to continue the fight to ensure that we protect funding for this critical program so that families in need don't fall through the cracks."

In October, Senator Markey and Senator **Elizabeth Warren** joined a coalition of 38 Senators urging the Farm Bill negotiators to reject cuts to food stamps for millions of children, seniors, and vulnerable families. Markey urged the negotiators to reject all eligibility changes that would prevent millions of children, seniors, and families facing a constant struggle against hunger from accessing nutritious food and hundreds of thousands of low-income children from accessing free school meals.

The Impact in Massachusetts: Heat or Eat?

Close to 1 million Massachusetts residents rely on the Supplemental Nutrition Assistance Program.

Massachusetts anti-hunger advocates are concerned about proposed changes to the program that would have a direct and significant impact on many state residents who rely on nutrition assistance benefits to feed their families. SNAP is the number one defense against hunger in America and is a vital lifeline for nearly 900,000 low income Massachusetts residents participating in 500,000 SNAP eligible households. For many households, limited income results in tough choices between "heating or eating." For families with young children, seniors and persons with disabilities, adequate nutrition may be jeopardized because limited funds must go to keeping a roof over their heads and the lights on.

Federal SNAP law gives states the flexibility to assist families with heating or cooling costs by providing a Standard Utility Adjustment (SUA). This is particularly important to areas of Massachusetts with severe winters and for seniors and persons with disabilities who need air conditioning in hot summer months.

In 2007, the Massachusetts Department of Transitional Assistance (DTA) expanded the number of households able to receive this SUA by implementing a "heat and eat" benefit from the LIHEAP energy assistance program. Coined "H-EAT", this special LIHEAP benefit simplifies the benefit calculation and verifications needed for these households and increases their SNAP monthly benefits. H-EAT also introduces these households to regular fuel assistance benefits.

The new Agricultural Act increases the threshold amount of LIHEAP needed to trigger the SUA to $20. The proposed changes would place the "heat and eat" option out of reach for states experiencing reductions in LIHEAP funding. According to the Patrick Administration, this change will reduce SNAP benefits for approximately 125,000 Massachusetts SNAP households by an average of $70 per household per month. DTA projects that of the SNAP households harmed by this cut, 80% are seniors or persons with disabilities (including disabled parents and disabled children). DTA data shows that over 35% of the SNAP households harmed include young children. The impact of the H-EAT cut is particularly grave for households with elder and disabled members due to the SNAP "math"- for multiple reasons:

- In calculating countable income, SNAP rules allow households to deduct a portion of shelter costs that exceed 50% of net income (rent or home ownership plus utilities). Households with elder or disabled members may claim the full shelter costs that exceed 50% of net income. Households without elder/disabled members get a capped shelter deduction, regardless of the amount of shelter costs.
- H-EAT has been critical to offset other basic living expenses incurred by elders and persons with disabilities. Massachusetts, like many states, has increased Medicaid co-pays and shifted medical costs out of Medicaid (such as dental and vision care). USDA data shows that less than 10% of elder/disabled SNAP households claimed out-of-pocket medical expenses that could otherwise increase SNAP.

- SNAP households with seniors and persons with disabilities routinely have the most difficult time with understanding the complex SNAP deductions and securing verifications. The H-EAT option has resulted in increased benefits for 30% of our SNAP caseload, resulting in an additional $100M in federal benefits spent in Massachusetts grocery stores. With a total of $9 of economic activity per each $5 of benefits spent, the "heat and eat" option has triggered over $180M in economic activity in the Commonwealth.

As Massachusetts continues to rebuild from the severe economic downturn, SNAP benefits are a

critical support to working families. This is not the time to restrict state options to streamline the program, or eliminate options that make SNAP more responsive to households affected by high heating or cooling costs.

Implementing the H-EAT option has helped streamline administration of SNAP and reduced the need for DTA staff to collect detailed client information on utility expenses. Between 2005 and 2013, DTA lost 30% of its SNAP workforce while the SNAP caseload has increased by over 300%. Implementing H-EAT as well as other options to streamline SNAP administration allows DTA to continue to provide timely benefits to eligible and hungry Massachusetts families.

In February, a coalition of elder advocacy groups, including Mass Home Care, sent a letter to Governor **Deval Patrick** regarding the SNAP/Food Stamp Program. Here are excerpts from that letter:

"On behalf of low income families, seniors and persons with disabilities in Massachusetts, we wish to thank you for your unwavering support for the federal Supplemental Nutrition Assistance Program, the nation's first line of defense against hunger. We are deeply thankful for the continued efforts of the Patrick Administration, our entire U.S. Congressional Delegation, the Massachusetts General Court and our urban Mayors. We are proud that Massachusetts is a leadership state in protecting and defending the SNAP program.

Congress [has] approved the Agricultural Act of 2014. The legislation makes a number of changes to the SNAP program including how shelter expenses are calculated in determining SNAP net income and benefits. As you stated in your October 30th letter urging Congress to reject cuts to SNAP, elimination of the special "Heat and Eat" option would harm over 125,000 Massachusetts SNAP households by cutting an average of $70/month in SNAP benefits. This SNAP policy change would disproportionately impact elder and disabled SNAP households.

Fortunately, the Act gives states flexibility in implementation of the SNAP changes in two ways: first, it allows states to maintain the higher shelter expense deduction if the state provides SNAP households with a minimum $20/year in federal or state-funded LIHEAP fuel assistance benefits; second, it gives states the option to delay implementation affecting current SNAP recipients for a five month period.

We urge Massachusetts to elect these two federal options including identifying funding to provide the $20 fuel assistance benefits which will leverage up to $870/year in SNAP

benefits per household. We also urge Massachusetts to implement changes in the SNAP application and recertification process to enhance identification of SNAP households that incur separate heating or cooling expenses as well as SNAP households that receive regular LIHEAP fuel assistance benefits. Many SNAP households – including seniors and persons with disabilities – find it difficult to understand and document expenses in order to claim income deductions that can boost their SNAP benefits.

We would appreciate the opportunity for members of the organizations below to meet with EOHHS, EOCD and DTA to discuss implementation options and ways that our organizations can work with the Administration to protect these

essential SNAP benefits. We look forward to working with you to minimize the loss of SNAP and continue to expand participation in the SNAP program for otherwise eligible residents of the Commonwealth."

Advocates Push MBTA For Affordable Transit

A coalition of advocacy groups have written to the MBTA Board of Directors, calling for more affordable transit services for the elderly and individuals with disabilities, and a "tiered rate" system of fares. Here are excerpts from their letter:

"Dear MBTA Board Members:

We were deeply troubled to learn that the MBTA included scenarios modeling a 5% increase to The RIDE's premium service fare. In addition, we continue to feel concern over the very existence of a premium service zone altogether.

All people need access to a variety of safe, affordable, dependable, and user-friendly travel options. For some people, regular, fixed-route public transportation services are ideal. For others, because of health issues or disability, services such as The RIDE are needed. This service is a lifeline for many older Massachusetts residents and persons with disabilities.

Changes enacted in 2012 to The RIDE have significantly impacted seniors and persons with disabilities. The implementation of a $5 so-called "premium" fare for trips beginning or ending outside the three-quarter mile Americans with Disabilities Act (ADA) corridor, trips outside the hours of operation of the fixed route system, and same-day requested or modified trips are imposing a heavy burden on some of the least able to afford it. We continue to reject the notion of a dual ADA/premium zone fare system.

The results from the Executive Office of Elder Affairs (EOEA) and the Massachusetts Office on Disability (MOD) report (September 2013) concerning the impacts of the fare increase on RIDE are chilling. Over 60 percent of RIDE users reported taking fewer transit trips and a majority of RIDE users with monthly incomes below $2,000 reported that they needed to cut back on food and personal grooming costs. But, perhaps most troubling was the revelation that one-fifth of RIDE users over 65 years old, and one-third of RIDE users under 65 years old, reported attending fewer medical appointments since the fare increase.

This very board and the MBTA administration publicly acknowledged the hardship caused by extreme fare increase when you took corrective action to reduce fares for the ADA RIDE fare from $4 to $3. Further, you acknowledged that the reduction was merely a mitigating step and that more work needed to be done to address the extensive impact of the 2012 fare hike on your most vulnerable constituents. The MBTA committed to continue actively working towards an equitable fare structure for the paratransit system.

With this in mind, we have serious concerns that a 5% fare increase would even be considered for any RIDE user and further express our continued concern of any differentiated "premium" fare.

While we very much appreciate your unprecedented action of rolling back The RIDE fare to $3, we want to emphasize that now is not the time to make public transportation less affordable and less accessible. We urge you to reject any proposals to increase fares for those most in need – older residents, persons with disabilities, students, and those with low incomes.

We urge you to establish a more equitable transit fee structure that incorporates a tiered fare and eliminates the premium fare. The tiered fare structure is fair in its reflectiveness of a person's ability to pay, thus making it both affordable and accessible. A working group that includes RIDE users

who are both older residents and people with disabilities, as well as representatives from advocacy groups, EOEA, MOD, and the MBTA should be established to address a tiered structure with the goal of developing a plan by May 1 for implementation for July 1, 2014."

The letter was signed by: AARP Massachusetts | Boston Center for Independent Living | ETHOS | Mass Home Care | Mass Senior Action Council | Massachusetts Association of Older Americans | Massachusetts Law Reform Institute | Multi-Cultural Independent Living Center of Boston, Inc. | Community Labor United | Disability Policy Consortium | Public Transit-Public Good | MA Advocates for Nursing Home Reform | 1199SEIU | MetroBoston ADRC

New Alzheimer Care Regulations for Nursing Homes

Advocates for Alzheimer's patients who worked to secure quality of care regulations of dementia care in nursing homes celebrated a victory in February. The Public Health Council approved final regulations that will require special training for all direct care workers in licensed long term care facilities in Massachusetts, as well as other quality of life standards.

"These regulations have really been a labor of love for thousands of people affected by this difficult disease," said **James Wessler,** President/CEO of the Alzheimer's Association, Massachusetts/New Hampshire Chapter. "Family members, health professionals and those with the disease have all advocated on behalf of regulations that will protect some of the most vulnerable in our population."

The regulations also close a loophole that had allowed nursing homes to market Dementia Special Care Units without any dementia specific training for staff, specialized activities for residents or physical accommodations for cognitively impaired residents.

Drafted by the Department of Public Health, and subjected to public hearings, the regulations have been more than eight years in the making—that was when they were first proposed via legislation drafted by the Alzheimer's Association.

According to the Alzheimer's Association, nearly 120,000 people have Alzheimer's in Massachusetts. That number is expected to grow dramatically as baby boomers age. While age is not the only risk factor for the disease, it is the most significant one. Nearly 32% of those aged 85 and older will develop Alzheimer's. Of those aged 65 or older, nearly 1 in 9 will develop the fatal disease. More than 5.4 million in the U.S. have Alzheimer's, according to the Association.

"We applaud all those who have played a role in bringing the regulations into being. There have been legislative champions, the legislature itself passed the bill calling for regulations, Governor **Deval Patrick** signed them into law, and of course the Department of Public Health for their hard work in crafting the regulations," Wessler said. "These regulations will increase the peace of mind to an estimated 350,000 family members of those affected by the disease."

Direct care workers in nursing homes will receive specialized training, and nursing home and dementia special care units will have to meet minimum care standards. The regulations outline minimum requirements for dementia specific activities for residents. The regulations also specify minimum safety and quality standards for dementia care units in long-term facilities, including physical design of the units that is therapeutic and mitigates dangerous wandering activity.

Unemployment Insurance: $107 Million In Benefits Lost to State

On February 6th, 58 U.S. Senators, including Senators **Elizabeth Warren** and **Edward Markey,** voted in favor of an amendment to S. 1845 (Emergency Unemployment Compensation Extension Act) to stop the obstruction and advance unemployment insurance for roughly 2 million long-term unemployed Americans. That wasn't enough - 60 were needed.

When it was clear it would fall short by one vote, Majority Leader **Harry Reid** (D-NV), a strong supporter of Unemployment Insurance (UI) restoration, switched his vote from yes to no so he can bring it back for reconsideration later., according to the Coalition on Human Needs.

The outcome in the Senate was a blow to increasingly desperate workers and their families. Every week, another 72,000 go without unemployment insurance. By March 1, that will be nearly 2 million workers - plus their families. In Massachusetts, 58,700 people lost their jobless benefits on December 28th, and by March 1st , a total of 77,672 people will have lost benefits. The federal UI benefits lost as of March 1st are estimated to be $107.3 million. Congress then went home for a break without addressing the critical issue of extending the federal Emergency Unemployment Compensation (EUC) program. EUC provides additional weeks of insurance when workers have exhausted their state benefits. Failure to extend the program before going home for the holiday break resulted in 1.3 million workers left without this safety net program when their EUC expired on December 28. Each week since then 72,000 additional workers are left without assistance. Contrary to some myths, these are not workers who refuse to look for work and are enjoying an easy, laid-back time. In order to receive EUC they must be actively looking for work, a daunting task when there are three job seekers for every available job.

In December, the national unemployment rate dropped to 6.7 percent from 7.0 percent in November, but jobs grew by a paltry 74,000. So, the decline in the unemployment rate is not attributable to more workers finding jobs, but rather to the drop in the workforce participation rate to 62.8 percent, the lowest rate in 35 years according to the Labor Department.

Of particular concern is the number of long-term unemployed – 37.7 percent of the unemployed have been out of work for six months or longer – the highest ever compared to times Congress has allowed EUC to expire after previous recessions. Investing in these workers who desperately need assistance to meet basic needs like housing and food is a strong anti-poverty strategy, said the Coalition on Human Needs. In 2012, unemployment insurance kept 1.7 million people out of poverty, including 446,000 children, according to a report from the National Employment Law Project.

EUC has long been considered an emergency program that does not have to be paid for by other spending reductions or revenue increases. Five times under President **George W. Bush**, when the unemployment rate was above 6 percent, unemployment insurance was extended without pay-fors and with the support of the majority of Republicans. This time around Republicans are demanding offsetting cuts. On January 7, in what looked like a potential breakthrough, all 54 Democrats and Independents present and 6 Republicans agreed on a procedural vote to move to debate on the extension of EUC.

The maximum number of weeks of EUC had already been cut from 99 to 47. In a significant concession, Democrats agreed to cut the maximum number of weeks again from 47 to 31, with workers in states with lower unemployment rates receiving

even fewer weeks of benefits. Republicans, however, soon filed and insisted on votes on amendments that were unpalatable to Democrats. One amendment would have paid for the extension of EUC by denying the Child Tax Credit to low-income children in immigrant families. These working families pay more than $13 billion in payroll taxes each year, and over 60 percent who use the refundable Child Tax Credit earn less than $25,000 per year. Another amendment would have helped pay for the extension of EUC by denying unemployment benefits to people who receive Social Security Disability Insurance, work part-time, and are now eligible for partial benefits if they become unemployed.

On January 14th., Senate Majority Leader **Harry Reid** (D-NV) attempted to end debate on the Emergency Unemployment Compensation Extension Act, S. 1845, which provides a 3-month extension of benefits. The vote which required a 60-vote threshold failed 55-45. A second vote on an amendment extending EUC for 11 months failed 52-48.

Democrats in the Senate say they are committed to finding a way forward on this legislation. They will press for a 3-month extension without offsetting cuts. Senator **Dean Heller** (R-NV), who co-sponsored S. 1845 along with Senator **Jack Reed** (D-RI), is working with other Senate Republicans to find ways to pay for an 11-month extension of EUC. Even if the Senate is successful, the Republican-led House will present another huge hurdle to passage.

According to the Council of Economic Advisors, reauthorizing long-term jobless benefits would save 7,067 jobs in Massachusetts.

One Care Plan, Many Issues

The state's new "One Care" managed care plan for individuals on Medicare and Medicaid ("duals") between the ages of 18 and 64 began on October 1, 2013. Four months later, supporters of the plan say One Care has many issues that need attention.

According to a Mass Home Care analysis of enrollment, more than 9 out of 10 new members in the plan have had no contact with an independent Long Term Supports Coordinator, a mandated feature of the plan.

Thousands of Massachusetts residents have been enrolled in this plan. The goal of this program, which Mass Home Care supported, was to integrate medical and long term support services for people age 18 to 64. A key member of the integrated care team in the One Care plan is the Long Term Services Coordinator (LTSC).

Roughly a year before the One Care launch on October 1, 2013, Mass Home Care began raising a number of design concerns about implementation of the LTSC position within the One Care demonstration. These concerns remain unaddressed.

As of January 31st, after 4 months of experience, enrollment has reached 9,541 members. A total of 26,086 people have been enrolled, either passively or actively. Of that total, 16,645 people have "opted out" of the plan. This means that 64% of those enrolled in the plan, chose to get out. Active enrollment is when an individual chooses on their own to enroll. "Passive enrollment" is when the state choose a plan for the individual, who then has to "opt out" of the plan.

The state decided it needed to passively enroll duals on the advice of actuaries who warned that if people were not assigned a plan, that not enough people would join One Care to make the risk pool financing work. Advocacy groups wanted enrollmenet to remain voluntary, as in the Senior Care Options (SCO) program, which is a similar managed care plan for elderly duals.

After 4 months of operation, the following issues have emerged as problems:
1. Very few One Care enrollees are

being provided with an initial assessment by a Long Term Services Coordinator (LTSC). Under state law (Ch. 118E, 9F(b)(1) members have a right to an initial assessment by a Long Term Services Coordinator (LTSC). Here is what the law says:

"Members of the MassHealth dual eligible pilot program on Integrated Care Organizations (ICOs) or any successor program integrating care for dual eligible persons shall be provided an independent community care coordinator by the ICO or successor organization, who shall be a participant in the member's care team. The community care coordinator shall assist in the development of a long-term support and services care plan. The community care coordinator shall (1) participate in initial and ongoing assessments of the health and functional status of the member, including determining appropriateness for long-term care support and services, either in the form of institutional or community-based care plans and related service packages necessary to improve or maintain enrollee health and functional status;"

This is not happening. Very few members are being provided with an LTSC, even fewer have actually had an LTSC assessment completed.

As January 31st, a total of only 630 individuals in One Care plans—some voluntary, some "passively" enrolled--have been referred for a LTSC assessment. Based on a survey of all 27 ASAPs conducted by Mass Home Care, a total of 404 referrals to ASAPs had been made by One Care plans for a LTS Coordinator initial assessment as of January 31st. As of February 12th, Independent Living Centers report 226 referrals for LTSC initial assessments, for a total of 630 referrals. Only 6.6% of enrollees have been referred for a LTSC initial assessment. The largest of the 3 One Care plans had referred only 133 members to an ASAP for an initial LTSC assessment, or 2.1% of their caseload.

2. The LTSC is not being included as a "participant in the member's care team."

The LTSC is not being utilized in the "ongoing assessment" of the member's functional status. One of the One Care plans has instructed LTSC's to keep a member who needs service coordination open for 3 months. Beyond that the LTSC must explain why the case needs to be kept open, and for how long. LTSS are not episodic or recuperative. While the rest of the member's care team (MD, RN, PA, Care Coordinator) remains in place, the LTSC is no longer a participant.

3. The 'ongoing' functions of the LTSC are not being utilized.

LTSCs are not carrying a caseload like other team members. Pursuant to Chapter 118E, 9F(b), the LTSC has 3 basic functions: (1) participate in initial and ongoing assessments of the health and functional status of the member, including determining appropriateness for long-term care support and services, either in the form of institutional or community-based care plans and related service packages necessary to improve or maintain enrollee health and functional status; (2) arrange and, with the agreement of the member and the care team, coordinate appropriate institutional and community long-term supports and services, including assistance with the activities of daily living and instrumental activities of daily living, housing, home-delivered meals, transportation and, under specific conditions or circumstances established by the ICO or successor organization, authorize a

range and amount of community-based services; and (3) monitor the appropriate provision and functional outcomes of community long-term care services, according to the service plan as deemed appropriate by the member and the care team; and track member satisfaction and the appropriate provision and functional outcomes of community long-term care services, according to the service plan as deemed appropriate by the member and the care team.

Several ASAPs have reported that their LTSCs do not participate in the care plan assessment at all---that the One Care plan does the whole assessment, then shows it to the LTSC for sign off. At one One Care plan, the LTSCs are not being used to "carry a caseload." They are not paid on a "per member per month" basis, but rather on a fee for service agreement, based on discreet activities like a home visit, team meeting, etc. Their involvement is episodic, and they may or may not be involved in care team meetings. The LTSC is being used more as an outside consultant.

After meeting the enrollee in an initial assessment, and discussing the care plan goals as articulated by the enrollee, the LTSC should prepare a LTS careplan as part of the Individualized Care Plan, for the review of the enrollee and the ICT. After the initial assessment is completed, as recommended by the Implementation Council, and as allowed under the Three Way Contract, the LTSC should assist in the development of the community-based service component of the ICP, "at the enrollee's direction."

The LTSC should perform the LTS component of the initial assessment either together with other team members, or separately. This assessment shall be face-to-face with the enrollee, preferably in the enrollee's home, or other location of their choosing.

4. The role of the LTSC as an independent agent is not being implemented. As Chapter 118E, 9F(c) states, the One Care plan "shall not have a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator. Providers of institutional or community based long-term services and supports on a compensated basis shall not function as an independent care coordinator." If effect, the One Care plans are internally performing the function of the independent LTSC assessment as their responsibility. As CMS has recently reiterated in its Final Rule on Home & Community Based Services, at the heart of "person centered care" is "independent evaluation, independent assessment" by an "agent" of the member who is not a provider.

5. There is no consistent process for One Care plans to use to inform members of their right to an LTS Coordinator. Members are being excluded from this right because of their rating classification. This should be a verbal and written communication. Members' choice should include written descriptions produced by the LTS Coordinator entities about what they do. The One Care Implementation Council has recommended that this happen after the LTSC has done an initial assessment, so the member knows who this person is, and what they do. ASAPs are unsure what enrollees are being told about the role of the LTSC, when they are informed, and by whom. We do not believe that any of the Plans are giving enrollees actual written materials from the LTS Coordinator entities. Furthermore, EOHHS requires LTSC Initial Assessments only for certain tier referrals, and enrollees classified as C1s are not on the referral list. As of January 31st. 75% of enrollees have been classified as C1s. These enrollees in the "Community Other" tier may have 3 or 4 ADLs—an indicator of the need for a LTS Assessment. But because they do not need skilled nursing care 3 times a week, or do not have behavioral or cognitive

impairment—they are not considered in need of LTS. A person who cannot bath, dress or walk without assistance, for example, is not going to be assessed for LTS needs. The Plan as constructed will not identify many enrollees with LTS needs, until those needs are combined with a skilled nursing need or a behavioral/cognitive problem. At this point, the tiered classification system---which bears no relationship to One Care statute—is screening out many people with LTS needs who can be maintained at a higher level of functioning with the proper supports.

Regardless of an enrollee's rating classification (F1, C3, C2 and C1), the initial LTSC assessment should be considered a baseline visit that reviews both ADL and IADL functioning; 'unhealthy lifestyle' patterns, such as tobacco or substance abuse addictions, poor nutrition/diet, lack of adequate exercise; and inadequate community supports, such as inadequate housing, lack of transportation, underemployment, inadequate income supports, money management needs, lack of medication management, insufficient personal supervision, etc.

6. There is no consistent process that One Care plans use with members turning 60--or already 60 and over---about their right to have an ASAP as their LTS Coordinator.

To our knowledge, this process for people turning 60 is not in place. In addition, we have seen cases in which elders in the 1915c waiver are being enrolled in One Care plans. Waiver clients are excluded from this plan. Six months before an enrollee turns 60, he or she should be informed by EOHHS of the right to receive the services of an ASAP LTSC. The Plan should verbally notify the enrollee of this right as well. Enrollee should also be informed of the right to enroll in a Senior Care Options plan or the Frail Elderly Waiver(s), along with information explaining the benefits provided by such options.

7. There are no protocols for addressing the needs of members turning 65 who may lose their MassHealth eligibility, or who may benefit by switching to a Senior Care Organization (SCO) plan.

Six months before an enrollee turns 65, he or she should be informed by EOHHS and/or their One Care plan that when they turn 65 their eligibility for MassHealth will have to be redetermined before they can continue to remain in any MassHealth plan, including the One Care Plan. The Plan shall also contact the enrollee and offer to assist the enrollee with his or her MassHealth application, set them up with a SHINE counselor, etc.

8. No data is being published regarding the use of the LTSC, and no performance metric.

The One Care Implementation Council has recommended a series of metrics to measure the frequency of use of LTS Coordinators, by plan, and by LTS Coordinator entity; the number of members who decline to have an LTS Coordinator, the number who switch LTS Coordinator entities, etc. This data has not been produced in any EOHHS monthly report. As a result, there is no measurement of a Plan's performance in providing an LTSC agent for its members.

9. There is no transparent process regarding member choice of LTSC

The member must be informed that they can replace the person in their LTSC role, or change to another LTS Coordinator entity at any point in time. This should be true of all members of the care team, including the primary care physician. Mass Home Care has asked how the choice of LTSC is presented, how the role of this team member is described, and how and when enrollees are told of their right to replace their LTSC---as well as any other member of their team.

10. There is no training for One Care Plan Regarding the Role of the LTSC.

EOHHS should assume responsibility for ongoing oversight of the implementation of the LTSC function at One Care plans, and should be responsible for collaborative training on the role of care

coordinators and the role of the independent LTSC as an "agent" for the member, and should provide training for those who supervise care coordinators at the One Care plans.

Conclusion

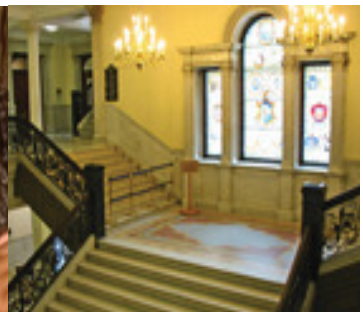
From its very inception, one idea behind the One Care Plan has been that by integrating the acute care and long term care systems, individuals would get more access to long term care services and supports. Our experience here in Massachusetts with the home care program has been that the provision of home and community based long term care, as a replacement for institutional care, has produced a net dividend to the state of at least $700 million per year.

Doctors, hospitals, and insurers are teaming up with home care providers in many different contexts to reduce hospital readmissions and promote healthy aging in place. All the evidence points to substantial cost savings. So it is ironic that enrollees in the new One Care Plans are being denied access to care coordination for home and community based long term services and supports. This not only weakens the capacity of the Plans, but will make them more costly in the long run, and of less value to its members.

What is lost by the member is the relationship with an active, engaged LTSC---the same kind of relationship that the PCP and the ICT hope to have with the member. The value of this relationship, which is developed over time, is the enhancement of the member's ability to meet a variety of health care, social and daily living needs. As a researcher at Kaiser Permanente said recently: "When we look at the research, we see that social and environmental factors are much more powerful drivers of health than someone's heredity or the medical care they need." This interplay of social supports between the member and the LTSC will generally not occur when the LTSC is only episodically involved. One Care members are missing the benefit of having an independent, experienced "agent" to support their aspirations for healthy living and independent functioning.

Mass Home Care has spent the past three years trying to illustrate for the medical community the value of incorporating these "social determinates" into their medical homes, which is where the community linkages really take hold. The One Care plan has the opportunity to capitalize on the existing infrastructure for these linkages—but only where the LTSC has been fully integrated into the member's care team.

Elder Lobby Day March 24th.



On March 24th, elder advocates will do some door-knocking on Beacon Hill at an Elder Lobby Day organized by Mass Home Care.

Several hundred advocates are expected to lobby their lawmakers for increased funding for home care services, affordable transportation for seniors and the disabled, mental health services, and a living wage for homemakers and care managers.

According to Mass Home Care President **Christine Alessandro,** Governor **Deval Patrick's** budget for FY 15 boosted home care services by $17 million---but persistent problems remain in several line items. "We have 17,000 homemakers in this state who make an average wage of $10 an hour. That's a fast food worker wage," explained Alessandro. She said the line item that funds operations and care management for the state's 27 non-profit Aging Services Access Points (ASAPs) has not seen a funding hike in 5 years. "This has put a real strain on our budgets," Alessandro noted, "because the cost of operating a business and paying your staff does not go on hold for 5 years."

Mass Home Care is supporting a $6.1 million increase for homemakers, and $3.3 million for the care manager /operations account that funds the Aging Services Acces Points.

Besides Mass Home Care, other sponsors of Elder Lobby Day include: The Caring Force, the Home Care Aide Council, AARP Massachusetts, Mass Senior Action Council, Mass Councils On

Aging, Mass Human Services Provider's Council, Mass Association of Older Americans, the LGBT Aging Project, Home Care Alliance, and the Jewish Community Relations Council of Greater Boston. For details contact info@masshomecare.org

"Doc Fix" Running Out of Time

Further budget cuts to the Medicare Advantage program have some health insurers worried.. Insurers are lobbying the Obama Administration not to cut the rates of Medicare Advantage programs, according to The Hill news.

"Seniors cannot afford another round of rate cuts to their Medicare Advantage coverage," said the president of America's Health Insurance Plans (AHIP). "[Medicare] should protect seniors in the program by maintaining current payment levels next year."

Medicare Advantage covers roughly one-quarter of the beneficiaries in Medicare. On average, the government pays more per Medicare Advantage patient than it does for beneficiaries in traditional Medicare. Democrats have sought to cut reimbursements to the private plans, but Republicans have opposed a rate cut to Medicare Advantage. The Affordable Act cuts Medicare Advantage by $200 billion over 10 years. "Thus far, it doesn't appear that the payment changes have had a major impact on the program," said **Tricia Neuman**, a Medicare expert and senior vice president with the Kaiser Family Foundation. The Centers for Medicare and Medicaid Services (CMS) were expected to announce the 2015 Medicare Advantage rates in late February.

The AHIP said that Medicare Advantage patients experienced cost increases and benefit cuts of $30-$70 per month as a result of last year's 6 percent cut to the program. If the White House imposes further cuts, and the Medicare plans respond by raising premiums, seniors would be hit with higher prices just weeks before the November election, The Hill notes.

The Hill writes that the Republican party "appears to be sharpening its attack lines against Democrats on the Medicare issue."

At the same time, a bipartisan group of Congressman filed legislation in February in which doctors would receive an 0.5 % increase for each of the next five years as Medicare transitions to a payment system designed to reward physicians based on the quality of care provided, rather than the quantity.

For more than a decade Congress has struggled to find a way to finance repeal of the "doc fix," shorthand for the 1997 formula used to set physician payments, known as the sustainable growth rate (SGR). Congress has passed temporary patches for years, and kicked the issue into the following year. The current SGR runs out April 1st. The new bill would provide "stability for physicians so they will no longer face the uncertainty of massive cuts, but also begins the process of improving how we pay for medical care to focus on positive results for seniors," according to one sponsor. Doctors face a 24% cut in their Medicare reimbursements if Congress doesn't change current policy. According to a fact sheet, the new bill:

• repeals the SGR and replaces it with a system focused on quality, value, and accountability.

• removes the imminent threat of draconian cuts to Medicare providers and ensures a 5-year period of annual updates of .5% to transition to the new system.

• consolidates the three existing quality programs into a streamlined and improved program that rewards providers who meet performance thresholds, improves care for seniors, and provides certainty for providers.

• incentivizes the use of care coordination efforts for patients with chronic care needs.

• introduces physician-developed clinical care

guidelines to reduce inappropriate care that can harm patients and results in wasteful spending. • provides a 5% bonus to providers who receive a significant portion of their revenue from an APM or patient centered medical home (PCMH).

According to *Kaiser Health News*, physician groups have generally welcomed congressional efforts to swap the SGR for a value-based payment system, The Congressional Budget Office estimated that holding Medicare physician payments at current rates – no increases but no cuts either -- would cost about $115 billion over the next decade, far less than previous estimates. Adding a payment update to the doc fix package will increase the cost. As they have before, lawmakers could look to cut payments to Medicare providers – such as hospitals – but that would likely create a major pushback from the industry since those same providers took a payment reduction as part of the federal health law and then had their Medicare payments cut by 2 percent as part of the 2013 automatic federal budget cuts known as the sequester. The recent budget deal extended those Medicare sequestration cuts for an additional two years, to 2023 from 2021.

Congress could also propose reforms to the Medicare program, such as combining Medicare's Part A and B deductibles, raising cost-sharing or overhauling Medigap, the supplemental insurance program, to find savings. Other proposals include increasing the amount that higher-income beneficiaries pay for their Part B coverage or raising the current Medicare eligibility age. But facing a midterm election, lawmakers may be reluctant to embrace any of those ideas.

Consumer groups, like AARP, have opposed shifting costs to Medicare beneficiaries. "Since Medicare beneficiaries already pay for a portion of the annual provider payment increases through their Part B premiums, we ask Congress to reject proposals that unfairly ask America's seniors to pay more," said **Joyce Rogers,** a senior vice president with AARP."

It is not likely that most seniors will follow the details of the "doctor fix," but for too long Congress has dealt with the cost implications of physician payment by not dealing with it , other than with temporary patches.

Saving QI

In related news, a coalition of aging groups, including the National Council on Aging (NCOA) is urging Congress to make the low-income Medicare Qualified Individual (QI) program permanent as part of the Medicare physician payment (SGR) bill.

The QI program pays Part B premiums for nearly half a million Medicare beneficiaries with incomes of between 120-135% of poverty (about $13,700-$15,500 a year) and less than $7,080 in assets. Without the QI benefit, these vulnerable seniors could be forced to drop their Part B benefit and lose access to their doctors—or pay over $1,200 in new, additional premiums.

Since December 2002, QI funding has been extended on a year-to-year basis—as part of "extenders" packages, crafted primarily to ensure that Medicare physician payments are not drastically cut. Once again, current QI funding will end March 31, 2014 unless Congress acts. While lawmakers are committed to addressing the concerns of physician specialists making $400,000 a year, they have yet to agree to help seniors with incomes of $14,000 a year.

Senior rights groups are asking Congress to make the QI program permanent as part of a broader, bipartisan package to reform Medicare physician payments. NCOA and the other leading national organizations are asking Congress to fix both problems at the same time, ensuring that all people with Medicare have access to physicians and quality, affordable health care.