

At Home

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With Mass Home Care

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Al Norman, Editor



Waiting for the Home Care Budget

Each year, as the state's fiscal year ends, the final weeks of June become an anxious waiting game for elder advocates as the budget for FY 15 is being finalized by state lawmakers.

Shortly after the State Senate finalized its proposed FY 15 budget in May, and the two branches of the General Court began meeting as a Conference Committee to hammer out a final budget, six elderly rights groups sent a joint letter on May 29th. to the Chairs of the Ways & Means Committee listing out their funding requests. Here is the text of that letter:

“Representative Brian Dempsey,
Chairman, House Ways & Means
Senator Stephen Brewer,
Chairman, Senate Ways & Means

Dear Chairman Dempsey & Chairman Brewer,

The FY 2015 budget Conference Committee deliberations present us with important opportunities to promote “community first” for older adults in Massachusetts. As advocates for the elderly, we want to urge you to work in Conference to advance the issues outlined in this letter.

We are submitting our list of items that we think best serves seniors, and that we hope will prevail during your discussions. The most significant of these items include:

- \$4.63 million in additional home care dollars

that will allow an increase in the basic home care benefit package, which has been stuck at \$8.76 a day since 2009, enough to provide an additional 1,307 elders with home care services for an entire year.

- \$6.1 million for a wage rate add-on of 75 cents per hour for 17,000 home care aides struggling to keep their families above the poverty line.
- \$1.3 million for ten new supportive housing sites in the community for more efficient delivery of home care services.
- \$750,000 in added meals on wheels funding, enough for 115,384 additional home-delivered meals.
- \$360,000 for the SHINE health insurance counseling program that helps adults of all ages find the health care plan that best meets their needs in an increasingly complex insurance marketplace.



- \$500,000 for a new Home and Community-Based Policy Lab housed at EOEA.
- \$500,000 to develop and submit a home and community-based services state plan to maximize opportunities that expand community services and increase federal reimbursement.
- \$250,000 for Project ABLE for workforce and skills training services.

We are challenged to provide sufficient care at home for today's seniors that allows them to live in "the least restrictive setting appropriate to their needs," as required under our MassHealth statute. The population aged 65 and over in Massachusetts will increase by over half a million (548,699), expanding from 14% of the state's total population in 2010 to 21% by 2030.

Home care programs are a smart investment.

These lower cost services are part of the reason that MassHealth patient days in skilled nursing facilities have fallen by 4.25 million patient days in FY 2012 compared to patient day levels in FY 2000. SNF patient days have plummeted -33% over this 12 year period. According to an analysis from the Executive Office of Elder Affairs, consumers who were discharged from home care programs in FY13 averaged 34 months of home care program experience of which 10 months were in a program requiring a nursing facility level of care need. The savings to the Commonwealth from these avoided SNF patient days is \$1.2 billion over the next 6 years. In addition to this huge "home care dividend," our work with seniors is bringing in as much as \$125 million in new federal matching funds for FY 15 from the Balanced Incentive Payment (BIP) program, and from a proposed 1915 state plan amendment.

We hope that the final FY 2015 budget that emerges from your Committee will enable us to meet the demographic challenges we are facing, and at the same time protect the civil rights of the elderly to remain in integrated community settings."

Signed by: **Lisa Gurgone**, Home Care Aide Council, **Carolyn Villers** of the Mass Senior Action Council, **Chet Jakubiak** of the Mass. Association of Older Americans, **David Stevens** of Mass Councils on Aging, **Mike Festa** of AARP Massachusetts, and **Al Norman** of Mass Home Care.

State Raises Home Care Rates For Coming Year

Two weeks after the advocates' letter was sent, the state Center for Health Information and Analysis (CHIA), announced a public hearing for July 11, 2014 to take testimony on two new rates for FY 15 and 16: Home Care Basic Purchased Services, and the Enhanced Community Options Program (ECOP).

Because these are two program rates that will apply to the FY 15 budget year, they could have an impact on what the legislative Conference Committee will recommend for home care and

enhanced home care funding.

The basic home care program serves just under 29,000 elders per month. The ECOP program serves around 6,000 elders per month who are not yet on MassHealth, and who need nursing facility level of care---but who are being cared for in the community instead. Under a state law known as Chapter 257, humanservicesrates that are not controlled by MassHealth are supposed to be recalculated by CHIA every other year to keep pace with the rising cost of providing care.

CHIA is proposing to raise the basic home care and ECOP rates for FY 15 and 16 as follows:

- increase the services portion of the Enhanced Community Options Program by 2.5% from \$661.12 to \$677.76
- the Home Care services rate would rise by 10.8% from \$266.52 to \$295.28.

The basic home care services rate is what the state provides for elders who are enrolled in the home care program, and has been frozen since 2009. The current rate means the average home care services package for a client enrolled in the home care program only allows for \$8.76 a day for care, which provides less than 3 hours a week in personal care supports. If the CHIA rate for basic home care rises to \$295.28, it will allow only one more hour of personal care per month.

Because the budget for FY 15 had not yet been finalized when CHIA issued its rates, the agency took the unusual move of issuing its rate increase in two separate parts: one assuming no new funding, and one assuming higher support from the legislature. Under the first rate step, the home care rate would raise by only \$6.92 per month. CHIA then proposes that if "sufficient funding" is appropriated, the home care rate would rise by another \$21.52 per month, plus a small cost of living adjustment. The rate for home care would go up a total of \$28.76.

The Executive Office of Elder Affairs is projecting that 28,878 elders per month will use home care in FY 15. Given this rate for home care, the Senate appropriation for home care of \$99.7 million would be at least \$2.8 million short.

At the same time, the ECOP program is running hotter than earlier projected. In ECOP, if the new CHIA proposed rate of \$677.76 is approved, and is added to the \$209.24 care management rate for ECOP, the total

rate for FY 15 would be \$887 per month. EOEA has projected that 6,044 elder per month will be enrolled in ECOP during FY 15, requiring a total appropriation from the General Court of \$64,332,336, which is roughly \$1.3 million higher than the ECOP figure for FY 15 proposed in both the House and the Senate, and now in play in the Conference Committee of \$63,077,339.

If the CHIA rates and the General Court's appropriations are not in synch, the CHIA rates will have to be cut back, depriving elders of the care they need. Mass Home Care is slated to testify at the July 11th CHIA hearing that both the home care and ECOP rates are still not adequate, or reflective of the actual cost of the service package that disabled seniors really require to remain living at home.

Minimum Wage And Home Care Wages



Seeking to expand economic opportunity for working people in the Commonwealth, the House and Senate have voted to increase the state's minimum wage to \$11 an hour by 2017. The measure as adopted by the General Court would increase the minimum wage gradually, to \$9 per hour in 2015, \$10 in 2016, and \$11 in 2017. The measure would also gradually raise the minimum wage for tipped workers, such as restaurant servers, from \$2.63 per hour to \$3.75 per hour, a 31% increase and the first since 1999. The final, compromise version of the bill dropped a provision which would have automatically linked future increases in the minimum wage to increases in the state's rate of

inflation. The inflation factor was included in a Senate version of the bill, but was not part of the House version.

According to the Mass Budget and Policy Center, the new law will raise the wages of about 600,000 people in the Baystate. In addition to helping these families and individuals, a minimum wage increase can also have positive effects on the overall economy, as higher wages allow workers to spend more at local businesses. When fully phased in, the increase will raise annual wages for affected workers by approximately \$1.1 billion.

These 600,000 workers whose wages will increase represent one-in-five wage earners in the Commonwealth. Over 85% are twenty years old or older -- and younger workers who are helped are often working to pay for college or to help their family with basic expenses. 57% are women. 140,000 of the affected workers are parents -- and 236,000 children live in households that will be helped by the increase.

The legislation will raise the wage in three steps: to \$9/hour in 2015, to \$10/hour in 2016, and to \$11/hour in 2017 (on January 1st of each year). These wage increases would not be indexed to inflation. In addition, the "tipped minimum wage" - which allows employers to pay tipped workers a lower wage (as long as tips bring the workers' pay up to the regular minimum wage) -- would rise slightly, from the current rate of \$2.63/hour to a final rate of \$3.75/hour, also by 2017.

At \$11 an hour in 2017, Massachusetts would have the highest state minimum wage in the nation -- unless other states raise their wage above that level during the next three years. Elder rights groups point out that by 2017, the wages of home care aides, which now average around \$10 an hour, will have to be raised to the minimum--but this also means that the minimum wage--which is now below the home care aide average--will catch up to the home care aide wage, in effect putting home care aides only at minimum wage. Mass Home Care has argued that the 17,000 home care aides should be paid at least 133% of the current minimum wage, which would be \$14.63/hour, in order to attract workers to the home care field, and away from other retail or fast food jobs. Personal Care Attendants (PCAs), who perform job functions for disabled adults on MassHealth similar to the home care aides, are making \$13.38 per hour as of July 1, 2014.

Advocates say the new minimum wage increase should also increase the pressure to raise the wages of home care aides and PCAs to keep them above the minimum wage level.

15 Years After Olmstead: Moving Money to Home Care?



Lois Curtis one plaintiff in Olmstead case.

On June 22, 1999, the Supreme Court held in *Olmstead* that "unnecessary isolation is properly regarded as discrimination based on disability." In this decision, based on a complaint filed by two women in Georgia who were being held in a psychiatric hospital against their will, the Court upheld the Americans with Disability Act (ADA) regulation that "public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

Disability rights Attorney **Steve Gold**, based in Philadelphia, has compiled a State-by-State analysis of how much progress has been made in moving funding from nursing facilities, into the community since the *Olmstead* decision. The total Medicaid Long Term Services and Supports (LTSS) funding includes expenditures both in the institution and in the community. The largest share of funding historically by Medicaid has gone to nursing facilities.

In FY 2000, says Atty. Gold, the national average for community-based Medicaid funded programs

and services was 18.7% of the total LTSS. Therefore, the remaining 81.3% went to keep older and younger people with disabilities "unnecessarily institutionalized" in nursing homes. These FY 2000 expenditures are the Olmstead/ADA base for comparison. In FY 2000 dollars, only \$9 billion Medicaid funding was spent to keep people in the community, while \$49 billion was spent to institutionalize them in nursing homes.

By FY 2012, the national average for community-based Medicaid funded programs increased to 38.8% of the total LTSS and the institutional expenditures decreased to 61.2%. In FY 2012, \$22 billion in Medicaid funding was spent in the community (up from the \$9 billion in FY 2000) but \$74 billion was spent to keep people in "unnecessary isolation," up from \$49 billion in FY 2000.

Attorney Gold compared States by focusing on the 38.8% increase in the national average of Medicaid funding for community-based programs in FY 2012. This comparison looks only at the percentage increase in funding going to community-based programs from 2000 to 2012. "We believe that a State's commitment to end discrimination against people with disabilities and to enforce the Olmstead decision and the ADA is reflected in its increase in community expenditures," Gold explains.

Based on Gold's state-by-state comparison of community-based expenditures as a percentage of their entire LTSS from FY 2000 to FY 2012, here are the top ten best states at "rebalancing" their long term care spending on the community side. The U.S. average is 38.8%:

% Community LTSS Spending	State
1. 65.4%	Minnesota
2. 62.4%	Alaska
3. 61.7%	Washington
4. 60.7%	Oregon
5. 57.1%	California
6. 50.1%	Texas
7. 47.9%	Wisconsin
8. 45.9%	New York
9. 45.5%	Colorado
10. 44.7%	Massachusetts & Vermont

The 2000 census reports that there were 1,720,500 persons of all ages with disabilities residing in nursing facilities. By March 31, 2013, the number had been reduced to 1,414,957---an 18% reduction in the population of institutionalized disabled people. While there has been an 18% reduction in the nursing facility population of people with disabilities nationwide, rates vary among the States. Hawaii had a 28% increase and Nevada had a 4% increase in nursing home population from 2000 to 2013; however, these were the only two states that increased their institutional populations. A few States had small reductions of less than 5% (Georgia had only a 1% reduction and Maryland had only a 5% reduction, which was followed closely by Texas and New Jersey reductions at 7% and 9% respectively.

On the positive side, Oregon was the most effective State at reducing its nursing facility population with a reduction of 47%, second was Alaska at 36% and the following States all reduced these populations by at least 30%: Idaho, Maine, Minnesota, Oklahoma, Vermont, D.C., and Wisconsin.



In 2011, the national average occupancy rate for nursing homes was 83%. One might think that a State that had low nursing facility occupancy rates would also be reducing its Medicaid expenditures on nursing facilities. After all, it seems that reduced numbers of persons with disabilities in the nursing facilities and many unused/unoccupied nursing facility beds should result in less total Medicaid funds going to keep people with disabilities unnecessarily isolated or at risk of such isolation. Yet between 2000 and 2012, Atty. Gold notes, there was a 31% increase in the total amount of Medicaid funding for

nursing facility residents. There was a \$12.4 billion increase in Medicaid funding for nursing facilities during those years despite both an 18% reduction in number of residents and only an 83% occupancy rate. “Sometimes I know I am in the wrong business,” Gold concludes.

“What is amazing,” he adds, “given these reductions and relatively low occupancy rates between 2000 and 2012, is that the national average of Medicaid nursing home expenditures actually increased by 31%! There was a total of \$12.4 billion more Medicaid expenditures over that period.” The States that increased their Medicaid nursing home expenditures by more than 80% during this 12 year period include: Arizona, Arkansas, California, Idaho, Indiana, Maryland, Mississippi, Nevada, Utah, Virginia. Delaware, Michigan and D.C. had less than a 10% increase, and there were a few States that actually reduced the percentage of their nursing home expenditures, including Hawaii, Minnesota, New Mexico, Pennsylvania, and Tennessee.

“So what is happening?” Gold asks. “The nursing home industry is ripping off your State budgets.” According to Gold, the Massachusetts nursing facility population between 2000 and 2013 decreased by -23%, which was the 18th largest drop in nursing home residents in the nation.

But in 2012, nursing homes in Massachusetts received an additional \$429,138,089 in funding above the funding level in 2000. This was the 8th largest increase in nursing home funding in the nation. On the community-based side, Massachusetts spending increased by \$650,078,374, the fourth largest dollar increase in the nation.

Finally, Atty. Gold notes that when you compare State spending in FY 2012 on LTSS for people with developmental disabilities (DD) with expenditure for people the aging/physically disabled population without developmental disabilities, many states allocate a much greater percentage of their Medicaid dollars on community-based care for the developmentally disabled. In Massachusetts, for example, 98.5% of Medicaid spending for the DD population was in the community, yet Medicaid spending on the aging/physically disabled in FY 2012 was only 44.7% in the community.

Gold has a number of explanations for this

discrepancy: 1) In 2000, spending for the DD population was equally split between the institutional side (Intermediate Care Facilities/MR) and the community side (MR Waivers), but 80% of Medicaid LTSS spending for the aged and people with physical disabilities went to the institutional side. “It’s like a hundred yard dash with some folks starting at the mid-point and others starting far behind,” Gold explains. 2) 58% of the institutions for the developmental disability community were publicly owned in comparison to the nursing facilities, of which only 6% are publicly owned



and nearly 70% are for-profit. This difference results in political differences because money and contributions to state-elected officials play an important role in how Medicaid funds are expended between the institutions and the community. 3) most people with developmental disabilities have moved from public institutions to private provider-based group homes and people with physical disabilities have moved from private institutions (nursing facilities) to their own apartments and homes. The providers of community-based services for DD individuals are very strong both financially and politically, just as private nursing facility proprietors are strong. 4) advocates must go into institutions to encourage and help people transition out of the institutions. “I am regularly amazed,” Gold concludes, “when I ask advocates for the aging and people with physical disabilities about people in institutions who want to reside in the community---and am told they do not know those people.”

Atty. Gold’s research shows that nursing homes continue to get higher appropriations despite the

fact that caseloads and occupancy rates have fallen. Yet most states have made considerable progress towards “rebalancing” their community care spending since 2000. “These changes do not come about by magic,” Gold admits, “but by hard grass-roots organizing efforts. These changes directly impact hundreds of thousands of people with disabilities.”

Partners Tells One Care Patients: “Find A New Doctor”

The state’s largest health care provider network, Partners HealthCare, is not participating in the state’s new One Care managed care program, which began October 1, 2013, and has roughly 14,000 enrollees after the 8 month mark. But no enrollees are Partners patients.

In a letter to its patients, Partners explained their relationship---orlackofit---withthethreeOneCareplans:

“If you have received a mailing from MassHealth, notifying you that you are eligible to enroll in the One Care program, and you receive your primary care from a doctor that is affiliated with Partners HealthCare, it is important for you to know that Partners HealthCare primary care doctors are not participating in the One Care program. This means that if you use a primary care doctor affiliated with Partners HealthCare and enroll in One Care, you will need to find a new primary care doctor.

Partners told its patients that “MassHealth is offering a new plan to people who now have insurance through both MassHealth and Medicare. The new program is called One Care: MassHealth + Medicare. If you are eligible for this program, you should have received information by mail from MassHealth. One Care is offering new insurance plans through Commonwealth Care Alliance, Fallon Total Care, and Network Health. These plans would replace the insurance you have now. Partners HealthCare affiliated primary care doctors do not accept any of these new insurance plans. Therefore, if you enroll in One Care, and your primary care doctor is a Partners doctor, you will need to find a new primary care doctor.”

As Partners explained to its members: “You

have a choice about One Care. There are two things you can do: 1. If you would like to stay with your Partners HealthCare affiliated primary care doctor, you will need to opt out of choosing a new plan. This means:

- You will keep the doctor you have now
 - You will still have insurance through Medicare and MassHealth
 - You will not choose insurance through Commonwealth Care Alliance, Fallon Total Care, or Network Health
- Or:

2. You can choose one of the new plans and pick a new primary care doctor. To do option #2: Call MassHealth at 1-800-841-2900 or mail back the enrollment paperwork that MassHealth sent you. Choose a One Care plan. Contact your new One Care plan and ask them to help you find a new doctor.”



Partners also told its patients: “Depending on the county you live in, MassHealth might auto-assign you to one of the participating One Care Plans. If you want to stay with your primary care doctor, you should be sure to choose not to enroll in the One Care program to prevent MassHealth from picking a plan for you.”

Health Care For All, a patient’s rights group, said it contacted the Attorney General’s office shortly after the Partners letter became public, asking for a meeting to discuss their concerns over the Partners position regarding the One Care program. “Pretty disturbing,” one disability rights advocate wrote.

“Bottom line, Partners tells its patients to opt out of one care if they want to keep their primary care providers.”

In its letter to patients, Partners does not provide a reason for its non-participation in One Care. Partners HealthCare is a not-for-profit, integrated health care system based in Boston. Founded by Brigham and Women’s Hospital and Massachusetts General Hospital, Partners HealthCare includes community and specialty hospitals, a managed care organization, a physician network, community healthcenters, homecare and other health related services.

Partners is the largest private employer in Massachusetts, with approximately 60,000 employees, including physicians, nurses, scientists, and caregivers.

One Care Plan: High Opt Out Rates



In mid June, the Executive Office of Health and Human Services (EOHHS) released its monthly report on enrollment statistics for the first eight months of the One Care program for people on Medicare and Medicaid. The report shows a high number of potential members are turning down the offer.

Here are some highlights:

- There are 94,358 people eligible for One Care in Massachusetts (some counties have no plans)
- Total enrollment is 13,409 as of June 1st, or 13.8% of those eligible
- 22,686 people have opted out of the program.
- 24% of the eligible population has opted out. Almost twice as many people have declined the program than have accepted it.

- A total of 36,095 have either joined One Care or declined. The opt outs represent 62.8% of the total people who have accepted or rejected the program. If only 37.2% of those approached actually enroll in the program, membership in One Care would peak out at only 35,101.
- EOHHS says that roughly 95,700 people have received One Care application packages, the combination of enrolled and opt outs is only 36,095---so it is not clear what the status is of the other 59,605 people who have been sent a package but are not in the program. More "passive enrollment" notices are coming this summer. Disability rights advocates urged the state not to enroll people in plans they did not choose. But the state responded that actuaries told them unless they passively enrolled people in the plan, the enrollment “risk pool” would not be large enough to make the plan financially viable for the three plans. Because no financial data has been released since the program began last October, no one knows how much money the plans are making, or what their ‘loss ratio’ looks like: comparing medical costs to premiums collected.

Monthly reports provide no data on service expenditures as a whole, or by service type, or on the number of assessment completed by the Long Term Support Coordinators. According to Mass Home Care surveys of its members, very few enrollees in One Care are actually seeing an independent Long Term Supports Coordinator, as required by law. Instead, One Care plans are using their own staff to assess people for long term support and services, circumventing the LTSC positions. State law requires that all enrollees in One Care have an LTSC visit as part of their initial assessment into the plan. As many as 85% of One Care members have not had such a LTSC assessment.

Medicare Agrees To Cover Transgender Care

The U.S. Department of Health and Human Services (HHS) Department Appeals Board (DAB), an independent federal appeals board, has ruled that Medicare must cover medically necessary care for individuals with “gender dysphoria,” just as it covers medically necessary care for those with other

medical conditions. Medicare will now cover transition-related care for transgender older adults.

This new Medicare policy was hailed by a coalition of gay rights groups, including Services and Advocacy for GLBT Elders (SAGE), the Gay & Lesbian Advocates & Defenders (GLAD) the American Civil Liberties Union (ACLU), Lambda Legal, and the National Center for Lesbian Rights. (NCLR).



“This is an important milestone for transgender older adults,” SAGE said, “who after a lifetime of being denied medically necessary care, are finally on a level playing field with other Medicare recipients. Older transgender individuals are now able to get the comprehensive medical coverage they need and deserve.”

SAGE says the ability to access complete gender-transition related health care is essential to ensuring the health and well-being of transgender patients. “The Medicare policy denying this care ran counter to decades of extensive scientific and clinical research, which supports surgically altering an individual's primary and secondary sex characteristics as a safe, effective and medically necessary treatment for severe gender dysphoria. This decision is lifesaving for many transgender individuals,” SAGE said. “Both the medical and mental health professions have recognized that when denied proper medical care, individuals with gender dysphoria can develop severe psychological distress, dysfunction, and debilitating depression -- placing them at increased risk for suicide and self-harm.”

Recognizing the dangers of denying proper medical care, the American Medical

Association and the American Psychological Association have issued policy statements recognizing the medical necessity for gender transition-related treatments including hormone therapy and/or sex reassignment surgeries, as well as mental health care.

Addressing Patients' Social Needs

According to an article published by *The Commonwealth Fund*, with support from The Skoll Foundation and The Pershing Square Foundation, social and economic factors in your life can have a major impact on your health. Extensive research documents the impact of social factors such as income, educational attainment, access to food and housing, and employment status on the health and longevity of Americans, particularly lower-income populations. These findings attribute as much as 40% of health outcomes to social and economic factors. As examples: Asthma is linked to living conditions; diabetes-related hospital admissions are linked to food insecurity; and greater use of the emergency room to homelessness.

These findings are not lost on health care providers: 80% of physicians conclude that addressing patients' social needs is as critical as addressing their medical needs. Yet until recently, providers rarely addressed patients' unmet social needs in clinical settings. However, changes in the health care landscape are catapulting social determinants of health into an on-the-ground reality for providers. The Affordable Care Act is expanding insurance coverage to millions more low- and modest-income individuals, and, for many, social and economic circumstances will define their health. Six years after analysts introduced the concept of the “Triple Aim,” its goals of improved health, improved care, and lower per capita cost of care have become the organizing framework for the health care system. As a result, growing numbers of providers are concluding that investing in interventions addressing their patients' social as well as clinical needs makes good business sense.

Public and private payers are introducing payment models that hold providers financially accountable for patient health and the costs of treat-

ment. These models—including capitated, global, and bundled payments, shared savings arrangements, and penalties for hospital readmissions—give providers economic incentives to incorporate social interventions into their approach to care. For example, in October 2012, the Centers for Medicare and Medicaid Services penalized 77% of safety-net hospitals for excess readmissions of patients with heart attack, heart failure, or pneumonia. Meanwhile a review of 70 studies found that unemployment and low income were tied to a higher risk of hospital readmission among patients with heart failure and pneumonia.

To be certified as a patient-centered medical home (PCMH) or Medicaid health home, providers must integrate social supports into their care models. And these certifications almost always trigger higher levels of reimbursement. More than 40 states have adopted PCMH programs, providing important funding opportunities for qualified providers. Even if new payment models do not require social interventions, many providers have concluded that they are essential to achieving quality metrics and earning available revenue.

Beyond these direct economic benefits, providers that incorporate social supports into their clinical models can also reap indirect economic benefits. Patient satisfaction rises when providers address patients' social needs, engendering loyalty. Patient satisfaction can also affect the amount of shared savings a provider receives from payers. Providers that include social supports in their clinical models also report improved employee satisfaction. And interventions that address social factors allow clinicians to devote more time to their patients, allowing them to see more patients and improving satisfaction among both patients and clinicians.

A range of tools, both broad and targeted, are available to providers to address patients' unmet social needs. Broad interventions—usually provided at primary care clinics—link clinic patients to local resources that can address their unmet social needs. Targeted interventions link individuals with chronic or debilitating medical conditions to social supports as part of larger care management efforts. As more low-income people gain health care coverage, evidence on which interventions are

most cost-effective in addressing their social needs and improving their health will grow, and value-based reimbursement will become standard across payers. With these changes in the health care landscape, the economic case for provider investment in social interventions will become ever more compelling.

Time Running Low For Spouse As Caregiver Bill



Michael Fernandes in State House March, 2014

The clock is running down on passage of H. 3716, the one sentence legislation that would allow spouses to be paid as caregivers in the Personal Care Attendant (PCA) program, and Adult Family Care program. The bill is a top priority for Mass Home Care.

The legislative year will end on July 31st. The bill must be reported out of House Ways and Means, be adopted by the House, and then make its way through the Senate. That's a lot of traveling---but legislation can pass in minutes if the legislative leadership is behind it.

Michael Fernandes, a disabled PCA client who lives on the Cape with his spouse, visited the State House last March to lobby for the bill, and presented an online petition bearing more than 1,300 signatures to lawmakers. With the help of Representative **Jennifer Benson** (D-Lunenburg), the House lead sponsor of the bill, and his own State Rep.

Sarah Peake (D-Provincetown), Fernandes has been aggressively lobbying for the bill.

Here is the letter Fernandes sent in June to House Speaker Robert DeLeo:

Dear Speaker DeLeo,

Please help to end the "marriage penalty" in the MassHealth PCA program that currently allows people needing a Personal Care Attendant to hire anyone they want except the person who knows them best, their SPOUSE!

Earlier this year I circulated a petition on behalf of all the MA families affected by this antiquated law, urging passage of H.3716. I personally presented the petition with more than 1,300 signatures at the State House early in March to the Chair and Vice-Chair of the Joint Committee On Health Care Financing. H. 3716 is currently in House Ways & Means after having received a favorable report from Health Care Financing - in large part as the result of the petition.

Seventeen (17) other states already allow spouses to be paid caregivers. Many individuals with disabilities do not want to---or do not have the ability to---rely on strangers to provide their personal care, especially when their spouse is willing and able to serve at least as one member of the care-team. Many also prefer their spouse to the sometimes difficult search for a reliable PCA. Many couples do not have children they can turn to, or the children are too far away to help. But the spouse is right in the home and is most often ready and wanting to be a key caregiver.

The states that have added spouses-as-caregivers have done so in a 'revenue neutral' manner - adding nothing to the bottom line of Medicaid because, with the additional help of spouses, the PCA program is far more able to keep people out of much higher-cost institutional care. H.3716 is a 'community first' bill that makes our MA home care programs better adapted to keeping people 'in the least restrictive setting.'

Families across the state want and desperately need this bill to pass. They do not want to be penalized for yet another year for simply being married, or to be forced---as has happened---to divorce as the only recourse in avoiding this outdated regulation. Please help us to get H.3716 to the Governor's desk before this legislative session ends."

O'Leary Elected President of Mass Home Care



At the June 16th meeting of Mass Home Care, **Dan O'Leary** was elected as the President of Mass Home Care. It is O'Leary's second time as the head of the Mass Home Care Association. He first served as Mass Home Care President from 1988 to 1990.

O'Leary is the Executive Director of Mystic Valley Elder Services, Inc., a state designated Aging Services Access Point (ASAP). MVES has a staff of 185, and an annual operating budget of approximately \$40 million. MVES' mission is to support the right of elders and adults with disabilities to live independently with dignity in a setting of their own choice.

From 1992 to 1997, O'Leary served as the Executive Director of the Alzheimer's Association, Massachusetts Chapter.

O'Leary is an adjunct faculty member of the Gerontology department at UMass Boston. He teaches Human Resources and Personnel Management in the graduate level Aging Services Management Program at UMB. Other FY 15 officers elected

include: Vice President: **Gregory Giuliano**, Exec. Director of Montachusett Home Care; Secretary: **Priscilla Chalmers**, Exec. Director of WestMass ElderCare; Treasurer: **Diana DiGiorgi**, Exec. Director of Old Colony Elder Services.

