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Al Norman, Editor

Gov. Baker's Long Term Services Challenge

One of the many challenges facing Governor-elect **Charlie Baker** when he assumes office in January is how to better coordinate health care with long term care supports.

In an effort to ease the transition, Mass Home Care has prepared for the Governor-elect a short-list of initiatives that will help reduce spending on long term support services (LTSS) , and improve health outcomes.

Here are excerpts from the introduction to Mass Home Care's transition document *The Long Term Services Challenge*:

"Since the mid-1970s, Massachusetts has been a leader in the field of home and community based services. The Commonwealth created a statewide network of 30 non-profit care management agencies that had locally-controlled boards of directors, and were independent from direct providers. The mission of the Aging Services Access Points/Area Agencies on Aging, is to enable individuals to live in the least restrictive setting appropriate to their needs. This not only saves state and federal taxpayers money, it is a policy of Mass Health under Chapter 118E, s. 9. Since the U.S. Supreme Court *Olmstead* decision of 1999, care at home is also a civil right.

Elders also have the choice now to "self-direct" their own care, and become more engaged consumers. Up until recently, the Commonwealth has spent 60% or more of its long term supports dollars on nursing facilities. But today we have "rebalanced" spending so that 55% of Medicaid spending for long term

supports are in the community. This is a national trend, urged by the federal government, to reduce costs and improve patient outcomes. Because of federal initiatives like the "Balancing Incentive Program," (BIP) the Commonwealth has a higher rate of federal matching funds to spend on home and community-based care.

Over the past 5 years, ASAPs have worked to become partners with the medical care system in ways that promote wellness and independent living. Physician groups, hospitals, and insurers are looking to the community care managers as an important way to gain control over costs by managing the whole person, not just their acute care needs. The next Administration has significant opportunities to bring care for elders back home, and save taxpayers hundreds of millions of dollars at the same time.

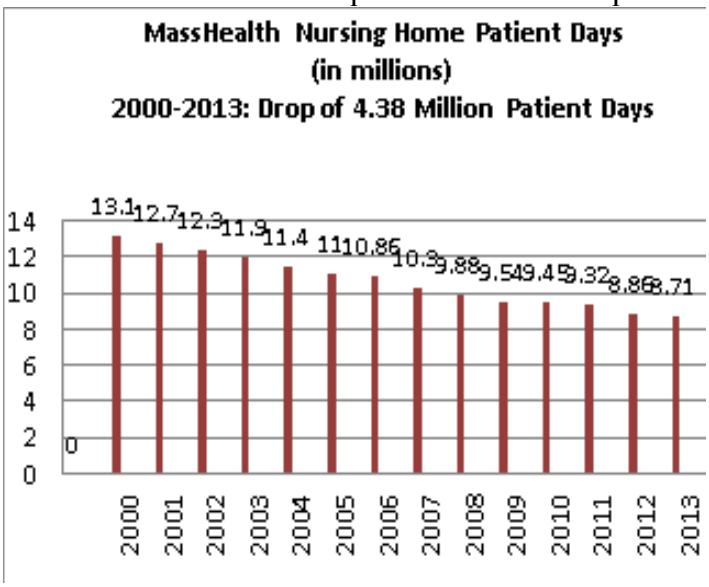
In its 2013 *Cost Trends Update*, the Massachusetts Health Policy Commission noted that the Commonwealth spent 63% more on Medicare per capita spending for nursing facility care, and 29% more for Medicaid per capita spending on nursing homes than the national average in 2009. The HPC noted:

"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…This continued transition is especially important for MassHealth, which is the predominant payer for LTSS in Massachusetts."

Hospitals in Massachusetts discharge patients into SNFs at a rate 8% higher than the U.S. average. 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. According to the HPC, "With its larger elderly population, Massachusetts would have a 13% 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% higher nursing facility residency rate than the U.S. average."

The HPC noted that the aging of the state's population will put upward pressure on utilization of these services, making them increasingly important to manage to meet the health care cost growth benchmark.

The population pressures on our home care programs keep growing. New estimates released recently by the Donahue Institute show that the population of people aged 65 and over in Massachusetts, as a percentage of total state population, will jump 50% between 2010 and 2030, from 14% of the population, to 21% of the population. Better management of rates of discharge to nursing facilities and home care, and reducing the average length-of-stay in post-acute care facilities will be important metrics to pursue.



Forty years ago, the Commonwealth created non-profit, community-based agencies to serve as the designated agents of the state to provide home care supports for elders with functional impairments. Unlike other entities in the health/long term care field, ASAPs were designed to manage and coordinate care---but not to own services. As such, ASAPs can tailor care plans to the needs of consumers, not to the needs of providers. ASAPs have no financial incentives to over-authorize care. In the context of the Affordable Care Act, ASAP independent coordinators can act as the 'agent' of the consumer.

Although these agencies---which have

come to be known as Aging Services Access Points (ASAPs) and Area Agencies on Aging (AAAs)---are not widely known by health care providers, their impact on health care costs has been significant. The availability of community-based LTSS have had a dramatic impact on lowering the use of skilled nursing facilities, saving taxpayers as much as $700 million per year (*see chart p.2*). Home care supports also reduce the length of stay in SNFs by delaying the entry into skilled facilities and keeping people at home with supports longer.

Between FY 2000 and FY 2013, the number of nursing home patient days paid for by MassHealth fell by 4,387,000 days (-33.5%). In FY 13, the Commonwealth avoided $700,735,510 in nursing home costs compared to FY 2000 use (based on $159.73 per patient day). In FY 15, the SNF cost per day to Medicaid is around $197.26, and the costs avoided from reduced patient days is closer to $865 million per year.

According to EOEA, 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. In other words, almost 30% of their time in home care they were eligible for a nursing home. The preponderance of the $1.2 billion in suggested savings will be realized over the course of 6 years. Over the next 6 years, the Commonwealth's Medicaid program will spend over $17.2 billion in long-term care services and supports.

According to EOEA data, the typical home care client spends 6 years in EOEA programming. MassHealth elders who are eligible for the "Community Choices" program---all of whom are eligible for SNF care---spend on average 2.89 years in the community while eligible for nursing home level care. Elders in the Enhanced Community Options program spend 1.86 years in the community while qualifying for institutional care. The typical elder in a MassHealth waiver costs around $3,097 a month in services, compared to $6,000 per month in a nursing home. For every one person in an institution, 2 people with a similar clinical level of care can be kept at home. So home care programs are not only significantly cheaper than institutional care, they also reduce the length of stays in costlier SNF settings. Of the 12,560 elders who exited EOEA programs in FY13, EOEA spent an estimated $321 million over the lifetime of these individuals. If these consumers had gone into a nursing facility when clinically eligible, EOEA would have spent an additional $344 million, or a total of $666 million. EOEA suggests if not for the availability of current home care programs, the Commonwealth would spend 7.2% more in long-term care services."

Mass Home Care gave Governor Baker's team a list of 18 specific initiatives to improve the management of long term services and supports.

Restoring the Executive Office of Elder Affairs

One of the key administrative changes recommended by Mass Home Care to the Baker Administration is the restoration of the Executive Office of Elder Affairs to a cabinet-level Secretariat.

The work of the Executive Office of Elder Affairs demonstrates that prudent investments in home and community based services will result in significant cost reduction in the institutional portfolio—which used to be called a "budget-buster." The ASAP network is an asset unique to Massachusetts, which has the experience and statutory presence which will be the principle tool to mitigate total public LTSS costs, while meeting demand in a manner that honors and supports consumer preference for aging in place.

In many respects, the 2004 reorganization of MassHealth has been successful, but it has not been maximized to the extent that it must be in order for the Commonwealth to meet the challenges of the near

future. The Secretary of Health and Human Services is always going to be the primary lead in health care and Medicaid Policy development by virtue of its so-called single-state authority for managing Medicaid programs. However it should also be recognized that health care and medical services have always, and will continue to, demand a remarkable amount of focus from the EOHHS bureaucracy. EOHHS expertise and interest is going to be in the health care arena. It is prudent and necessary to have a cabinet-level official who has the ability to advance and mobilize LTSS policy and program development, now so more than ever, as we are on the eve of contending with the impacts of the boomer generation.

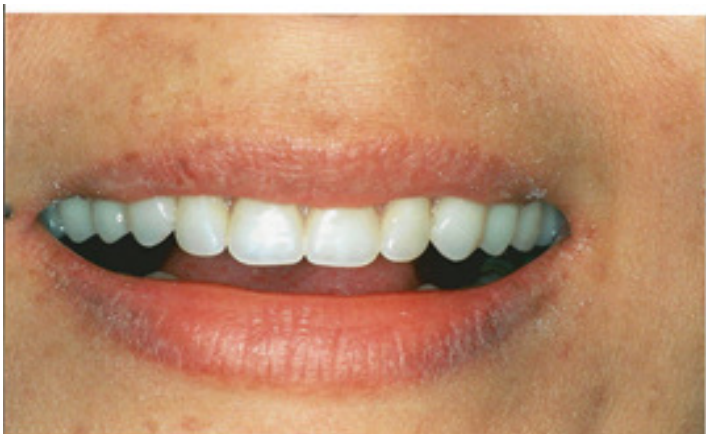
The Commonwealth must adopt a proactive posture in the regard. The Commonwealth was slow to launch a Money Follows the Person (MFP) initiative, and the Balancing Incentive Payments (BIP) program---both created to shift care out of institutions. But in 2004 the state set in place the mechanism to better manage these rebalancing initiatives. Under the provisions of Chapter 19A,4B of the M.G.L. the EOEA "shall manage the home care program established in section 4 with respect to clinical screening, service authorization activities and case management for Medicaid community-based long-term care made available to eligible elderly persons pursuant to chapter 118E…The primary goal of the coordinated system of care shall be to assist elders in maintaining their residences in the community-consistent with their clinical and psychosocial needs in the most cost-effective manner possible."

Under existing statute, the Aging Services Access Points) ASAPs "shall be responsible for… conducting intake, comprehensive needs assessments, preadmission screening and clinical eligibility determinations for elders seeking institutional and community care services from Medicaid or the home care program." Existing statute assigns the coordination of home care and Medicaid LTSS to EOEA.

The Patrick Administration in its second term sought to move management control over LTSS back to EOHHS. When this initiative was strongly opposed by elder advocacy groups, the Governor abandoned his formal reorg plans, but without seeking any new authority, proceeded to remove from EOEA the ability to affect LTSS decisions.

The statutory authority of EOEA to manage LTSS was transferred to EOHHS---without any specific Executive authority--downgrading the role of functions of EOEA to a department level. The EOEA lost management control over elder LTSS. These statutory roles and functions should be restored, to create once again a coordinated approach to elder LTSS. The EOEA Secretary should be restored to a full cabinet-level Secretariat with direct access to the Governor. The following language from Chapter 19A, section 1 is already in statute---it just needs to be implemented: *The secretary [of Elder Affairs] shall administer chapter 118E relative to medical care and assistance to eligible persons age 65 and older except for acute care services as defined by the secretary of health and human services. The secretary shall be responsible for administering and coordinating a comprehensive system of long-term care benefits and services for elderly persons, including institutional, home-based and community-based care and services.*

Dental Care: The Great Unmet Need of Elders



A report on Massachusetts health trends released at the end of October by the Massachusetts Health Council, a non-partisan statewide group of 150 health and policy-related organizations, gave policy-makers something to chew on.

According to the report, "Com-

mon Health for the Commonwealth," oral health is a major issue in Massachusetts:
* One in 4 adults (24%) in Massachusetts have not seen a dentist in the past year, up from 19% in 2010.
* The percentage of adults who had six or more missing teeth rose in 2012 to 15%, compared to 13% in 2010.

The report explains that oral health is an integral part of total health. Oral diseases affect nutrition, digestion, speech, social mobility, employability, self-image, self-esteem, and quality of life

Groups at highest risk are children and the elderly. The report notes that "seniors in long-term care facilities also face particular problems accessing dental care; the three major barriers are: the cost of dental care, lack of insurance, and lack of available dentists. The lack of basic dental care benefits in Medicare increases the barriers for all seniors to accessing treatment."

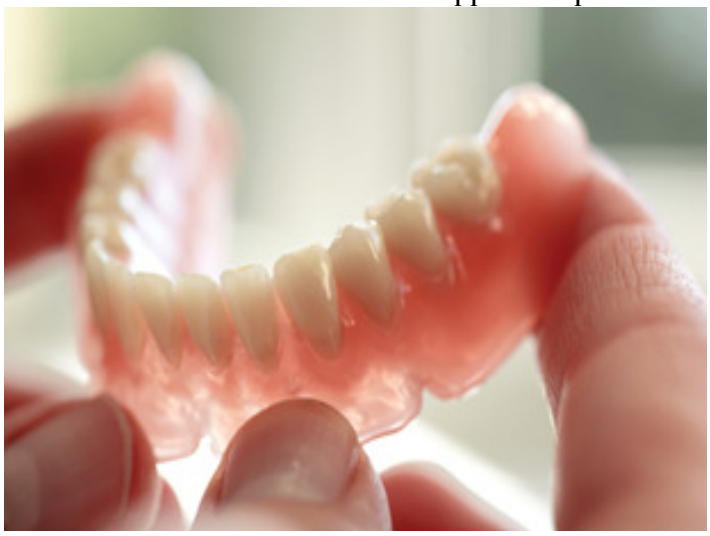
The oral care statistics are dramatic:
* 74% of seniors in long-term care facilities had gingivitis
* 59% of nursing home seniors had untreated tooth decay
* 79% of seniors at meal sites did not have dental insurance
*34% of seniors at meal sites have major to urgent dental needs
* 35% of seniors at meal sites had untreated decay
* 17% having major to urgent dental needs
* 20% of seniors at meal sits had not had a dental visit in more than 5 years

The MHC says "a state wide strategy needs to be developed and implemented to respond to the great un-met oral health needs of seniors, and especially the homebound and those in long term care facilities.

MassHealth coverage for dental benefits has been unpredictable. "Access to dental services for vulnerable adults has frequently depended on whether MassHealth covered these services," the report notes. "Historically, coverage has fluctuated. In 2010, adult dental coverage for MassHealth members aged 21 or older was eliminated except for cleanings and extractions. As a result, community health centers saw a dramatic increase in the number of emergency adult dental patients, with 22,047 new patients in 2010. By 2012, emergency room dental visits at Boston Medical Center increased by 16%.

In 2012, MassHealth restored adult dental coverage for white fillings in front teeth. In 2013, it added coverage for fillings in all teeth, effective July 1, 2014. Coverage for complete dentures will start on May 15, 2015. The dental program represented only about 3.6% of the MassHealth budget in FY 2013.

The primary dental safety net in Massachusetts consists of approximately 53 community health center dental programs and satellites, which had about 600,000 patient visits in FY 2013. However, they are severely stretched beyond their capacity due to cutbacks in adult MassHealth coverage, the increase in the number of MassHealth members, and the great unmet need of vulnerable populations. Many of these programs need financial support to expand, improve efficiencies and make better use of support personnel.



One issue is the number of dentists who accept MassHealth insurance. In FY 2013, only 1,439 dentists were active providers (that is, providers who billed more than $10,000 a year for treatment); this was a 13% increase since FY 2011. However this represents only about 21% of dentists licensed in Massachusetts and 60% of the 2,386 dentists enrolled as MassHealth providers.

The MHC report says since 2002, adult Medicaid dental benefits nationwide have slowly eroded, with some states scaling back the dental benefits they offer to adults and other states eliminating adult dental benefits altogether. Advocacy from varying sources at the local, state, and national level emphasizing the importance of oral health in overall health, the associated pain and suffering caused by untreated dental disease, and the societal impact and associated costs of poor oral health and lack of coverage (most

importantly the rise in ER expenditures) has prompted several states to revisit their support of adult dental Medicaid benefits. Within the first six months of 2014 California, Colorado, Idaho, Illinois, Massachusetts, South Carolina, and Washington have all expanded benefit packages. Other states appear poised to do the same in the coming months. Missouri and Virginia were forced to roll back efforts.

As for recommendations, the MHC study says "the adult MassHealth dental program budget needs to be completely restored with a reasonable fee schedule so that adults in need may obtain necessary treatment. The number of dentists actively treating MassHealth patients' needs to be increased and... fluoride varnish should be included for high-risk seniors on the MassHealth fee schedule and by other 3rd party payers. The regulation that allows physicians' offices to administer fluoride varnish as a preventive measure for high risk children should include high risk seniors and be better promoted to the medical profession. A state wide strategy needs to be developed and implemented to respond to the great unmet oral health needs of seniors, and especially the homebound and those in long term care facilities."

The percentage of Massachusetts adults who did not visit a dentist in the past year rises as income and education falls. 12% of adults with incomes above $75,000 had not seen a dentist, compared to 40.5% of adults with less than a $25,000 annual income. Among adults with a college degree 14.5% had not seen a dentist, while 40.6% of those with less than a high school degree had not seen a dentist.

The full report of the Massachusetts Health Policy Council can be found at: http://c.ymcdn.com/sites/www.mahealthcouncil.org/resource/resmgr/Docs/2014-HSIR.pdf

One Care Plan Ends 1st Year In the Red

A first-in-the-nation managed care health plan for low income adults marked its first birthday on October 1st. Because the state has not released financial reports on the so-called "One Care" plan for "duals" on Medicare and Medicaid, there is no way of estimating what level of care the plan is providing, and how much long term care vs. acute care is being given to enrollees. Plan administrators suggest that One Care will not start showing black ink until 2016---but since the plans have released no data, advocates cannot determine what the first year's experience really means for both patients and the public payors.

One Care

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All that is known about the One Care plan is its enrollment number. Out of a total eligible population of 95,352, a total of 17,465 people were enrolled in the plan as of its first birthday. (Cape Cod and the Islands, and Berkshire County are not in the plan, because none of the plans applied to serve these areas.) After a full year of operations, 18% of those eligible are in the plan, 82% are not.

A total of 25,840 people have "opted out" of the plan, which means for every 1 person who has stayed in the plan, 1.5 have disenrolled. Another way to put that is that disenrollment rates are 50% higher than enrollment rates. More people are turning away from the plan, even with "mandatory enrollment," which advocates strenuously opposed. People between the ages of 18 and 64 are automatically enrolled in the plan—but they have the right to 'opt out.' Around 66% of people in the plan were "auto assigned" a plan, only 33% "self-selected" to be in the One Care program. Since July, 2014, when 18,821 people were in the plan, membership has declined by 7.2%, or 1,056 fewer than three months ago.

Enrollees in the One Care plan are "rated" based largely on their functional impairments or behavioral health needs---not their medical needs. About 59% of

the One Care enrollees are categorized as "community other," which does not mean they don't have long term support needs. A "community other" designation simply means these are consumers who do not have a daily need for skilled nursing, or who do not have 2 activities of daily living plus three days of skilled nursing need, or do not have a chronic behavioral health diagnosis. But in that "community other" category are people who can have as many as 3 activity of daily living impairments.

After a year of operations, no data has been seen about actual long term support care plans that people are receiving. But in an "early experiences" survey released in August, 2014, a total of 375 plan members indicated that many enrollees have not been offered a long term support coordinator (LTSC), and many were unsure if they needed one. 40% of those surveyed said they wanted a LTSC, 40% said they did not, and 20% were unsure. Of those who had an LTSC, 95% said they were completely or somewhat satisfied with their LTSC. By state law, every enrollee is to receive an "initial and ongoing" assessmenet by the LTSC, but the state unilaterally decided to make this an optional service, and to have access to such positions only through the filter of the One Care plans, not direct contact with consumers. As a result, many enrollees are not getting access to the independent, conflict-free LTSC, who is supposed to act as the "agent" for the member.

In early November, the *Boston Globe* reported that "officials have repeatedly declined to release detailed information about the program's finances or the quality of patient care because they say they want to be able to analyze a year's worth of data first." One of the three plans said in an internal memo that the company was losing $1 million a month at one point. The companies said they have been surprised by the extent of patients' needs.

A state official told *The Globe* that the state has agreed to share more of the One Care Plan losses for the next two years because of the large number of unexpected difficulties they faced. This means the program will cost more to the state than originally projected. "The lack of information has frustrated patient advocates," *The Globe* reported, "who say it is impossible without details about finances and the quality of patient care to gauge whether the program is effective and should be continued.

Hospital Observation Stays Are Under Observation

Consumer complaints and anger of the Medicare policy known as "observation status" is finally stirring up the waters.

According to an article published November 10th by *McKnight's news*, a group called the Medicare Payment Advisory Commission concludes that observation status is "not working as a way of classifying hospital patients and should be eliminated."

That would be good news to elders, who have been complaining that when hospitals categorize them as "observation" patients, they often don't know it, and it could leave them with a huge out-of-pocket payment if they need nursing home care after their hospital stay.

Medicare only covers skilled nursing services after a beneficiary has spent three days as a hospital inpatient. Observation status is not a form on inpatient care, and is not counted toward this threshold. According to MedPAC, 11,000 hospital stays ended with a non-covered discharge to a skilled nursing facility in 2012.

One solution floated at the MedPAC meeting was eliminating observation status entirely. But some members of the Commmission said that would "wreak havoc with billing procedures and increase costs for beneficiaries."

Looking at the problem from the other end of the pipeline led to the suggestion that it was time for Medicare to end its requirement that a SNF stay must be proceeded by a 3 day hospital stay to be payable by Medicare. The 3 day prior stay rule

was called "archaic." But eliminating the three-day rule could increase Medicare spending for more nursing home stays. Medicare might move to pay SNFs less to make up the difference, others said. Medicare might have to reduce SNF payments, the MedPAC staffers noted. Another way to make up the cost would be for Medicare to impose penalties on nursing facilities that inappropriately re-certify long-term residents.

Governor-Elect Baker on Home Care

For voters who were "having trouble cutting through the political campaign cludtter," **AARP Massachusetts** published a Voter's Guide to the November 4th election. "We are non-partisan," AARP Massachusetts explained, "we don't support or oppose any political candidates or contribute any money to campaigns or political action committees. Our priority is ensuring you know where the candidates stand before you cast your vote."

AARP Massachusetts posed the following eldercare question to the five major Gubernatorial candidates :

The majority of Massachusetts residents want to stay in their homes and communities as they age. How will you help expand the Commonwealth's seniors' access to quality services provided at home and in the community?

AARP spelled out its own position on this question as follows:

"AARP believes that no one should be forced out of their homes to receive the care they need. AARP calls on state lawmakers to redirect spending away from costly nursing home care and into supports and services in the community. AARP supports states' use of new and existing federal financial incentives and strategies to improve access to home and community-based services, including through consumer-directed care, home health and personal care, help people better navigate the system and understand their care options, address racial disparities in access and quality of care, and expand and improve the quality of the direct care workforce."

Here is the answer offered by **Charlie Baker**, who is now Governor-elect:

"I was proud to work in the Weld and Cellucci administrations when we did a lot of work to help seniors access services at home and in their communities. As governor, I would work with the federal government (as I did when I was Secretary of Health and Human sServices) to make sure Massachusetts has as much control and flexibility as it needs to provide for our seniors and vulnerble residents in the way that is best for them. I would also increase investment into "Dual Eligible" CMS (Medicare and Medicaid) demonstrations to improve care for the most vulnerable and highest-cost patients, many of whom are seniors."

Warren: "Expand Social Security For Our Seniors"

We give the last word this month to U.S. **Senator Elizabeth Warren**, (D-MA) who published the op-ed below in *The Washington Post* in mid November:

It's time to work on America's agenda

"There have been terrible, horrible, no good, very bad Election Days for Democrats before -- and Republicans have had a few of those, too. Such days are always followed by plenty of pronouncements about what just changed and what's going to be different going forward.

But for all the talk of change in Washington and

in states where one party is taking over from another, one thing has not changed: The stock market and gross domestic product keep going up, while families are getting squeezed hard by an economy that isn't working for them.

The solution to this isn't a basket of quickly passed laws designed to prove Congress can do something -- anything. The solution isn't for the president to cut deals -- any deals -- just to show he can do business. The solution requires an honest recognition of the kind of changes needed if families are going to get a shot at building a secure future. It's not about big government or small government. It's not the size of government that worries people; rather it's deep-down concern over who government works for. People are ready to work, ready to do their part, ready to fight for their futures and their kids' futures, but they see a government that bows and scrapes for big corporations, big banks, big oil companies and big political donors -- and they know this government does not work for them.

The American people want a fighting chance to build better lives for their families. They want a government that will stand up to the big banks when they break the law. A government that helps out students who are getting crushed by debt. A government that will protect and expand Social Security for our seniors and raise the minimum wage. Americans understand that building a prosperous future isn't free. They want us to invest carefully and prudently, sharply aware that Congress spends the people's money. They want us to make investments that will pay off in their lives, investments in the roads and power grids that make it easier for businesses to create good jobs here in America, investments in medical and scientific research that spur new discoveries and economic growth, and investments in educating our children so they can build a future for themselves and their children.

Before leaders in Congress and the president get caught up in proving they can pass some new laws, everyone should take a skeptical look at whom those new laws will serve. At this very minute, lobbyists and lawyers are lining up by the thousands to push for new laws -- laws that will help their rich and powerful clients get richer and more powerful. Hoping to catch a wave of dealmaking, these lobbyists and lawyers -- and their well-heeled clients -- are looking for the chance to rig the game just a little more.

But the lobbyists' agenda is not America's agenda. Americans are deeply suspicious of trade deals negotiated in secret, with chief executives invited into the room while the workers whose jobs are on the line are locked outside. They have been burned enough times on tax deals that carefully protect the tender fannies of billionaires and big oil and other big political donors, while working families just get hammered. They are appalled by Wall Street banks that got taxpayer bailouts and now whine that the laws are too tough, even as they rake in billions in profits. If cutting deals means helping big corporations, Wall Street banks and the already-powerful, that isn't a victory for the American people -- it's just another round of the same old rigged game.

Yes, we need action. But action must be focused in the right place: on ending tax laws riddled with loopholes that favor giant corporations, on breaking up the financial institutions that continue to threaten our economy, and on giving people struggling with high-interest student loans the same chance to refinance their debt that every Wall Street corporation enjoys. There's no shortage of work that Congress can do, but the agenda shouldn't be drawn up by a bunch of corporate lobbyists and lawyers.

Change is hard, especially when the playing field is already tilted so far in favor of those with money and influence. But this government belongs to the American people, and it's time to work on America's agenda. America is ready -- and Congress should be ready, too."