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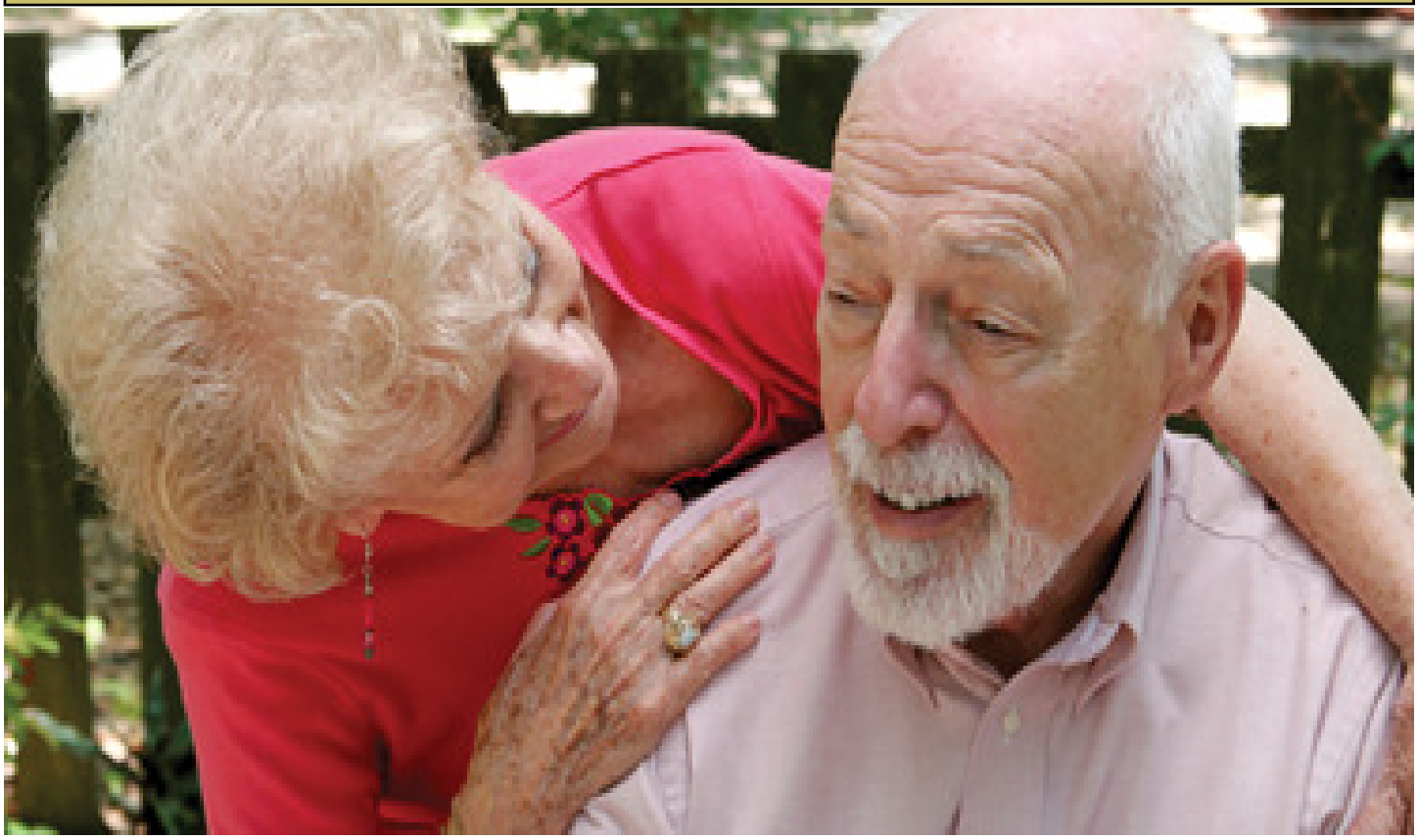
Al Norman, Editor



Spouse As Caregiver Bill Dies in House

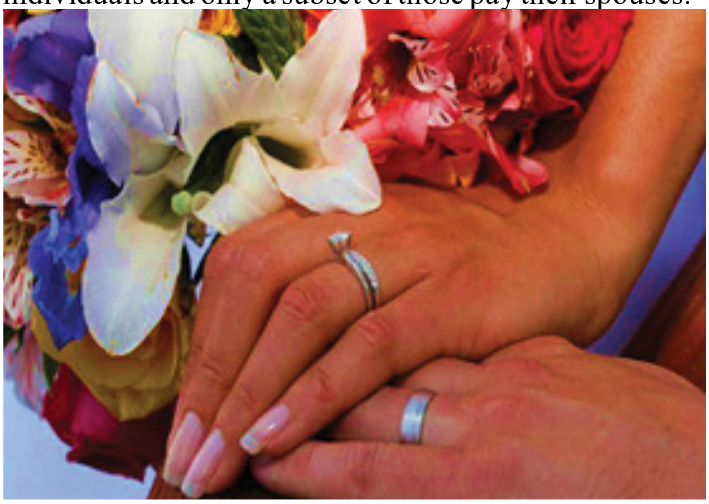
The spouse as caregiver bill, S. 2277 died in the final hours of the legislative session on Beacon Hill on July 31st. The bill never emerged from the House Ways and Means committee, despite the fact that the legislation sailed smoothly through the Senate a couple of weeks earlier on a 39-0 Senate vote.

The one sentence bill would have allowed spouses to join the list of family members who can currently be paid to be a Personal Care Attendant (PCA) or Adult Foster Care provider.

Because S. 2277 was never reported out of Ways and Means, the bill was never openly debated in the well of the House chamber, and a vote on the measure was never taken. Bill proponents, including Mass Home Care, said that if the bill had been allowed to come to the floor, there were enough Representatives in favor of the measure to pass it. But the House simply did not take the measure up. Bill opponents reportedly claimed that the potential cost of allowing spouses to be paid caregivers was one issue that stalled the bill. But lawmakers warning of cost implications had no hard numbers as evidence, only conjecture.

Mass Home Care checked with state officials in Oregon, which has offered a spousal pay program for ten years now. **Jane-Ellen Weidanz**, who manages Oregon's Spousal Pay program for Medicaid, told Mass Home Care:

"We did not see any significant increase because: 1.These individuals are eligible for our in-home services and would receive more hours if they had not chosen their spouse (see below). 2. If the individual was not able to select their spouse, most of them would choose another in-home provider or end up in a licensed care setting. 3.The eligibility criteria is much more stringent than our average consumer. (individuals must have more ADL needs and have a progressive illness). We typically have between 80-150 individuals out of more than 12,500 individuals receiving in-home services. With the policy changes, we expect to have the number go up but don't think it will change the costs compared to other service choice. We also have a State Plan J, Independent Choices Program. We cash out consumers and they purchase their services from whomever they choose, including spouses. Even with this program, we have not seen a significant increase. ICP has about 350 individuals and only a subset of those pay their spouses."



"The arguments against this bill," explained **Al Norman**, Executive Director of Mass Home Care, "which were passed on to us third hand, were completely undocumented." Norman said there is no evidence at all that spouses as caregivers costs more in any of the 17 states that have gone ahead of Massachusetts to pay spouses." A number of states have allowed spouses to be paid under a "cash and counseling" waiver with the federal government, which is done on a "revenue neutral" basis.

Norman said lawmakers give home care no credit for lowering the use of nursing facilities by -33% since the year 2000. "We save state and federal taxpayers $700 million annually due to the drop in MassHealth patient days at skilled nursing facilities," Norman explained. "There are few state services that begin to save money immediately, because every day we keep someone out of a nursing facility bed, is a day we save money. We call that the home care dividend," Norman noted. There are about 30,000 MassHealth members in the PCA program today, plus 8,000 people in Adult Foster Care—the two programs that already allow family members—other than spouses---to be paid as caregivers.

Mass Home Care considers this bill giving consumers more caregivers to choose from as a form of civil rights legislation, because the goal of MassHealth is to help members live "in the least restrictive setting." Many married couples have no children, or their children live far away. Not giving these members their full range of caregiver choice is compromising their civil right to live in the most integrated setting possible.

Norman said the blockage of the spouse bill hurt thousands of low-income married families across the state. "We should be passing family-friendly laws," Norman concluded. "The House is sending the message that married couples on MassHealth who want to care for each other should get divorced instead."

Advocates vowed to file the bill again in the next legislative session, which begins in January 1, 2015, and to get the bill to the Governor's desk. Norman also said the content of this bill could be advanced by Gubernatorial administrative action, and that advocates would seek to have the spouse as caregiver concept presented to the next Governor as a family support that can be done without General Court action.

"Bridge The Gap" Health Care Campaign

The Massachusetts Senior Action Council (MSAC) has launched a health care campaign that seeks to lower health costs for seniors by urging the state to adopt income and asset eligibility changes allowed in the Affordable Care Act for federal Medicare and Medicaid plans that lower copays and deductibles.

According to MSAC, "high out-of-

pocket healthcare costs prevent too many seniors from accessing needed care and/or affording other basic needs such as food, transportation and housing. It is time for Massachusetts to bridge the gap to affordable healthcare for residents age 65 and over just as Massachusetts has strived to do for children and the uninsured."

MSAC says that Medicare has been the foundation of health security for people age 65 and over since it was first established in 1965. Yet despite its success, large out of pocket costs---including premiums, deductibles and co-payments, as well as coverage gaps such as dental, eye care, and hearing---create significant barriers to healthcare for Medicare beneficiaries, particularly for lower income seniors.

Recognizing this growing problem, Congress created the federal Medicare Savings Programs (MSP) in 1988, to bridge the gap between the cost of healthcare and the amount seniors have to spend. Since that time, Congress has created opportunities for states to streamline enrollment and expand eligibility to ensure that those in need are able to access assistance. "While these programs provide promise to reduce barriers to needed healthcare,' MSAC notes, " the current eligibility standards in Massachusetts deny many who require this assistance the most, and lags behind other states."

Massachusetts has been recognized as a national leader in healthcare reform---however these advancements have left seniors behind. Today, people over the age of 65 spend on average three times the amount as their younger counterparts (15% vs. 5%) for healthcare. This disparity is even greater amongst lower income individuals. Individuals age 65 and over with incomes between $15,750 and $23,000 are paying hundreds more each month than their younger counterparts in premiums alone. For many lower income seniors this leads to delaying or going without needed medical care and prescriptions, or cutting back on other areas of need such as food and transportation. Several states have taken the lead in bridging the healthcare gap for seniors by expanding eligibility to the federal Medicare Savings Programs and Medicaid.

To remedy this situation, the MSAC campaign seeks to make the following three programmatic reforms that will help thousands of lower income seniors access needed healthcare while increasing state access to federal resources and benefits:
1) **Expand Access to Medicare Savings Programs (MSP):** Medicare savings programs, also known as "buy-in programs," use Medicaid funds to help reduce out-of-pocket costs for Medicare beneficiaries with limited income. There are four Medicare Savings Programs:
* **Qualified Medicare Beneficiary program (QMB)**, Medicaid funded with a federal match.
* **Specified Low-Income Medicare Beneficiary (SLMB)** also Medicaid funded with a federal match.
* **Qualifying Individuals (QI)** fully funded by the federal government but has a state spending cap.
***"Extra Help,"** the Medicare Part D Low-Income Subsidy program to assist with prescription costs.

All MSP beneficiaries are automatically enrolled in the federally funded "Extra Help" Low Income Subsidy.
2) Eliminate the MSP Asset Test: reduces barriers for income eligible seniors, increases access to federal benefits, allows for simpler application processes, and reduces administrative costs. Massachusetts applies an MSP asset limit of $7,100 for an individual and $10,750 for a couple. Nine states have eliminated asset limits including: Alabama, Arizona, Connecticut, Delaware, D.C., Maine, Mississippi, New York, and Vermont. The MSP asset test includes retirement and personal savings accounts, life insurance policies in excess of $1,500, among others resources.
3) Raise MSP Income Eligibility: to 300% of the Federal Poverty Level decreases the disparity between lower income seniors and their younger counterparts,

increases access to federal benefits, and better aligns assistance with level of need. Massachusetts' MSP income limits are currently set at the federal minimum, ranging from 100-135% FPL ($11,670 to $15,755). In contrast, individuals between 19 and 64 are eligible for state healthcare subsidies with incomes up to 300% of the FPL ($35,010). Three states have taken the lead to raise income limits for MSPs including: Connecticut, District of Columbia, and Maine.

4) Raise MassHealth Asset & Income Eligibility Limits for Individuals over 65: reduces the existing age-based inequity, and increases access for low income seniors to affordable comprehensive healthcare. To qualify for MassHealth, MA residents over the age of 65 face an asset limit of $2,000, and income limits of 100% FPL ($11,670). Individuals 19-64 have no asset limit and are eligible with incomes up to 138% FPL. Ten states have raised asset limits: Arizona, Arkansas, D.C., Maryland, Minnesota, Mississippi, Nebraska, New Jersey, New York, Oregon, and Rhode Island.

5) Simplify the Application Process: maximizes enrollment of eligible beneficiaries and reduces administrative costs. Studies reveal that lengthy applications discourage many from applying for needed assistance; approximately two-thirds of seniors eligible for MSPs are not enrolled. Massachusetts has simplified the application process for some programs but still requires seniors to fill out multiple applications including the "Senior Medical Benefits Request Form" which is over 20 pages. Massachusetts must ensure the simplest form is being used for all programs, including MSPs and the Health Safety Net, and that information is shared across programs to minimize duplication. Several states have streamlined their MSP application to 2 pages (front and back), others rely on data sent electronically from Social Security to determine eligibility.

Mass Home Care has voted to support the MSAC "Bridge the Gap" campaign, which reflects a number of the bills that Mass Home Care has filed on Beacon Hill, such as legislation eliminating the asset test for people age 65 and over, and a bill that would fast track MassHealth applications by adopting what is known as "presumptive eligibility." Under this concept, an elder who looked close to being MassHealth eligible would be "presumed" to be eligible, and quickly enrolled in the program, while the paperwork was processed. Any errors would be reconciled later with state funds if the elder was not MassHealth eligible. In some of the states that have implemented presumptive eligibility, the error rate is around 1%.

According to the Medicare Advocacy Project of Greater Boston Legal Services, Alabama, Arizona, Connecticut, Delaware, Maine, Mississippi, New York, Vermont, and the District of Columbia have done away with their asset limits for MSP programs. Connecticut, Maine, and Washington D.C. have raised their income limits as well. For QMB eligibility, Connecticut has raised their income limit to approximately 211% FPL ($2,053 per month for an individual). Maine has raised its income limit to MSPs to 140% FPL ($1,362/month for an individual). Washington, D.C. has lifted its income limit to 280% FPL ($2,728/month for an individual). "States are generally worried about the increased costs expected to come with increases in eligibility," the MAP notes. "However, many of the states that have increased their income limits and/or eliminated their asset limits have found that there can be significant savings that at least partially offset the higher costs.

"There are opportunities for significant savings that can serve to offset the increased costs of coverage," MAP says. "Massachusetts is one of the states with substantial State Pharmacy Assistance Programs (SPAPs), using state funds to provide prescription drug coverage for those eligible. By raising income and/or asset limits for MSPs to the point where most of the Medicare beneficiaries covered by Prescrip-

tion Advantage were also eligible for an MSP, the additional drug coverage costs would be shifted to the federal LIS program and free up funds for the added costs of MSP coverage. Additionally, with the Medicare Part D coverage gap incrementally closing through 2020 [due to the Affordable Care Act] the State should start to see more savings from Prescription Advantage, which is often utilized to help offset the coverage gap costs for beneficiaries; these savings could be used to help offset expanded MSP coverage."

"We know there are thousands of seniors who need financial assistance to cover their health care costs," explained Mass Home Care President **Dan O'Leary**. "We need to take advantage of federal incentives to help these seniors, maximize the federal match that is available through these programs, and thereby lower state costs."

Bill Filed To Require RNs in Nursing Homes 24/7

Legislation has been introduced in Congress, H.R. 5373, entitled *The Put a Registered Nurse in the Nursing Home Act,* introduced in the U.S. House of Representatives by Congresswoman **Jan Schakowsky** (D-Ill.) on July 31st. The bill would require all nursing homes receiving Medicare and/or Medicaid reimbursement to have a registered nurse (RN) on duty twenty-four hours per day, seven days a week. Although most people believe RNs are already required round-the-clock, this is not the case. Under current federal law, nursing homes are only required to have a RN eight hours each day regardless of facility size – no matter how many residents they have or how sick they are.

Registered nurses play a critical role in the nursing home. RNs are the only nurses in a nursing home that can assess a resident's condition. The absence of RN staffing for up to 16 hours each day means there is no one present capable of assessing and responding when residents' medical conditions suddenly change or deteriorate. When not properly assessed, changes in condition can have serious and even fatal consequences. In addition, residents are entering nursing homes from hospitals "quicker and sicker," and their overall care needs have increased over time. They require a high level of nursing skill and knowledge to anticipate, identify and respond to changes in condition, ensure appropriate rehabilitation and maximize the chances for a safe and timely discharge. Residents don't just have these needs between 8 am and 4 pm during the week – this level of oversight and care is needed 24 hours a day, 7 days a week.

The Consumer Voice and other long-term care advocacy organizations have long advocated for a RN round-the clock. Research has shown that higher RN staffing levels in nursing homes result in improved care outcomes, such as lower antipsychotic use, fewer pressure ulcers, less restraint use and cognitive decline, fewer urinary tract infections and catheterizations, less weight loss and less decrease in function. Higher RN staffing is also essential to prevent the unnecessary hospitalization of nursing home residents, which can have devastating consequences to residents and place a high amount of preventable costs upon our nation's health care system.

According to **Richard Gelula**, Executive Director of the Consumer Voice, "H.R. 5373, the Put a Registered Nurse in the Nursing Home Act, is a simple and straight-forward solution that will help improve the quality of long-term care within our nation's nursing homes. We have long known that the current federal requirement of eight hours of RN presence per day is woefully inadequate to meet residents' care needs and we applaud

Congresswoman Schakowsky for her leadership on this crucial policy change."

Mass Home Care sent the following letter to Congressman **John Tierney** and Senator **Elizabeth Warren** in support to the RN in nursing homes bill:

Dear Congressman Tierney and Senator Warren,

On behalf of Mass Home Care, I am writing to urge your support for stronger staffing standards in our nation's nursing homes. Over the past 20 years, more than 100 studies, articles and government documents have identified the important relationship between staffing levels and outcomes of care in nursing homes. Despite these well-established findings, the federal government does not require nursing homes to have a minimum number of nurses and nursing assistants on duty. Instead, federal law only holds nursing homes to a vague and hard-to-measure standard of providing "sufficient staff and services to attain or maintain the highest possible level of physical, mental, and psychosocial well-being of each resident."

This current requirement is inadequate. A Department of Health and Human Services (HHS) report has determined that nursing home residents need at least 4.1 hours of total nursing time (registered nurses, licensed practical/vocational nurses; certified nursing assistants) per day to prevent poor outcomes. Without minimum staffing standards, there is nothing to prevent nursing homes from cutting staffing to dangerously low levels. Low staffing levels place residents at greater risk of harm, including greater susceptibility to malnutrition, dehydration, infections, weight loss and injuries from falls. Even top-notch nurses and nurse aides can't deliver quality care if there aren't enough of them.

In my conversation with skilled nursing facilities, they do not oppose a strong RN staffing requirement, they note that augmenting RN staff will require higher rates for SNFs. Assuming that current rates are reasonable, accommodating for higher staffng is also reasonable.

On behalf of our nation's most vulnerable citizens, I ask you to support stronger nursing home staffing standards. Please work to adopt the 4.1 hours per resident per day staffing standard put forth by the HHS study.

--Al Norman, Mass Home Care"

Antibiotics Can Do More Harm Than Good

If you take an antibiotic you don't need, it can do you more harm than good.

That's the message from the Mass Coalition for the Prevention of Medical Errors. You are exposed to the drug's side effects--and none of its benefits. These side effects can include: fever, rash, diarrhea, nausea, vomiting, headache, and nerve damage. It may lead to a drug interaction, where one of your medications could become less effective or cause you to develop new symptoms. You also increase your risk of developing a resistant infection in the future.

Older people may also have more side effects from medications, and these side effects can cause multiple problems. These are all bad health outcomes you don't want.

Antibiotics are drugs that fight infections caused by bacteria. Although antibiotics have many beneficial effects, their use has created the problem of antibiotic resistance – which is the ability of bacteria to resist the effects of an antibiotic. When resistance occurs, bacteria change, survive, and multiply, causing more harm, which can make you sicker. Fighting resistance requires stronger drugs and more health care, which may cause a longer recovery time.

Resistance issues are causing a crisis that the Director of the Centers for Disease Control warns is a "threat to health. If we don't act

now, our medicine cabinet will be empty and we won't have the antibiotics we need to save lives."

As many as half of all the antibiotics prescribed are not needed or are not prescribed appropriately. One common situation is when a urinary tract infection (UTI) is suspected. UTI is caused by bacteria that involves any part of your urinary system including the urethra, bladder, ureters and kidneys. UTI symptoms include:

• a burning feeling, discomfort or pain with urination.
• pain in the lower abdomen or back.
• increase in frequency (needing to "go" more often than usual).
• repeated strong urges to urinate.
• blood in the urine.

These symptoms may or may not be accompanied by fever. A urine culture test may show bacteria—but that doesn't mean there is a UTI—which requires both finding bacteria in the urine and the presence of specific symptoms listed above. Bacteria can and do live naturally in the bladder without causing pain or symptoms.

In the past, when a urine specimen tested positive for bacteria, people thought it should be treated with antibiotics--even when specific symptoms were not present. The American Geriatric Society now recommends to doctors that they should not prescribe antibiotics for these harmless bacteria unless specific symptoms are present.

Non-specific symptoms, such as confusion, a sudden change in behavior, fatigue, or a fall, may be caused by other factors including: dehydration, medication side effects, poor sleep, inadequate nutrition, constipation, depression, or pain. It is important to consider these possible causes, to prevent missing the real diagnosis.

Here are some questions for you and your loved ones to ask your doctor:

• Why do I need an antibiotic?
• When should I stop taking this medication?

Understanding the risks of using antibiotics when not needed leads to good, safe care. The safest care happens when you partner closely with your medical team, to understand and follow the most current advice. For more background, go to: http://www.macoalition.org/uti-elderly-tools

Is Medicare Really Facing "Substantial Shortfall?"

On July 28, 2014, the Obama administration released its annual report on when it expects the Medicare Trust Fund to run out of money. This projection comes as part of the Medicare Trustees Report.

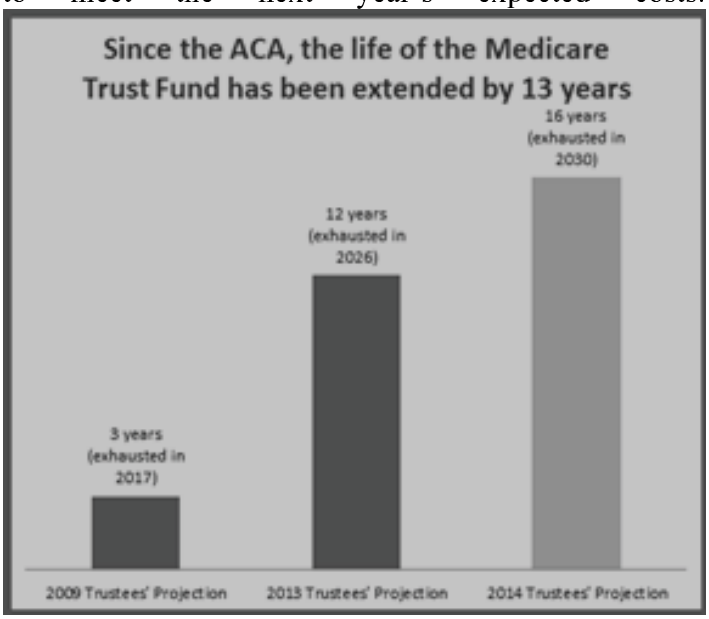
In past Reports, the news of Medicare's death have been, as **Mark Twain** would say, greatly exaggerated. For decades the Trustees have published predictions on when Medicare would run out of money if nothing else in the world changed. And in every case, lots of things in the world changed — and Medicare never found itself short on funds.

In their 2014 Report, the Trustees project that the Medicare Hospital Insurance (HI) Trust Fund, known as Part A, will face depletion in 2030, four years later than projected in last year's report. At that time dedicated revenues will be sufficient to pay 85 percent of HI costs. The Trustees project that the share of HI cost that can be financed with HI dedicated revenues will decline slowly to 75 percent in 2047, and will then stay about flat. The projected HI Trust Fund's long-term actuarial imbalance is smaller than that of the combined Social Security trust funds under the assumptions employed in the Trustee's Report. The estimated 75-year actuarial deficit in the HI Trust Fund is 0.87 percent of taxable payroll, down from 1.11 percent projected in last year's report.

According to Trustees, "the improve-

ment in the outlook for HI long-term finances is principally due to lower-than-expected spending in 2013 for most HI service categories, which reduced the base period expenditure level about 1.5 percent and contributed to the Trustees' decision to reduce projected near-term spending growth trends.

The Medicare Part B cost projection baseline assumes that physician payment rates will remain at their current levels through the end of 2015, and will then rise at the same rate currently slated for the 10-year period ending March 31, 2015 (0.6 percent annually) through 2023. The Trustees project that Part B of Supplementary Medical Insurance (SMI), which pays doctors' bills and other outpatient expenses, and Part D of SMI, which provides access to prescription drug coverage, will remain adequately financed into the indefinite future because current law automatically provides financing each year to meet the next year's expected costs.



However, the aging population and rising health care costs cause SMI projected costs to grow steadily from 1.9 percent of GDP in 2013 to approximately 3.3 percent of GDP in 2035, and then more slowly to 4.5 percent of GDP by 2088. General revenues will finance roughly three-quarters of these costs, and premiums paid by beneficiaries almost all of the remaining quarter. SMI also receives a small amount of financing from special payments by States and from fees on manufacturers and importers of brand-name prescription drugs.

The Trustees project that total Medicare costs (including both HI and SMI expenditures) will grow from approximately 3.5 percent of GDP in 2013 to 5.3 percent of GDP by 2035 and will increase gradually thereafter to about 6.9 percent of GDP by 2088.

In recent years, the Trustees say, U.S. national health expenditure (NHE) growth has slowed relative to historical patterns. There is uncertainty regarding the extent to which this slowdown in the rate of cost growth reflects one-time effects of the recent economic downturn and other non-persistent factors or structural changes in the health care sector that may produce additional cost savings in the years ahead. The Trustees are hopeful that U.S. health care practices are in the process of becoming more efficient as providers anticipate a future in which the rapid cost growth rates of previous decades, in both the public and private sectors, do not return. Indeed, the Trustees have revised down their projections for near-term Medicare expenditure growth in response to the recent favorable experience.

The methodology for projecting Medicare finances had already assumed a substantial long-term reduction in per capita health expenditure growth rates relative to historical experience, to which the Affordable Care Act's cost-reduction provisions would add substantial further savings. Notwithstanding recent favorable developments, both the projected baseline and current law projections indicate that Medicare still faces a substantial financial shortfall that will need to be addressed with further legislation. Such legislation should be enacted sooner rather than later to minimize the impact on beneficiaries, providers, and taxpayers.

But the website Vox adds a grain of salt to this debate. Vox notes that the Congressional Research Service tallied up the old projections in a 2009 report. According to Vox, the Trustees have predicted, many times in the past, that the Medicare Trust Fund would run out of money. "But it's never actually happened," Vox says, "each time the projected insolvency date gets close, there's typically a pattern where Congress steps in and passes some type of policy to make trust fund dollars stretch at least a decade longer. At its core, the Medicare Trust Fund is an accounting mechanism. It's where payroll taxes go to help finance the Medicare program — and it's where the government-run

insurance program draws funds to pay seniors' hospital bills."

"The projected date of insolvency speaks to a world where Congress never changes anything about Medicare, the world of health financing stays static, and, if we keep spending payroll tax dollars at current rates, the fund can't pay its bills. In other words, the date of projected insolvency speaks to a world that doesn't really exist," Vox explains.

"Health financing isn't static, and Congress has lots of tools in its legislative tool box to ensure Medicare can continue paying seniors' bills. That's what they've done in the past and, given that seniors are pretty big fans of Medicare (as well as pretty big fans of voting), its a decently safe assumption that its what they would do in the future, too."

"Whatever the new insolvency projection released today is," Vox concludes, " you can rest pretty sure that Medicare won't pack up and stop paying bills that year — or any other time soon."

Bouncing From Hospital to Nursing Home And Back

A new report from the Heritage Foundation, *How Competitive Private Plans Can Improve Care for Dual-Eligible Beneficiaries of Medicare and Medicaid* focuses on people who receive both Medicare and Medicaid benefits, the so-called "dually eligible." The study says that federal Medicare and Medicaid rules are poorly coordinated, and lead to higher care costs and worse health outcomes.

"Dual eligibles present unique policy challenges given their high cost and complex medical issues," Heritage says. "The current fractured incentive structure increases the cost of care while promoting poor health for some of the most vulnerable Americans."

One example of how Medicare and Medicaid conflicting policies create incentives for care providers to "cost shift" is in the field of long term care. Nursing homes are incentivized to send patients to hospitals. "This fragmentation also distorts the incentives of those caring for the one in seven dual eligibles living in long-term facilities. In nursing homes, for example, financial incentives encourage re-hospitalization. After a three-day hospital stay, Medicare's skilled-nursing benefit restarts, and it reimburses at a higher level than Medicaid. Nursing homes thus can increase their revenues by readmitting residents to the hospital. While the nursing home resident is hospitalized, some nursing homes take advantage of Medicaid's bed-hold policy where the state Medicaid program pays the nursing home to reserve the bed of a resident receiving acute care."

"If a state's Medicaid bed-hold reimbursement is higher than its long-term care payment, nursing homes are incentivized to hospitalize their residents and collect the bed-hold reimbursement. In states with bed-hold policies, the odds of hospitalization were 36 percent higher than in states without the policy. Therefore, fragmented coverage between Medicare and Medicaid incentivizes some nursing homes to send patients back to the hospital, collect Medicaid's bed-hold reimbursement, and readmit the patient to their facility to receive Medicare's skilled-nursing benefit. Taxpayers pay a high price for these distorted economic incentives because hospital treatment normally costs more than nursing home treatment. In fact, roughly one in four nursing home residents is hospitalized annually despite research showing that they could be treated in the nursing home for less money."

The Heritage report finds that distorted incentives between Medicare and Medicaid undercut care coordination. "That would be expected, of course,

since two different government programs operating with separate budgets are covering the same patients," Heritage says. "Urban Institute researchers **Lisa Clemans-Cope** and **Timothy Waidmann** observe in *The New England Journal of Medicine* that the disjointed Medicare and Medicaid structure that serves dual eligibles provides little incentive to coordinate primary care and long-term care and supports that could reduce hospitalization. Under the current system, the savings for the federal government under Medicare normally mean higher costs for state governments through Medicaid. Thus, despite the high cost and the negative health consequences, neither program actively coordinates the care that patients receive under both programs.

But the Heritage Foundation notes that in Massachusetts, the MassHealth Senior Care Options program (SCO), an integrated managed care program, is one of several states which have achieved excellent outcomes among its elderly dual enrollees. The SCO program lowered enrollees' nursing home usage and kept frail enrollees in the community and out of nursing homes for longer periods of time than the state averages for beneficiaries receiving traditional Medicare and Medicaid coverage. The success of similar coordinated-care models in Arizona, California, and Massachusetts all suggest that integrated care Medicare Part D Special Needs Plans (SNPs) can improve dual eligibles' health outcomes and help direct dual eligibles to more appropriate, less costly care settings.

"There is little doubt that these impressive improvements in care coordination could reduce overall health care costs if they were widely adopted," the report concludes, "but the approach particularly helps patients with multiple chronic disorders who may also lack strong social support structures, which is the case for many dual eligibles."

The report notes that "private coordinated-care plans can provide care managers to guide dual eligibles through the care cycle, including the provision of long-term care supports and services….Plans could offer supplementary options that tailor coverage to beneficiaries' particular needs in similar ways to how Part D-SNPs currently allow dual eligibles to forgo certain supplementary benefits in some areas in favor of more supplementary coverage in other areas that matter to them, such as vision, prevention, or dental care."

Care-coordination models for dual eligibles could save Medicare $125 billion and Medicaid $34 billion over 10 years according to one report from Emory University.

President Signs Proclamation on ADA

At the end of July, President **Barack Obama** signed the following proclamation marking the 24th anniversary of the federal Americans with Disabilities Act:

"Over two decades ago, Americans -- some in wheelchairs, some using sign language, and all with an abiding belief in our Nation's promise -- came together to strengthen our commitment to equality for all. At a time when people with disabilities were turned away at movie theaters, rejected for employment, and measured by what so many thought they could not do, leaders and activists refused to accept the world as it was. In small towns and big cities, they spoke out. They staged sit-ins, authored discrimination diaries, and scaled the Capitol steps. Finally, they realized their call for simple justice in one of the most comprehensive civil rights bills in our country's history. On the anniversary of the Americans with Disabilities Act (ADA), we honor those who fought against discrimination, and we recommit to tearing down barriers and guaranteeing all Americans the right to pursue their own measure of happiness.

The ADA promises equal access and equal opportunity -- regardless of ability. It secures each person's right to an independent life, and it enables our country and our economy to benefit from the talents and contributions of all Americans.

Even as we commemorate this milestone, we recognize that too often, casual discrimination or fear of the unfamiliar still prevent disabled Americans from achieving their full potential. That is why my Administration is pushing to fulfill the promise of and better enforce the ADA. Fifteen years after the Olmstead decision -- in which the Supreme Court ruled it discrimination to unjustifiably institutionalize someone with a disability -- we have increased the number of homes integrated into communities that are available for persons with disabilities. Under the Affordable Care Act, insurance companies are banned from discriminating on the basis of pre-existing conditions, medical history, or genetic information.

Expanding on my Executive Order to establish the Federal Government as a model employer of individuals with disabilities, my Administration is also providing Federal contractors with the tools and resources to recruit, retain, and promote people with disabilities.

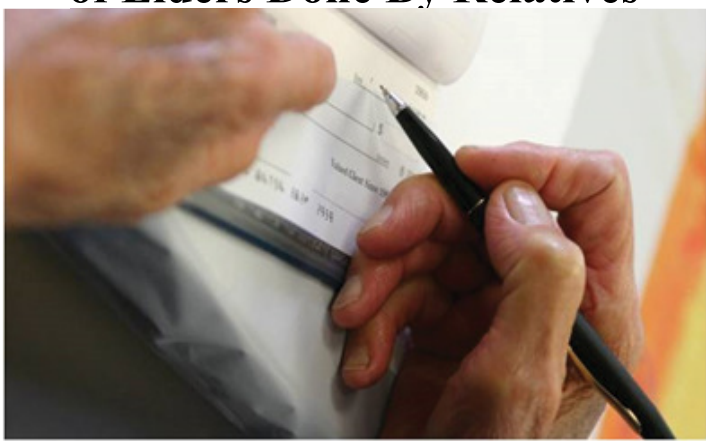
The nearly one in five Americans living with a disability are our parents, children, neighbors, colleagues, and friends. They are entitled to the same rights and freedoms as everyone else.

Today, we celebrate their accomplishments, stand against discrimination in all its forms, and honor all who sacrificed so future generations might know a more equal society.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim July 26, 2014, the Anniversary of the Americans with Disabilities Act. I encourage Americans across our Nation to celebrate the 24th anniversary of this civil rights law and the many contributions of individuals with disabilities.

IN WITNESS WHEREOF, I have hereunto set my hand this twenty-fifth day of July, in the year of our Lord two thousand fourteen, and of the Independence of the United States of America the two hundred and thirty-ninth.

Most Financial Abuse of Elders Done By Relatives



According to a story from *HealthDay News,* as many as one in 20 older adults in the United States may be financially exploited, and most exploitation is a family affair.

Researchers found that most older adults have had their money or property stolen or used improperly at some point. What's worse is that this abuse often occurs at the hands of their relatives.

Although financial exploitation is the most common form of elder abuse, it has not gotten the scrutiny it deserves from doctors, policy makers and caregivers, the researchers concluded. The findings were published Aug. 6 in the *Journal of General Internal Medicine*.

"Financial exploitation of older adults is a common and serious problem, and especially happens to elders from groups traditionally considered to be economically, medically and socio-demographically vulnerable," **Janey Peterson**, of Weill Cornell Medical College, said in a journal news release. "In addition to robbing older adults of resources, dignity and quality of life, it is likely costing our society dearly in the form of increased entitlement encumbrances, health care and other costs," she said.

Older people are particularly vulnerable to various forms of abuse since they are often socially isolated or facing mental decline, the researchers noted. To more closely examine the prevalence and contributing factors of financial exploitation among older adults, the researchers interviewed more than 4,000 adults aged 60 and older living in New York state.

The study revealed that about 3 percent of those

questioned reported being financially exploited in some way over the past year, and nearly 5 percent said they were victims of this type of abuse at some point late in life.

Roughly 80 percent of those interviewed had money or property stolen or misused over the past year. For just over 40 percent of the participants, this happened two to 10 times. The researchers pointed out that 9 percent of the older people questioned said it happened more than 10 times. In some cases, the older people were forced or tricked into giving up their rights or property. Others were forced or misled into signing or making changes to a legal document. The older people interviewed also reported being impersonated so that others could acquire property or services. Some admitted to paying for all household expenses without contributions from their family members. A small number of the participants said they were very poor and not receiving any support from family or friends. Often -- about 60 percent of the time -- the financial abuse faced by the older people interviewed was carried out by their adult children. Friends and neighbors were responsible approximately 17 percent of the time and paid home aides were the perpetrators about 15 percent of the time. Most often, the older people who were exploited were very poor and black, according to the study. Often, victims were living in large households without their spouse. The older people needing the most help maintaining their independence were particularly at risk for financial abuse, the researchers added. Those who need help shopping and making meals often provide others access to their finances.

Medicare To Pay Doctors To Care Manage Patients

The New York Times reported August 16th that the Centers for Medicare and Medicaid Services (CMS) has agreed to pay doctors beginning this January to coordinate the care of their Medicare patients who have two or more chronic care conditions.

"Paying separately for chronic care management services is a significant policy change," **Marilyn B. Tavenner**, the administrator for CMS told *The Times*. The concept is that better care coordination will pay for itself by keeping patients healthier and out of hospitals. There are roughly 54 million Medicare patients, with 70% of them still receiving traditional Medicare fee for services coverage.

According to *The Times*, physicians will be paid to develop and implement a comprehensive plan of care for each patient who signs up for one. Patients will have access to doctors or other health care providers on a doctor's staff 24 hours a day and seven days a week to deal with "urgent chronic care needs." Two out of three Medicare beneficiaries have at least two chronic conditions, and they account for 93% of Medicare spending, according to the federal Department of Health and Human Services.

Doctors will be expected to assess patients' medical, psychological and social needs; check whether they are taking medications as prescribed; monitor the care provided by other doctors; and make arrangements to ensure a smooth transition when patients move from a hospital to their home or to a nursing home.

For this work, doctors will be paid $42 a month for managing the care of a Medicare patient--if the patient agrees in writing. Medicare will charge the patient about 25% of the monthly fee as is done with other Medicare Part B doctor's services. Medicare will also require doctors to use electronic health records (EHRs) so they can share information with other health care providers treating a patient.

CMS will also allow nurse practitioners and physician assistants to provide the new care management services. Medicare officials expect doctors and other providers to focus on patients

with four or more chronic conditions. The care coordination payment will give people on traditional Medicare the same access to coordination that someone now enrolled in a Medicare Advantate plan can get. It puts the two options on a more equal footing. In the past, the Obama Administration had not consented to giving doctors a separate fee for care coordination.

Medicare only covers limited long term supports, so it is not clear how doctor's will coordinate "social needs" of their patients, and whether such assistance will duplicate the role currently provided by community-based agencies. Services like checking on medication compliance, arranging for a smooth transition after a hospital discharge, or arranging for a discharge from a nursing home, are all functions that can be provided by agencies like Aging Services Access Points, Mass Home Care said. "It would be redundant for doctors to hire more staff to perform services that are already available to doctors and their patients in the community," explained **Dan O'Leary**, Mass Home Care President. "Doctor's offices may need help to coordinate care in the community, but it would be a shame if practices added another layer of coordination staff to work around community agencies that have been coordinating and managing custodial care for decades."

Most individuals dealing with chronic conditions have a complex series of social issues to deal with as well: such as lack of income, housing, money management and life managments skills, difficult family relationships, lack of transportation, poor nutrition, etc. Many of these non-medical social needs are most appropriately handled by social services coaches or care managers, and not medical professionals.

In Massachusetts, managed care plans for people on Medicare and Medicaid---the so-called elderly or disabled "duals" population---are required by state law to have access to an independent Long Term Support Services Coordinator, or Geriatric Support Services Coordinator, who works with the enrollee, but is not owned by the managed care organizadtion. So they can act as the patient's agent. It is not clear how the new payment plan from CMS will affect duals plans.

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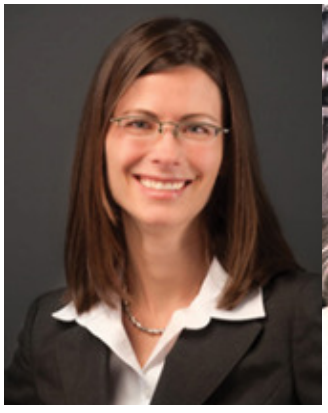

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Tuesday, Sept. 30, 2014

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