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Al Norman, Editor

Michael Fernandes & spouse Susumu Kishihara

Senate Approves Spouse As Caregiver Bill

On July 16th, the spouse as caregiver bill, now numbered S. 2277, passed the state Senate unanimously in the form of an amendment to an existing bill defining Personal Care Attendants (PCAs). The one sentence legislation, originally filed by Mass Home Care, would allow spouses to serve as a PCA. Most other family members---with the exception of dependent children---are already allowed to be a paid PCA worker.

Here are excerpts from the *State House News* version of what was said on the floor of the Senate when the spouse amendment came up for a vote:

"PERSONAL CARE ATTENDANT: Question came on adopting a Health Care Financing Committee amendment to clarify the definition of a personal care attendant.

Sen. Gale Candaras moved to amend the bill. Sen. Candaras said this [amendment]...would allow spouses to be caregivers for purposes of compensation. Presently, any relative but the spouse may be the caregiver. The language has been endorsed by the Mass Home Care. Sen. Candaras said some folks have gone to extremes to be the compensated caregiver. They have had to get a divorce. They have had to postpone marriage. We know any law that postpones marriage, or prohibits marriage is bad law. Seventeen other states allow

spouses to be caregivers. There are approximately 25,000 people with personal care attendants, and another 4,000 in adult foster care. Allowing spouses to be personal care attendants does not cost the commonwealth any additional money. They are allowed a certain number of hours. The spouse would simply step into the shoes of that individual. It does not mean they are going to be paid 24-7. It would not create any newly eligible people. Those who qualify for care must still qualify. There is a shortage of people for personal care attendants and the baby boom generation is about to explode as a demographic who need a personal care attendant. She asked for a roll call vote. There was support.

Sen. **Patricia Jehlen** said I want to second the comments of my friend. It is a priority for AARP and Mass Home Care. It will make a gigantic difference for some people. Thank you to the senator from Wilbraham for making this a priority. And we are very excited to see it move forward.

Sen. Bruce Tarr said I want to commend the chief sponsor of this amendment, I too hope it is adopted. The concept is extremely cost-effective, number one we don't have to involve other outside providers. It recognizes a real hardship when spouses need to care for their spouse, and it creates an impoverished situation. The spouse may be in the best position to be an effective care giver.

Sen. James Welch said this amendment is very important and further strengthens this piece of legislation passed today, in dealing with spouses and allowing them to deal with their loved ones.

BY A ROLL CALL VOTE OF 39-0, AMENDMENT ADOPTED. The new draft was adopted, and the bill, S 2273 was ordered to third reading. The Senate then engrossed the bill."

The actual one sentence text of the Senate bill is as follows: "Ms. Candaras, Messrs. Wolf and Tarr move to amend the amendment by inserting at the end thereof the following new section: Section 9 of Chapter 118 E is hereby amended by adding in the second sentence of the second paragraph, after the words "requirements for Title XIX" the following new language:- Any program of home and community based services funded pursuant to the provisions of this chapter or pursuant to the provisions chapter one hundred and eighteen G, in which family members are permitted to serve as paid caregivers, shall include spouses within the definition of family member."

Fernandes visits Sen. James Welch. & Rep. Jennifer Benson

One of the leading advocates for passage of S. 2277 is **Michael Fernandes**, a retired psychotherapist and individual with disabilities living in Provincetown. Fernandes organized a petition on MoveOn.org in support of the spouse as caregiver bill. In a recent Op-Ed in the *Cape Code Times*, Fernandes wrote:

"Last March, my spouse and I traveled to the State House to meet with lawmakers and urge them to pass a one-sentence bill to 'Allow Spouses To Be Paid' as part of home care provided by MassHealth. We delivered a petition signed by more than 1,300 folks from across the state, along with a document containing personal stories from families describing the needless, often extreme hardships created by this regulation. The bill passed favorably from one committee after our visit, and now sits in the House Ways and Means Committee. My spouse and I — along with all the other affected families we've come to know — are simply but desperately trying to end this senseless pressure on families toward far more expensive state-funded nursing facility care. For those who qualify for MassHealth, state law states that we have the right to be cared for in 'the least restrictive setting.' Meanwhile, I still must turn to hiring and training strangers for my care while my spouse watches helplessly in disbelief. I have

managed my own disabilities for decades, but a needlessly disabled state regulation can be far more challenging."

As of press deadline, S. 2277 is in the House Ways and Means committee and has not been acted on by the full House.

State Seeks To "Rebalance" Its Long Term Supports Spending

Last April, the Patrick Administration announced that Massachusetts had applied to the federal government to implement the Balancing Incentive Program (BIP). Under this program, part of the Affordable Care Act, Massachusetts plans to "rebalance" its spending on long term care services and supports---spending a greater percentage of its spending in the community, and a smaller percentage on institutions. The goal is to help consumers live in the least restrictive setting—a fundamental goal of the MassHealth law.

The purpose of the BIP initiative is to improve access to home and community based services (HCBS) for those with physical disabilities, intellectual disabilities, and/or behavioral health needs. To achieve this goal, the Commonwealth will implement three structural changes required under BIP:

- **No Wrong Door (NWD) System:** The state will use the Massachusetts Aging and Disability Resource Consortia (ADRC) network model to augment the skills of social service access points that serve populations needing information, referral and assistance for long term services and supports.
- **Core Standardized Assessment Instrument:** Massachusetts will work with all agencies performing functional needs assessments to ensure compliance with the assessment elements required by BIP.
- **Conflict-Free Case Management Services:** The Commonwealth will ensure that all consumers will have access to an independent care manager that does not own direct services, and can truly serve as the agent MassHealth enrolless.

The BIP plan in Massachusetts also will review the integration of an initial screen or self-screen assessment tool into a No Wrong Door website that would be available to all network access points and explore ways to expedite financial eligibility determinations and enrollment into MassHealth.

The BIP plan will better support individuals living in the community. These initiatives include integrated care systems for dually eligible adults in special needs plans like Senior Care Options (SCO), the Program for All-Inclusive Care for the Elderly (PACE), and One Care, a Massachusetts demonstration for dually eligible adults under 65; nursing facility diversion activities including Money Follows the Person grant; the consumer-directed personal care attendant program under the Medicaid State Plan; ten 1915(c) home and community based services waivers; the Enhanced ADRC Initiative; the ACA Community Care Transitions Program; and Chronic Disease Self-Management Education programs.

Ken Smith, OLTSS. SSES photo,

Massachusetts estimates under BIP receiving an additional 2% in federal matching funds, equaling $110.6 million. This will allow the Commonwealth to continue its rebalancing efforts including: transitioning and diverting individuals who are elderly and/or disabled from institutional to community based settings; increasing community based opportunities for individuals with behavioral and intellectual disabilities; and expanding opportunities that address the needs which are critical for elders and people with disabilities to remain living in community-settings, espe-

cially individuals with behavioral health support needs.

On April 1st, **Ken Smith** from the OLTSS, and EOEA Secretary **Ann Hartstein**, conducted a one hour session on the BIP initiative. According to EOEA and the OLTSS, BIP funding can only be used for community based services. The state estimates that the new federal match will be available between April 1, 2014 and Sept. 30, 2015. This is an 18 month initiative at this point, because under the ACA, BIP runs out on Sept 30, 2015. Some funding may be extended into 2016.

The BIP benchmark year used by the Feds was FY 2009, when the Massachusetts percentage share of Medicaid spending on HCBS was 44.8%. BIP is only for states below 50% so when the Commonwealth applied, the state qualified for an extra 2% FMAP. As of FY2011, the percentage share of HCBS had risen to 53%.

People of all ages and chronic care needs qualify for BIP services: the physically disabled, intellectually disabled, developmentally disabled, and those with cognitive disabilities.

The state is currently in the middle of a BIP planning process to identify "opportunities to purpose funds." BIP funding must be spent to "increase offerings to or access to non-institutional LTSS." It must also benefit Medicaid recipients, and be something that Medicaid typically spends money on. Funds cannot be used for brick and mortar entities, or maintenance of effort, or be used to supplement the state's General Funds.

A BIP workplan will be written and submitted to the Center for Medicare/Medicaid Services (CMS) by July 31st. The plan will detail the NWD agencies, assessment procedures, and caremanagement practices; funding for structural changes; sustainability issues; and planned uses for this enhanced Federal matching money.

Mass Home Care Lists BIP Program Needs

On July 10th, Mass Home Care testified at a hearing in Boston to solicit ideas for potential BIP services. Here are the ideas presented by Mass Home Care for the BIP funds:

Mass Home Care recommendations fall into three general categories: 1) administrative actions, 2) care coordination enhancement, and 3) purchased services categories. Programs which are new, gap-filling options are marked with an *.

1. **BIP-Related Administrative Actions:**

• * **Raise the income eligibility for MassHealth to 300% of SSI.** The BIP program (section 10202 (c) (1)(B) allows states to raise the income eligibility for Medicaid from 150% of FPL ($17,505 for one person in 2014) to 300% of the SSI benefit rate ($25,956 for one person in 2014). This will allow new access to populations in need of HCBS in the state plan, and allow federal matching of the cost of these services that may now be 100% state funded.

• * **Raise the income eligibility for home care and ECOP to 300% of FPL** as a wrap around to the MassHealth program. The home care program could pick up where MassHealth leaves off by setting eligibility over 300% of SSI ($25,957) up to 300% of FPL ($35,010). This would allow home care to assist elders who are not yet eligible for MassHealth, but whose progression onto MassHealth and risk of institutional care could be slowed down or avoided entirely. Whatever income eligibility level is used for home care must be the same as that used for ECOP, to prevent a situation when an elder “graduates” to ECOP level due to increasing disability, but is dropped from the program because of different income eligibility standards. These two programs must have identical financial eligibility rules to ensure continuity of care.

• * **Implement presumptive eligibility**, or Fast Track application program for MassHealth. This is a state election permitted under BIPP. This would cut down on lengthy application approval for clients who need

services quickly, e.g. during a transition from an institution to a community placement. Applicants may be presumed eligible by the care coordinator staff responsible for conducting an assessment, determining level of care and authorizing home and community based waiver services.

• * **Amend MassHealth regs to allow spouses to be paid caregivers** under PCA and AFC programs. This can be done administratively. Such a policy would maximize the use of available caregivers, but would not affect eligibility for these two MassHealth programs. At least 17 other states currently allow spouses to be paid caregivers.

• * **Amend MassHealth regs to allow PCA consumers to receive care if they require cueing and supervision**, not just 'hands on' care. This would allow some clients to remain living in "the least restrictive setting" in accordance with the MassHealth mission. This policy has already been approved in the One Care duals demonstration.

• **Conflict Free Care management in the One Care program:** BIP requires the state to have in place a conflict free care management system. A good place to demonstrate the state's fidelity to this commitment is to correct the implementation of the One Care program for duals, which is not providing to enrollees the "conflict free community care coordinator" required under Chapter 118E, 9F. Most enrollees ion One Care have not seen a conflict free 'community care coordinator.

• * **Amend the MassHealth community spend down to be the same as the SNF spend down.** Current rules for community spend down are cumbersome, confusing, and disruptive to care. Current rules make it easier to spend down under SNF stays than in the community. This creates a disincentive for community-based rebalancing efforts.

• * **Amend ECOP Program To Add Respite Care and Care To Under 60 Population with Alzheimers.** These two options are currently offered to people in the basic home care program. Individuals who are more disabled in the enhanced programs should also have these options to prevent unnecessary institutional use.

2. Enhance the "full service" range of the ASAP Care Management/Coordination Portfolio.

The existing home care/care management portfolio is lacking a number of key innovative approaches to managing care in a community setting:

• **Pre-Admission Counseling and Assessment Program:** Provide additional funding to expand the staffing for this program (now funded under item 4000-0600) which diverts individuals from SNF admission. $2.5 million has been the funding level for this counseling program since it was created. Pre-Admission staff should be available to every hospital and rehab in the Commonwealth to ensure that no one is admitted to an institution who has the capacity and is given the choice to live in a community setting.

• * **Care Transitions Coach:** create staff at the ASAP level to work with individuals who are transitioning out of ERs, hospitals, rehabs, SNFs, or other settings to keep patients living independently at home. This is based on the CMS 3026 Community Care Transitions Program, which in Massachusetts are currently led by ASAPs with hospital partners. Only 4 such projects exist, but the Care Transitions Coach should be available statewide to reduce readmissions and create stable community placements.

• * **Community Living Coach:** care coordination staff assigned to work with 'hotspotters' who are having difficulty managing their chronic conditions, or individuals who need frequent, even daily contact with a mentor who will help them make life decisions about their health, e.g. taking meds, improving diet, dealing with stressors like addiction or depression, or homelessness.

• **Options Counselors/Family Services Counsel-**

ors: Expand financial support for these care coordination staff who can work with families who are not eligible for other state or federally funded services, and who need help sorting through their HCBS options vs. the more well-known institutional options.

• * **Medical Advocates:** a volunteer-based program that would provide individuals to accompany clients to medical appointments, keep notes, ask questions, and ensure consumer is understanding their conditions, how to manage them, and the treatment options being offered to them.

• **Money Management:** Expand the capacity of volunteer Money Management program to deal with the rising incidence of financial exploitation of the elderly, in concert with regional Financial Abuse Specialist Team pilot project in the FY 15 budget.

• * **Benefit Enrollment Specialists:** workers trained to help individuals gain access to federal, state and local benefits they are eligible for, and assist them from the initial gathering of documentation through the successful application process.

• * **Medication Therapy Management:** A model based on CMS guidelines for Medicare Advantage plans, using care coordination staff to make home visits pre-Comprehensive Medication Review, to inventory medications and analysis potential "alerts" for medication issues, which are reviewed by a pharmacist as part of the annual CMR. Alerts are communicated to primary care physician or other medical practitioner.

• * **Nutritional Assessment & Counseling:** The provision of nutritional counseling and medically-tailored, home-delivered meals to those with acute or chronic illnesses is a cost-effective intervention that produces measurable positive results for patients. It can shorten the length of a hospital stay, reduce the need for hospital admission, and increase the likelihood that a patient will be able to return to his or her home and community after a hospitalization. ASAPs, as nutrition providers, are well-positioned to provide such nutritional counseling and medically-tailored meals.

• * **Care Management Emerging Technologies:** for use in the home setting, these emerging technologies help care coordinators/coaches/direct care staff monitor and stay ahead of developing health concerns with high-risk clients living at home. Create a joint EOEA/ASAP technology workgroup to demo new products that offer promise in the detection of threats to patient well-being.

3.Expand the range of purchased services available to state home care clients: The following services should be added to the home care/ECOP/Choices programs

• * **Medication Technicians:** staff who work with consumers who need frequent, even daily visits to maintain medication adherence, motivation to stay on meds. Amend regs to allow this service outside of DMH programming. Lack of medication adherence is a major precipitating factor for unnecessary use of medical services.

• **Chronic Disease Self-Management Programs:** expanding programs through the Healthy Living Center of Excellence network as a preventive, health maintenance initiative.

• * **In-home Mental Health counseling:** Currently most seniors are not able to get mental health, behavioral health, or in-home substance abuse services because MassHealth rates are considered inadequate to accommodate travel time for in-home visits.

• * **24/7 "Small Home" residential projects:** provide sufficient funding to scale up the development of regional small homes serving up to 4 unrelated individuals in a home environment as an alternative to institutional spending.

FY 15 Budget "One Of The Best In Years"

"Sometimes things work out for the best in the end." That's what Senate Ways and Means Chairman

Steve Brewer (D-Barre) told Mass Home Care this spring. The budget released on the evening of June 29th did work out in the end for seniors. It is one of the best budgets for home care services in many years.

Looking at some of the core home care items, such as home care purchased services, home care aide wages, Enhanced Community Options Program (ECOP), nutrition, protective, and SHINE---the new funding comes to $23.46 million.

Here are some highlights from the Conference version: (in descending order of magnitude)
• An additional $344 million in the large MassHealth Senior Care Plans account, the line item with Community Choices, Senior Care Organizations, nursing facilities, and the nursing home pre-screening program.
• $15 million for the FY 15 costs of rate implementations under chapter 257, including ASAP purchased services;
• $10 million (+19%) in additional funding for Enhanced home care (ECOP)

Senator Steve Brewer, at Mass Home Care rally.

• $8 million for a human services salary reserve (which does not apply to ASAP workers)
• $6.1 million in a homemaker wage rate add on in an outside section from the Community First Trust Fund (the Governor later removed this from the budget, but it was restored.)
• $5.659 million (+5.7%) in home care purchased services above the FY 14 appropriation, with $4.6 million of this increase to come from the new Community First Trust Fund. LGBT funds also included.
• $1.3 million more for supportive housing, which will allow 10 new sites (28 new proposals have been submitted)
• $1.1 million (+10.6%) in new funding for Councils on Aging, including $115,000 in special earmarks.
• $1 million increase for elder nutrition, ($750,000 for meals on wheels, and $250,000 earmark for a geriatrics program run by Community Physician's Associates)
• $776,831 increase (+3.5%)for protective services, including $50,000 for a new FAST Team (Financial Abuse Specialist Team).
• $428,000 in new funds for the congregate housing line item, with Naturally Occurring Retirement Communities earmarked at $642,000.
• $400,000 in new funds for state officials to prepare a HCBS State Plan including a new 1915i state plan.
• $250,000 for a Home and Community Based Services Policy Lab Fund managed by EOEA, with another $250,000 that can be transferred into the fund.
• $180,000 earmark for SHINE health insurance counseling funding in the Prescription Advantage line item

The FY 15 budget also includes $2 million for a reserve to be administered by the Health Policy Commission to accelerate and support behavioral health integration within patient-centered medical homes. The budget also establishes a new Community First Trust Fund. The secretary of health and human services may expend not more than $16,000,000 deposited in the fund without further legislative appropriation, and may enter into interagency service agreements as necessary to ensure compliance with the state balancing incentive payment program (see earlier BIP article). Any funding over the $16 million level is subject to legislative appropriation by the General Court. Expenditures from the fund may be made for services provided in prior fiscal years.

According to the Mass Budget and Policy Center, the FY 15 budget increases rates for nursing homes by about $47.5 million over FY 2014. The Legislature re-bases the rates using 2007 costs rather than 2005, and follows the House proposal to start in October. The Legislature also states that if federal reimbursement is not available for these rate increases, the Commonwealth will make a one time payment to the nursing homes of $23.7 million, and rates will continue to be based on 2005 costs. Nursing facility patient days paid for by

MassHealth have fallen by -33% since the year 2000.

For full budget report, go to: https://malegislature.gov/Budget/FY2015/House .

Mass Nursing Facility Residency Rate 46% Above Average

HPC Exec. Director David Seltz with Sen. Patricia Jehlen. SSES photo.

In July, the Massachusetts Health Policy Commission (HPC) released its 2014 Supplement to its 2013 Cost Trends Report. The HPC was created by the legislature as part of Chapter 224, health care reform law. The HPC 2014 supplement includes a section focusing on the potential cost savings by reducing post acute care placements and nursing facility placements, and shifting care to less costly, least restrictive community settings.

Here are key findings from the HPC Cost Trends 2014 Supplement: (emphasis in italics)

Massachusetts residents use post-acute care more frequently than the national average, and there is wide variation among hospitals in the rate of hospital discharge to nursing facilities and home health agencies.

According to the HPC, Massachusetts has a higher proportion of aged and blind/disabled enrollees than the average Medicaid program. Average spending per enrollee in these complex needs groups is 2.4 to 3 times overall average spending per enrollee. Massachusetts has higher spending per enrollee than US average within each eligibility group: Aged: +31%; Disabled: +4%; Adults: +13%; Children: +59%\

In FY2010, aged and blind/disabled enrollees constituted less than one-fourth of enrollees for each of the U.S. and Massachusetts, but 66 percent of national Medicaid spending and 79 percent of MassHealth spending. *The aged segment of the MassHealth population is of particular interest because spending per enrollee is $4,812, or 31 percent higher than the national average.*

This difference is concentrated in two categories of service-- institutional long-term care and home health care--which together account for nearly three-fourths of Massachusetts' higher spending on aged enrollees. *Institutional long-term care alone explains more than half of the higher spending level for this category of enrollees.*

In its 2013 report, the Commission noted that Massachusetts spent $771, or 72 percent, more per resident than the U.S. average on long-term care and home health in 2009. *For nursing facilities, Massachusetts spent 74 percent more per capita than the national average in 2009.* The state's older age profile explains 13 percentage points of this difference and its *higher prices paid to nursing facilities (driven by wage levels) explain 23 percentage points of the difference.* These two factors account for less than half of the 74 percentage points of higher spending on nursing facilities, suggesting a large utilization difference that is not driven by demographics. Similarly, for home health services, demographics and prices paid account for less than half of the higher levels of spending in Massachusetts relative to the national average.

Both nursing facilities and home health care agencies provide two types of care: post-acute care and long-term services and supports (LTSS). Post-acute care is delivered to support recovery after an acute hospitalization, while LTSS care supports those with significant cognitive or physical impairment in their activities of daily living (ADLs). Massachusetts' higher use of nursing facilities and home health care agencies spans both post-acute care and LTSS uses. This is evident in higher spending both for Medicare, which pays for post-acute care services but not LTSS, and for MassHealth, which is the primary payer for LTSS. Like Medicare, commercial payers typically pay for post-acute care, but not LTSS. As a result, most LTSS services provided for populations not covered by MassHealth are paid out-

of-pocket. Long-term care insurance covers those long-term care needs, but has a low adoption rate and represents a small percentage of the LTC market.

For post-acute care, Massachusetts has a higher rate of discharge from hospitals to nursing facilities relative to the national average, suggesting an opportunity to manage post-acute care more efficiently. For LTSS, there are opportunities to deliver more supports in home-and community-based settings, expanding options for patients to receive care in their preferred setting while potentially achieving savings over time

Opportunities in post-acute Care:

Utilization of nursing facilities for post-acute care occurs after a hospital stay and discharge. As a result, utilization is driven by the frequency of hospital admission and by the proportion of people hospitalized who are discharged to nursing facilities. The 2013 report highlighted the fact that *Massachusetts residents utilize 10 percent more hospital services than the average U.S. resident. In addition, Massachusetts' rate of discharge to nursing facilities and home health care agencies is higher than the national average rate.* Adjusted for patients' demographic and clinical characteristics and for the type and intensity of inpatient care delivered, we estimate that *Massachusetts hospitals are 2.1 times as likely as the national average to discharge patients to either nursing facilities or home health agencies.* We did not find a large difference in the use of nursing facilities relative to home health agencies between Massachusetts and the rest of the country. National studies have found that the majority of geographic variation in spending for public payers is in post-acute care, suggesting that this is an important area to examine to identify opportunities to improve efficiency. *Within Massachusetts, discharge rates to nursing facilities and home health agencies vary greatly across hospitals. This variation suggests a significant opportunity for Massachusetts providers to deliver episodes of care more efficiently by improving management of post-acute care.* Payment policies have been a significant driver of post-acute care utilization. The creation of the Medicare Inpatient Prospective Payment System in the 1980s encouraged hospitals to reduce length-of-stay in hospitals, leading to a shift in care from the inpatient setting to various post-acute care settings. The construction of Medicare prospective payment systems for post-acute care providers encouraged changes in length-of-stay and intensity of care in post-acute care settings. *More recently, policies penalizing hospitals with high readmission rates may have encouraged greater use of post-acute care intended to provide patients better support after a hospitalization in order to avoid readmissions.* Greater use of post-acute care may generate net savings for the health care system if it can reduce the use of higher-intensity hospital settings.

In Massachusetts, average length-of-stay in acute hospitals was seven percent below the national average in 2011, while readmission rates were above national averages. Hospital practice patterns in use of nursing facilities do not correlate with hospitals' average length-of-stay or with hospital performance on risk-adjusted readmission rates. With the increasing adoption of global budget payment methods, provider organizations are putting greater focus on management of post-acute care utilization, particularly for Medicare Accountable Care Organizations (ACOs), as use of post-acute care is a particular driver of Medicare spending variation. Initial evaluation results from the first year of the Pioneer ACO program do not show significant savings in spending on post-acute care, although *several Massachusetts Pioneer ACOs have described coordination and management of nursing facility care as an area of focus,* with potential for savings in later performance years.

To monitor whether post-acute care is being used

effectively and appropriately, provider organizations and state agencies should observe whether post-acute care use is improving outcomes, readmission rates, and efficiency across full episodes of care

Opportunities in long-term supports and services:

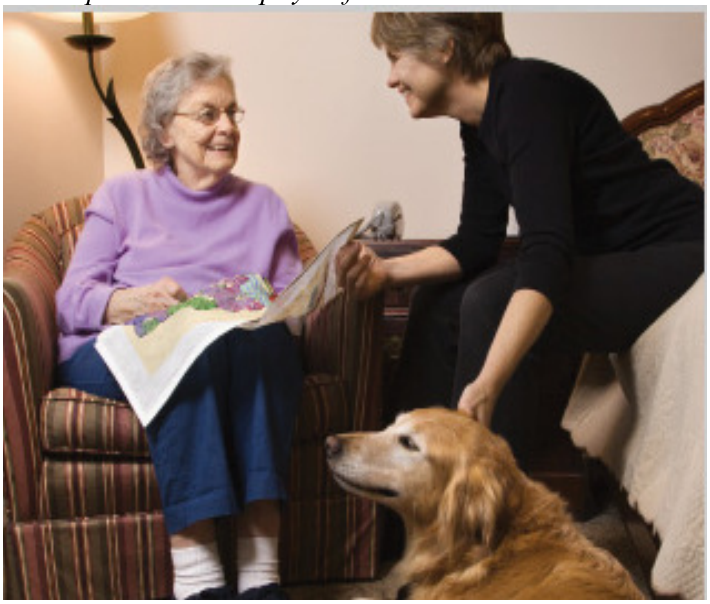
LTSS clients typically have disabilities that require custodial support, but there are often opportunities to make use of lower-intensity care settings, providing supports in home- and community-based settings rather than admitting clients into nursing facilities. With its larger elderly population, Massachusetts would have a 13 percent higher rate of nursing facility residency than the U.S. average if Massachusetts residents used nursing facilities at the same rates by age as the rest of the country. Instead, *Massachusetts has a 46 percent higher nursing facility residency rate than the U.S. average.* Ongoing policy efforts have promoted the delivery of LTSS in the least restrictive setting for each client. In particular, enhancing the availability and use of home- and ommunity-based services has been a focus for MassHealth, which has pursued opportunities to expand these services through its waivers. Intended to provide supports that enable individuals to live at home rather than in an institution, these services range from limited supports for those living independently to intensive supports for those requiring around-the-clock care.

A growing proportion of MassHealth enrollees have used community-based services: between 1999 and 2009, the Personal Care Attendant (PCA) program doubled its participation rate, and between 2004 and 2009, participation in Group and Adult Foster Care and Adult Day Health programs grew by more than a third. Still, *there may be continued opportunities to increase the use of these settings, as MassHealth patients in nursing facilities have a lower average acuity than the U.S. average for Medicaid programs.*

While utilization of services for both nursing facilities and home health care providers is above national averages, *shifting care from institutional settings to home and community-based settings may further increase home health utilization while decreasing total health care expenditures over time, since nursing facilities have significantly higher per diem costs than care provided in home- and community-based settings.*

Conclusion:

Massachusetts's higher levels of spending on long-term care compared to the national average is driven in part by the state's demographics and by higher prices driven by wages, but significant utilization differences suggest potential opportunities for improved efficiency. In post-acute care in particular, large differences between discharge patterns across Massachusetts hospitals suggest an opportunity for a discussion and review of practices for management of patients after discharge. *Opportunities also exist to continue to provide community-based LTSS rather than institutional services, enabling residents to live in less restrictive and potentially more cost-effective settings. This continued transition is especially important for MassHealth, which is the predominant payer for LTSS in Massachusetts.*



Long-term care will continue to be an area of active interest for the Commission. The aging of the population will put upward pressure on utilization of these services, making them increasingly important to manage to meet the health care cost growth benchmark. As provider organizations under global budgets seek to manage post-acute care more efficiently, trends in rates of discharge to nursing facilities and home health agencies, the choice of post-acute providers, and the average length-of-stay in post-acute care facilities will be important dimensions to observe. Affiliations and contracting

structures in post-acute care will be increasingly important to observe to understand market trends and referral patterns.

Elder Justice Roadmap To Combat Elder Abuse

Leaders in the fight against elder abuse announced a framework in July for tackling the highest priority challenges to elder abuse prevention and prosecution, and called on all Americans to take a stand against the serious societal problem of elder abuse, neglect and financial exploitation.

According to the federal Administration for Community Living (ACL), research suggests that 1 in 10 Americans over the age of 60 has experienced elder abuse or neglect, and that people with dementia are at higher risk for abuse.

Supported by the Department of Justice (DOJ) and the Department of Health and Human Services (HHS), the Elder Justice Roadmap was developed by harnessing the expertise of hundreds of public and private stakeholders from across the country and by gathering their input. The goal of these expert summits was to identify the most critical priorities and concrete opportunities for greater public and private investment and engagement in elder abuse issues. The Elder Justice Roadmap reflects the knowledge and perspectives of these experts in the field and will be considered by the Elder Justice Coordinating Council and others in developing their own strategic plans to prevent and combat elder abuse.

"The Roadmap Project is an important milestone for elder justice," said Associate Attorney General **Tony West.** "Elder abuse is a problem that has gone on too long, but the Roadmap Report can change this trajectory by offering comprehensive and concrete action items for all of the stakeholders dedicated to combating the multi-faceted dimensions of elder abuse and financial exploitation," he explained. "While we have taken some important steps in the right direction, we must do more to prevent elder abuse from occurring in the first place and face it head on when it occurs."

"From now until 2030, every day, about 10,000 baby boomers will celebrate their 65th birthday. And the fastest-growing population is people 85 years old, or older," says **Kathy Greenlee**, HHS' assistant secretary for aging and administrator of the Administration for Community Living. "Stemming the tide of abuse will require individuals, neighbors, communities, and public and private entities to take a hard look at how each of us encounters elder abuse—and commit to combat it."

To support the mission of elder abuse prevention and prosecution, DOJ has developed an interactive, online curriculum to teach legal aid and other civil attorneys to identify and respond to elder abuse.

The federal HHS is developing a voluntary national adult protective services (APS) data system. Collecting national data on adult mistreatment will help to identify and address many gaps about the number and characteristics of adults who are the victims of maltreatment and the nature of services that are provided by APS agencies to protect these vulnerable adults. In addition, the data will better inform the development of improved, more targeted policy and programmatic interventions.

"While federal and state governments certainly have critical roles to play, the battle against elder abuse can only be won with grassroots action at the community and individual level," said Greenlee. "Turning the tide against elder abuse requires much greater public commitment, so every American will recognize elder abuse when they see it and know what to do if they encounter it."

Two steps local communities, families, and individuals can take are:

• Learn the signs of elder abuse. The National Center on Elder Abuse, a program of the Administration on Aging at ACL, has developed a helpful Red Flags of Abuse Factsheet (PDF) that lists the signs of and risk factors for abuse and neglect.

• Report suspected abuse when you see it. Contact your local adult protective services agency. Phone numbers for state or local offices can be found at the National Center for Elder Abuse website, or call 1-800-677-1116.

"We must take a stand to ensure that older Americans are safe from harm and neglect. For their contributions to our nation, to our society, and to our lives, we owe them nothing less," said Associate Attorney General West.

Health Care Delivery Focus of New State Commission

David Seltz, Health Policy Commission

The story below is reprinted from the SeniorScope *newsletter, a publication of the City of New Bedford:*

The Health Policy Commission (HPC), an independent state agency that monitors the reform of the health care delivery and payment systems in Massachusetts, was established in 2012. The agency is charged with developing health policy to reduce overall cost growth while improving the quality of patient care in the Commonwalth.

The HPC's ambitious goal is to bring health care spending growth in line with growth in the state's overall economy, explained **David Seltz**, executive director of HPC, at the annual meeting of Mass. Home Care on June 16 in Burlington. "We are focused on what's best for the patient and how to deliver that care in the best and most cost effective way." He added, "There are ways to improve care and outcomes that are more efficient and better for the patient."

Massachusetts is a national leader in health care policy, Selz said. "We became the model for the Affordable Care Act," he said. "We are always thinking about finding solutions, and the challenge now is cost containment. The Commission can't set prices but we can provide guidance."

Seltz said the HPC is looking at ways to improve tracking of patient outcomes as well as changing the way health care is paid for. "We now have a fee-for-service system where doctors and hospitals are paid on volume." The more services, such as appointments, tests and hospital admissions, they provide, the more they get paid, while they receive less money for preventive care. "We have to flip this," Seltz said, "and create a value-based payment system," where health care providers are rewarded for keeping patients healthy. "A lot of times what happens now is that fees are decided between insurance companies and hospitals behind closed doors," Seltz said.

The HPC also wants to engage businesses, patients and consumers in the Commission's work so that they are partners in the solution.

While other areas of the state budget have declined, since 2001 health care's portion of the state budget has grown by 60 percent. "We need to be able to bring costs down," Seltz said, adding, "there is an estimated 30 percent waste in the health care system in the state."

Long term care is the major contributor to health care costs in Mass., more than in other parts of the country, Seltz added. "We have an opportunity to cut this cost by rebalancing our spending and putting more dollars into home care rather than nursing home care," Seltz said.

The HPC is requesting proposals from eligible Massachusetts community hospitals through the second phase of its Community Hospital Acceleration, Revitalization, and Transformation (CHART) program, funded through an assessment on hospitals and insurers. "The goal of Phase 2 of the CHART Investment Program is to help community hospitals transform and thrive in a changing environment," said Commissioner **Paul Hattis.** HPC is looking for innovative proposals that aim to maximize appropriate hospital use, enhance behavioral health care, and improve hospital-wide processes to reduce waste and improve safety. The agency is encouraging regional partnerships, such as joint hospital applications and partnerships between hospitals and community based providers and other organizations.

With approximately $60 million in funding available, the aim of CHART is to "inspire long-term, sustainable change in community hospitals across the Commonwealth," Seltz said. The HPC expects to announce award recipients in fall 2014.