At Home January, 2015

With Mass Home Care Vol 28 #1

Al Norman, Editor

Patrick Starts Wait List For Home Care

Just after Thanksgiving, **Governor Deval Patrick** notified 27 Aging Services Access Points (ASAPs) that on December 1st certain elders applying for home care services will be placed on a waiting list for care. The wait list could be in effect until at least the end of June, 2015—unless Governor-elect **Charlie Baker** rescinds the cuts. Advocates are hoping the wait lists will end much earlier.

In a message dated November 28th, the Executive Office of Elder Affairs issued a "program instruction" that was used before by the Patrick Administration in September of 2008, when several thousand seniors were prevented from receiving home care services.

"Due to recent 9C budget reductions." the EOEA message began, "Elder Affairs will once again need to implement the managed intake process. This process will be effective as of December 1, 2014." The purpose of a 'uniform managed intake" process is to ensure that all elders applying for home care are subject to the same rules, regardless of where they live.

According to the wait list protocols, elders already referred or assessed prior to December 1st are exempt from the waitlist---but elders seeking help as of December 1st were to be put on a wait list, depending on their level of need. An elder enrolled in a Medicaid waiver, or with mental health or substance abuse issues will not be wait-listed. An elder with protective services needs, or residing in congregate housing or supportive housing also will not be wait listed. If an elder's

needs increase, they may be allowed into the program. All elders still will be assessed for need, and those with "critical unmet needs" will be allowed into the program. As openings occur in the wait list, elders will be admitted to the program based on their "priority level assignment."

There are approximately 28,200 seniors in the home care program today. Funding for the home care program is lower today than it was in 2009---partly due to budget cutbacks made in the program by Governor Patrick in the fall of 2008.

"There is no good time for a wait list," explained Mass Home Care Executive Director **Al Norman**. "But we encourage all seniors and their families who need care to apply—because this wait list does not apply to most seniors, and the wait list will have openings."

Norman said that six elder rights groups wrote to Governor Patrick roughly a week before the wait list was announced, urging the Governor not to cut funding for disabled seniors.

Mayor Walsh Lobbies for Fuel Assistance Funds

Energy prices may be falling, but low-income households dependent on fuel oil will still be challenged to find the resources to pay their heating bills this winter. On December 1st, Boston Mayor **Marty Walsh** organized a letter from Mayors across the nation urging President **Barack Obama** to increase fuel aid assistance for the current winter heating season. Mayor Walsh's letter was signed by over 80 Mayors in 20 states. Here is Mayor Walsh's open letter to the White House: Dear Mr. President:

As Mayors of major cities across the United States, we are writing to request that you include no less than $4.7 billion for the Low-Income Home Energy Assistance Program (LIHEAP) in your Fiscal Year (FY) 2016 budget request.

LIHEAP is an essential resource for our communities' most underserved populations, including the working poor, the disabled and the elderly living on fixed incomes. LIHEAP is an exceptionally efficient and targeted program, with state block grants flowing to local agencies which provide short-term assistance to help cover a portion of their heating costs in the winter and cooling costs in the summer.

We are concerned that funding for LIHEAP has declined by more than 30 percent in recent years. Total funding has been reduced from $5.1 billion in FY2010 to the $3.4 billion as specified in the recent FY2015 continuing resolution. During this period, the number of households served fell from approximately 8.1 million to 6.7 million. In addition, the average LIHEAP payments have been reduced by more than $100 since 2010, dropping from $520 in FY2010 to $406 in FY2013.

According to recently reported 2013 data from the US Census Bureau, 14.5 percent of the country, 45 million people, have incomes below the poverty threshold. While this is a slight decrease from the previous year, this total is still significantly larger than the 12.3% in poverty in 2006, before the recession began. Energy costs continue to place an enormous burden on households.Increased financial burden as a result of rising energy costs, recent patterns of severe weather and record numbers of households coming forward for assistance are just some of the reasons we urge you to include no less than $4.7 billion in your FY2016 budget.

We thank you for your consideration of this request and look forward to working with you. Sincerely,

Martin J. Walsh,
Mayor
Boston, Massachusetts

Ending the 3 Day Prior Hospital Stay Rule?

The federal agency which oversees Medicare and Medicaid accounced in early December that it is proposing a series of changes to the rules which affect Accountable Care Organizations and their elderly patients.

The Centers for Medicare and Medicaid Services (CMS) released its much anticipated accountable care organizations (ACOs) proposed rule titled, "Medicare Program; Medicare Shared Savings Program, Accountable Care Organizations." According to the group Leading Age, there are several proposals that could impact long-term care:

- Waivers for the skilled nursing facility (SNF) 3-day stay requirement.
- Waivers for referrals to post-acute care settings.
- Transitional care management codes (TCM).

For decades, Medicare has had what's called the "3-Day Stay Rule," which requires a patient to have a 3 day stay in a hospital in order for Medicare to pay for a stay in a skilled nursing facility. Medicare is only a short-term payer of nursing facility care---but without this prior 3 day hospital care, it will pay nothing for nursing facility care. CMS wants to waive this 3 day rule for ACOs because they believe a waiver of this requirement would allow ACOs to achieve cost savings and to improve care coordination that would incentivize them to participate in the ACO program.

CMS believes the greatest savings could be achieved by permitting the elimination, where appropriate, of the entire prior hospital stay and improving quality of care for patients who can receive appropriate care through a direct admission to a nursing home. (Massachusetts already has a waiver just for people who are enrolled in an ACO in the Commonwealth).

In a second area under consideration, CMS would give the ability to recommend high-quality nursing facility and home health agency (HHA) providers with whom they have established relationships, rather than presenting all options equally. CMS has proposed allowing some ACOs to waive the requirement that a hospital "not specify or otherwise limit the qualified provider which may provide post-hospital home services." CMS indicate that they are not considering a complete waiver of the requirement that a hospital, as part of the discharge planning process not specify or otherwise limit the qualified providers that are available to a patient. However, under a waiver discharge planners in hospitals would have the flexibility to recommend high quality post-acute providers with whom they have relationships (either financial and/or clinical) for the purpose of improving continuity of care across sites of care.

CMS acknowledges that such a waiver would not cover a situation in which a post-acute provider paid the ACO participant or ACO provider/supplier to be included as a recommended post-acute provider. In addition, CMS emphasizes the need for ACOs to respect the patient or patient's family's preference regarding the choice of a post-acute provider.

Thirdly, CMS is taking comments on Transitional Care Management (TCM) codes, which pay a patient's physician or practitioner to coordinate the patient's care in the 30 days following a hospital or SNF stay. CMS believes that providing separate payment for the treatment physicians provide patients prior to discharge, ensures better continuity of care for these patients and helps reduce avoidable readmissions. But the CMS rules do not require doctors to coordinate post-discharge care with any of the community groups already providing such care.

New Assisted Living Regs Raise "Aging in Place" Concerns

Residences at Wingate

On December 15th, Mass Home Care testified on a new set of regulations from the Executive Office of Elder Affairs updating the Assisted Living Residence program. Here are excepts from the Mass Home Care testimony, which was written by **John O'Neill**, the Executive Director of Somerville Cambndge Elder Services, and **Al Norman**, the staff of Mass Home Care:

"Many of the revisions drafted by the Executive Office of Elder Affairs are a positive attempt to address and improve Assisted Living resident protections, update safety codes, and mandate increased staff training. They also are geared to make sure that any "special care" units within the residences are properly maintained, have specially trained staff in place, and are properly supervised, with new reporting requirements to assure that in fact all this is done. Mass Home Care supports these regulatory updates.

However, there is a serious internal conflict found in both MGL Chapter 19D, the Assisted Living statute, and repeated in 651 CMR 12.00, the proposed modifications to the regulations.

The ALR statute itself is internally inconsistent. Under M.G.L. Chapter 19D, Section 9. (a):

"Every resident of an assisted living residence shall have the right to: (6) freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community." (7) Directly engage or contract with any licensed health care professionals and providers to obtain necessary health care services, in the resident's unit or in such other space in the assisted living residence as may be made available to residents for such purposes to the same extent available to persons residing in private homes.

The ALR statute promises residents the right to contract for "necessary health care services…as made be made available…to persons residing in private homes." ALR residents are to be treated, as a class, the same as individuals living in their own homes. The statute also gives ALR residents the right of "freedom to participate in and benefit from" community care, to keep them at the "highest possible level of independence."

This last phrase echoes the mandate of MassHealth eligibility, found in MGL Chapter 118E, S. 9: "A person determined by the division to be clinically eligible for long-term care services shall be given the choice of care setting that is the least restrictive and most appropriate to meet his needs as determined by the division."

But Chapter 19D also contains another section that directly conflicts with the resident's rights section 9(a) cited above: "Section 11. No assisted living residence shall admit any resident who requires twenty-four hour skilled nursing supervision. No assisted living residence shall provide, or admit or retain any resident in need of skilled nursing care unless all of the following are the case: 1. The care will be provided by a home health agency certified under Title XVIII of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C. 301, as amended or an entity licensed under chapter one hundred and eleven, on a part-time, intermittent basis for not more than a total of ninety days in any twelve-month period, or by a licensed hospice. 2. The certified home health agency, entity licensed under chapter one hundred and eleven of the General Laws, or hospice does not train assisted living residence staff to provide the skilled nursing care. 3. The individual to whom the skilled nursing care is provided is suffering from a short-term illness. For the purposes of this section "short-term illness" is defined as either a medical condition for which recovery can be

expected to occur with not more than ninety consecutive days of skilled nursing care or a medical condition requiring skilled nursing care on a periodic, scheduled basis. For the purposes of this section, nursing services provided by a certified home health agency or entity licensed under chapter one hundred and eleven such as injection of insulin or other drugs used routinely for maintenance therapy of a disease, or licensed hospice care may be provided without respect to the ninety day limitation."

Thus Chapter 19D creates a favorable status for potential residents based on whether their illness is short or long—episodic or chronic---forcing applicants with long-term chronic conditions to be referred to more segregated settings, like a nursing facility, and denying them their protected rights under section 9(a) of the same ALR statute to the "highest possible level of independence, autonomy, and interaction within the community." Section 11 of the ALR statute also violates the "least restrictive setting" provisions of MassHealth eligibility section, Chapter 118E, s. 9.

The draft ALR regulations as a whole are also internally inconsistent. 651 CMR 12.01: Scope, Purpose, and Authority, states: "Assisted Living Residences are an important part of the spectrum of living alternatives for the elderly in the commonwealth, and they should be operated and regulated as residential environments with supportive services, and not as medical or nursing facilities, and should support the goal of aging in place through services, available either directly or through contract or agreement, to compensate for the physical or cognitive impairment of the individual while maximizing his or her dignity and independence." It also states in 651 CMR 12:08(3)(1)(g), under Resident Rights: that residents have the right to "directly engage or contract with licensed or certified health care providers to obtain necessary health care services in the resident's Unit or in such other space in the Assisted Living Residence as may be available to persons in their own homes"

The proposed regulations also mirror the statutory conflicts over the issue of short term vs. long term illnesses. 651CMR 12:04(3)9b) under Skilled Care Services says: "no Assisted Living Residence shall provide or, admit or retain any Resident in need of Skilled Nursing Care unless …unless The Resident requires no more than ninety consecutive days or such care is limited to a periodic scheduled basis." This language clearly contradicts both the ALR Purpose clause, as well as the Resident Rights clause referenced above. It also is in violation of both Chapter 211 of the Acts of 2006 (Chapter 118E, s. 9) commonly referred to as the Equal Choice Law, as well as the 1999 U.S. Supreme Court's Olmstead decision.

The implementation of this regulation would almost certainly mean the institutionalization of the elder to whom it was applied. The Assisted Living Facility is their only residence, and given the dearth of alternative housing options in most communities for elders in need of support services, the elder's only option would be a nursing facility. Gone is any choice for the individual, and Community First as a guiding principle of long term care in Massachusetts would be contravened for such persons. This situation also highlights the need for the Executive Office of Elder Affairs to allow elders living in Assisted Living residences the same access to all Home Care services as any other elder resident of the Commonwealth.

The discrimination against those who choose to make their home in an Assisted Living residence should end. The Commonwealth should extend to ALR residents the same rights as someone living at home, consistent the with language contained in MGL Chapter 19D, s. 6 and 7.

Mass Home Care therefore urges the Executive Office of Elder Affairs not to implement these proposed modifications to the ALR regs, and to notify the General Court's Joint Committee on Elder Affairs that Chapter 19D needs to be amend-

ed by striking section 11 in its entirety, to end discrimination against people with long-term/chronic illness in the provisions of assisted living supports, and that all ALR residents should be able to receive ancillary health services, or any other supports, to the same extent available to persons residing in private homes."

MassHealth Long Term Care: "Looming Crisis"

In mid Decembaear, the Massachusetts Medicaid Policy Institute (MMPI)—a program of the Blue Cross Blue Shield of Massachusetts Foundation—published an analysis of one of the state's largest expenditure items: the Medicaid program, known as MassHealth.

MassHealth is by far the largest payer of LTSS in Massachusetts, with smaller contributions from Medicare (which pays only for short-term, post-hospitalization use of nursing facility, rehabilitation, and home care services), out-of-pocket spending, private long-term care insurance, and state health and human service agencies.

Here are excerpts from the new MMPI report:

"As one of the largest health care insurers in the state and the steward of health care coverage and financing for an expected 1.7 million low- and moderate-income individuals, or one in four residents, MassHealth is at the center of these reforms. With anticipated expenditures of $13.7 billion in 2015, MassHealth spending represents over 30 percent of the total state budget. This gross figure includes both state and federal Medicaid dollars. The federal government reimburses more than half of this total dollar amount. The MassHealth program is expected to generate $7.7 billion in federal revenues this fiscal year, representing more than 80 percent of all federal revenues to be received by the Commonwealth. As a result of this spending and revenue generation, MassHealth is a major contributor to the Commonwealth's overall economy, supporting health care providers and health plans that employ thousands of people."

The Blue Cross Foundation published this new report right before Governor-elect **Charlie Baker** took office, because "as a new Governor takes office, there is a unique opportunity to take a fresh look at MassHealth and its role in the Commonwealth's health care system. Given the program's size and critical role in providing health coverage to one-quarter of the state's residents, MassHealth will, by necessity, be one of the Governor's top priorities."

One of the priorities in the MMPI report focuses on the need to address reform of long term services and supports. "MassHealth's dominant role in paying for long-term services and supports (LTSS) for a large and growing number of seniors and people with disabilities adds up to a looming crisis as we prepare for the changing demographics that the aging of the baby boomers will bring. The greatest opportunity to ensure MassHealth's future sustainability is to take on the complex task of reforming the long-term care delivery and funding systems. While stakeholders laud recent MassHealth efforts to expand access to community-based LTSS and integrate comprehensive services for high-need subpopulations, they express serious concern about the lack of a more comprehensive and deliberate strategy to ensure access to community-based LTSS that are person-centered and in compliance with the Americans with Disabilities Act (ADA) for all enrollees who need these services. They also point to the need for MassHealth leaders to develop focused LTSS cost-containment strategies, to advance a strategic plan for the future role of nursing facilities as more care moves into the community, and to work with the private sector on a long-term LTSS financing plan to help ensure the financial sustainability of the MassHealth program.

"Over the last 15 years," says MMPI, "enrollment in MassHealth has grown steadily to 1.5 million people in 2014, and enrollment is expected to reach 1.7 million in 2015…MassHealth is a major payer for

virtually every type of health care provider, including hospitals, physicians, community health centers, ancillary services such as laboratory and radiology, and nursing facilities. In addition to being the second largest payer of health care services in the state, with spending projected to be $13.7 billion in state fiscal year (FY) 2015, MassHealth is the primary payer for LTSS, including nursing facility services and home- and community-based support services essential to elderly and disabled Commonwealth residents. In fact, MassHealth represents half of nursing facilities' patient revenues and covers roughly two-thirds of nursing facility residents. At over $3.5 billion in SFY 2015, MassHealth's LTSS budget represents more than one-quarter of the program's total budget. In addition, MassHealth covers a comprehensive range of behavioral health services for most of its members, including many community-based services not traditionally covered by private insurance… each dollar spent on MassHealth results in as much as $2.21 in additional economic activity in the state."

"Accounting for 35 percent of the state's budget and more than 80 percent of all federal revenue to the state…federal reimbursement—projected to be $7.7 billion in SFY 2015—has a significant impact on the overall burden of the program on the state budget. On a net cost basis, subtracting out the federal reimbursement from the budget total, MassHealth and health reform spending represent 23 percent of the state's net budget."

The MMPI report notes that of the roughly 270,000 dual eligibles—MassHealth enrollees also eligible for Medicare—roughly 20 percent of dual eligibles are enrolled in several small, but growing, managed care programs: Senior Care Options (SCO), Programs of All-Inclusive Care for the Elderly (PACE), and One Care. "These programs integrate the full set of Medicaid and Medicare services and financing with the goal of providing coordinated, integrated care that better meets the needs of these members," the report explains. "The remaining dual eligibles receive MassHealth on a fee-for-service (FFS) basis, where behavioral health services in particular are limited both in terms of benefits covered and providers participating, and care often is fragmented since there is no mechanism for coordination and providers must follow the rules of the two different payers, Medicare and MassHealth." MMPI sees these kind of managed programs as the most promising trend in LTSS programming.

But all MassHealth managed care provides frequently call attention to the inadequacy of MassHealth rates to cover the cost of delivering services under the program…Recently, the MCOs that contract with MassHealth have raised the alarm regarding their reported $140 million in losses since the start of the year due to the inadequacy of MassHealth capitation payments.

One of the priority reform areas for the MMPI is Masshealth, because of its "dominant role in paying for long-term services and supports (LTSS) for a large and growing number of seniors and people with disabilities adds up to a looming budget crisis. The greatest opportunity for ensuring MassHealth's future sustainability is to take on the complex task of reforming the longterm care delivery and funding systems."

MMPI predicts that LTSS utilization and spending are expected to explode in coming years with the aging of the baby boomers and increased longevity for people with chronic and disabling conditions. One analysis projected that Massachusetts' elderly population will grow by 35 percent, and its population over age five with disabilities will grow by 13 percent, between 2007 and 2020. As the primary payer of LTSS, these trends disproportionately impact MassHealth, which covers over 400,000 seniors and people with disabilities of all ages. The same analysis predicted that "Long-term care is an issue screaming for intervention—and it impacts a significant number of people with a disproportionate resource use."

"MassHealth LTSS costs—estimated to be over $3.5 billion in state fiscal year 2015, could, without intervention, more than double to nearly $8 billion in 2030—a cost that would be unsustainable for the Commonwealth. State leaders have made important, but piecemeal, progress in strengthening the Commonwealth's LTSS system in recent years—particularly in advancing the state's 'Community First' LTSS policy agenda, which aims to maximize the use of high-quality, person-centered LTSS in people's homes and communities (settings vastly preferred by most individuals and their families), while preserving critical access to facility-based care for those who need it."

"Community-based LTSS utilization and spending has grown rapidly over the past decade, with MassHealth LTSS fee-for-service spending now roughly evenly split between community-based and facility-based care. The state is also advancing a managed care purchasing strategy for populations dually eligible for MassHealth and Medicare, who historically have been served in the fee-for-service system. Building on its Senior Care Options (SCO) program and Programs of All-Inclusive Care for the Elderly (PACE) for seniors, the Commonwealth implemented the One Care program in 2013 to integrate Medicare and MassHealth services and financing for dually eligible individuals under age 65."

"Massachusetts has taken advantage of several federal funding opportunities, some with enhanced federal match, in implementing these reforms, including the Balancing Incentive Program (BIP), the Money Follows the Person (MFP) Rebalancing Demonstration, the Personal and Home Care Aide State Training (PHCAST) program, and the federal fiscal alignment demonstration to implement One Care. Balancing Incentive Program (BIP) allows Massachusetts to draw down an increased federal Medicaid match to implement diversions to nursing homes and increase access to home- and community-based services (HCBS) through a 'no wrong door' single entry point system, conflict-free case management services, and core standardized assessments.

The MMPI says that stakeholders laud MassHealth's efforts to improve the LTSS system, but they express serious concern about the lack of a comprehensive and deliberate strategy to ensure access to LTSS that are person-centered and in compliance with the Americans with Disabilities Act (ADA) for all enrollees who need these services. They also urge MassHealth leaders to develop focused LTSS cost-containment strategies and to work with the private sector on a long-term LTSS financing plan to help ensure the financial sustainability of the MassHealth program. MMPI says the areas of "greatest concern" are:

• Equitable access to community-based LTSS based on identified need. Current access to critical MassHealth community-based LTSS, including care management services, is based on age, diagnosis, disability, or dual eligibility status. These patchwork eligibility criteria leave major gaps in access to and financing of community-based LTSS for people who do not fit the current eligibility standards but have similar incomes and functional needs.

• The future role of nursing facilities as more care moves to the community. With the state's successes to date in expanding access to community-based LTSS, stakeholders are concerned that there has not been a commensurate reduction in institutional spending, a clear LTSS savings reinvestment strategy, or a strategic plan for nursing facility practice redesign or diminishing excess bed capacity as more care moves into the community.

• Sustainable long-term LTSS financing. Given the demographic trends, the current financing system for LTSS, with MassHealth at its core, is not sustainable. To ensure the long-term sustainability of the MassHealth program, state officials must work with LTSS providers to achieve cost efficiencies and with the

private sector to create viable private financing vehicles to more equitably share the costs of LTSS.

• The role of LTSS in the state's broader health system reforms. LTSS providers have largely been left out of the state's broader delivery system and payment reform discussions around ACOs and other integrated delivery systems. LTSS providers play a critical role in ensuring continuity of care for enrollees, meeting their critical behavioral health needs, and addressing complications that can reduce hospital admissions, readmissions, and Emergency Department use. Because people using LTSS have costly and complex needs, their care is mostly unmanaged, and because they primarily receive care in the fee-for-service system, they represent a significant opportunity to improve care outcomes while lowering health care costs."

"Stakeholders identify other critical components of a comprehensive LTSS reform strategy including ensuring access to affordable housing and employment supports; providing critical respite and other supports to informal caregivers; enhancing patient/family education and navigation resources; developing a plan to recruit, retain, and train both direct service workers, such as home health aides and personal care attendants, and non-traditional providers, such as community health workers and peer counselors, particularly as the state plans for future growth in demand for these services; expanding the use of telehealth and other creative technologies, such as remote monitoring of home care, to address care needs more efficiently; and reexamining MassHealth coverage policies around emerging effective treatment modalities (for example, around rehabilitation science)."

"Comprehensive LTSS reform remains a major gap in health and social policy both nationally and in Massachusetts. This is due, in part, to a decades-long focus by policy makers on expanding access to health insurance coverage and other reforms to the acute care system, and in part to the scope, complexity, and contentiousness of long-term care issues. Tackling LTSS reform requires a 'paradigm shift' in how policy makers, providers, and health plans think about health care. The nature of LTSS is different from medical care, as LTSS primarily address individuals' functional and social support needs, often over a long period of time, in addition to their clinical needs. Additionally, MassHealth eligibility, benefit coverage, and financing rules for both institutional and community-based care are complex and very difficult for families and policy makers to navigate. Finally, LTSS financing decisions implicate broader societal questions about the role of private savings and inheritances in paying for LTSS."

One of the solutions posed by the MMPI report is strengthening MassHealth as a source of LTSS financing by strategically expanding MassHealth coverage of community-based LTSS to achieve equitable access to LTSS (the One Care program represents one important step in this direction). Another option is promoting the development of a social insurance, contribution, or other savings program that allows people to prepare for financing their LTSS needs. MMPI also praises the year-old One Care for its "comprehensive stakeholder engagement process," and key programmatic features, including access to community-based LTSS and behavioral health services, care management, and a dedicated independent-living long-term supports services (IL-LTSS) coordinator. The report notes, however, that these features "should be monitored and evaluated to see what is working and what is not working for populations with chronic, complex, and high-cost care needs." (Mass Home Care has noted that less than 20% of One Care enerollees has been connected to the independent LTSS coordinator, because direct access to these workers by enrollees is not allowed, and that after 14 months in operation, no financial data on the One Care plans have been published.)

MMPI also recommends the state develop "targeted strategies to increase enrollment in the Senior Care Options (SCO) program, which provides integrat-

ed and managed Medicare and MassHealth benefits to over 30,000 seniors who are eligible for both programs. Strategies could include better marketing of the care coordination, family respite, and other SCO benefits that enrollees do not have access to in the fee-for-service system, or implementing incentives to encourage eligible individuals to enroll in the voluntary SCO program, which could require MassHealth to engage Medicare in discussions around its freedom of choice policy. MassHealth should also conduct a comprehensive outcomes evaluation of the now 10-year-old SCO program to determine its effectiveness in expanding access to community-based LTSS, avoiding or reducing nursing facility use, improving enrollee's quality of care and outcomes, and lowering overall health care costs."

One final recommendation from the MMPI report was opposed by most elder rights groups in the state. MMPI suggested "transferring oversight of the MassHealth LTSS budget and program staff from the Secretary of Elder Affairs to the Medicaid Director and giving the Medicaid Director primary oversight of MassHealth's full budget and key staff and programs. This option, which could be accomplished without any other structural changes to the program, is not one on which all stakeholders agree, although it is strongly supported by former MassHealth leaders."

As advocates know, Governor Partrick in fact transferred power away from the Executive Office of Elder Affairs at least 5 years ago. The Governor proposed an executive reorganization that would have changed state law by moving EOEA management over MassHealth LTSS back to the Executive Office of Health and Human Services (EOHHS). Elder groups opposed this plan, and Governor Patrick withdrew his plan---but he implemented it anyway---without making any statutory changes.

In section 1 of Chapter 19A, EOEA is given clear authority to manage LTSS for people age 65 and over who need either institutional care or home care. EOEA has the statutory language, but lost the power. The MMPI recommendation, in fact, happened half a decade ago, and LTSS today remains an uncoordinated, costly system. Mass Home Care called the MMPI plan to weaken EOEA "off the mark," and a demonstrated failure."

BayPath Elder Services Launches Interactive Caregivers Website

(L-R) Caregiving MetroWest Program Manager Douglas Flynn, BayPath Elder Services Director of Strategic Initiatives Stephen Corso, Rep.Kate Hogan and Senator James Eldridge. Credit:Office of Sen. Eldridge.

BayPath Elder Services, Inc, based in Marlborough, a Mass Home Care member agency, launched a new website in December devoted to meeting the needs of the steadily growing ranks of MetroWest family caregivers.

Funded through grants from the MetroWest Health Foundation, CaregivingMetroWest.org provides caregivers in 25 MetroWest communities robust access to information, connections to resources and enhanced support. Customized website features developed specifically for MetroWest caregivers provide real-time information and state-of-the-art interaction.

"Anyone caring for a loved one knows how frustrating it can be to find needed services and supports," said **Martin Cohen,** president of the MetroWest Health Foundation. "That's what makes this website such an important resource for families, and why the foundation has supported its development.

"Three years ago, the Foundation's MetroWest Commission on Healthy Aging identified the need to expand information and support for caregivers," added Cohen. "The Caregiving MetroWest site responds directly to that recommendation by providing a simple and tailored way for families to see what services are available in their community."

Customized website features developed spe-

cifically for CaregivingMetroWest.org provide real-time information and state-of-the-art interaction for area caregivers. Those resources include a clickable map of MetroWest that allows users to click on each of the 25 towns and cities in the MetroWest Health Foundation's coverage area to produce a listing of caregiving resources for that community in over 20 categories.

There is also a discussion forum that will allow users to connect with fellow caregivers, share their knowledge and experience, or simply chat about whatever is on their mind to help forge a feeling of community, decrease isolation and provide a measure of respite to caregivers. The site also features an interactive glossary of caregiving terms, a regularly updated blog and an extensive content section covering all aspects of caregiving.

"BayPath Elder Services, Inc. is fully committed to improving the access to information, resources and social connections for caregivers and their elder care recipients who live in MetroWest," said **Christine Alessandro**, the executive director of BayPath Elder Services, Inc. "The number of caregivers in MetroWest is growing at a significant rate. This website will greatly enhance our ability to meet the needs of those caregivers throughout MetroWest."

AARP Massachusetts: The Longevity Economy

On December 15th, AARP Massachusetts convened a Leadership Forum in Boston on the Buying Power of the Massachusetts' 50+ Population. The Keynote Speaker, **Jody Holtzman**, Senior Vice President, AARP Thought Leadership from AARP's Washington, D.C. Office, led a discussion of the findings of important new research about the spending power of this population, from a report called T*he Longevity Economy: Generating Economic Growth and New Opportunities for Business.*

According to AARP, "a powerful new force is changing the face of America, composed of 106 million people responsible for at least $7.1 trillion in annual economic activity---a figure that is expected to reach well over $13.5 trillion in real terms by 2032." This is the "Longevity Economy,' the sum of all economic activity serving the needs of American over 50, and including both the products and services they purchase directly and the further economic activity this spending generates. These older workers and retirees represent a "transformative force," says AARP, "a fast-growing contingent of active, productive people who are working longer and taking the American economy in new directions. Rather than being a burden to society, these older people will continue to fuel economic activity far longer than past generations."

Business owners and policymakers might be surprised at how much economic activity in Massachusetts is generated by people over age 50, AARP notes. Across the nation, the aging population has proven to be an important and vital source of economic growth:

• In Massachusetts, people over 50 contribute to the economy in a positive way that is disproportionate to their share of the population. Despite representing just 35% of the population, the total economic contribution of the Longevity Economy accounted for 49% of Massachusetts' gross domestic product (GDP) of $219 billion.

Jody Holtzman, AARP Photo

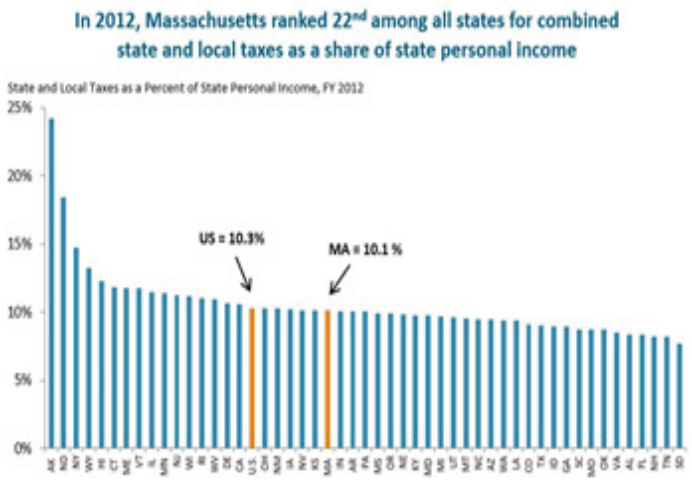
• The Longevity Economy's buying power accounted for the largest share of consumer spending on health care (67%), other nondurables such as pharmaceuticals and household supplies (60%), and financial services (58%).

• In 2013, the Longevity Economy supported 55%, or 2.4 million of Massachusetts jobs; 49% of employee compensation, valued at $125 billion;

and 49% of state taxes, to the tune of $20 billion.
• The greatest number of jobs supported by the Longevity Economy were in health care (571,000), retail trade (342,000) and accomodations and food services (205,000).

The $219 billion impact of the Longevity Economy was driven by $137 billion in consumer spending by over-50 households in Massachusetts, or 55% of total comparable consumer spending. People over 50 make up 34% of the Massachusetts workforce. 50% of those in the 50-64 age group are in professional occupations.

Massachusetts Ranks 22nd. For Tax Burden On Income



According to the Massachusetts Budget & Policy Center, U.S. Census Bureau data for FY 12 shows that the amount of state and local taxes paid in Massachusetts as a share of total personal income was 10.1 percent in FY 2012. By this measure, Massachusetts had lower taxes than 21 other states and was below the national average of 10.3%. Both the Massachusetts and U.S. ratios are modestly lower than in the prior year, FY 2011.

Elder Groups Seek Mobile Mental Health Funding

A coalition of elder groups is requesting $8 million in new federal funding to launch a "mobile mental health service for seniors in Massachusets.

The federal Balancing Incentive Program (BIP) authorizes grants to states to rebalance their long-term services and supports (LTSS) toward community settings, allowing individuals to be served in the most appropriate, least restrictive and least-costly settings--namely their homes.

The Massachusetts Aging and Mental Health Coalition (MAMHC) is requesting a portion of this new BIP funding for community-based geriatric mental health services. The failure to address an older adult's mental illness in their homes and communities greatly increases the likelihood of unnecessary nursing home placements. The requested allocation of BIP funds will decrease the costs of care, and help these older adults to remain in the community.

The group says current funding favors institutional care for older adults with mental illness. Older adults with mental illness are an extremely vulnerable population, at high risk of hospitalizations and nursing home placements. Many factors contribute to these risks, including limited resources, poor insurance coverage, housing instability, social isolation and impairments in mobility or cognition that lead to difficulty getting to appointments. This population requires an integrated, coordinated and home-based system of behavioral health care that is not supported by current policies because they do not reimburse home visits. Studies have shown that failure to treat an older adult's mental illness in the community increases the likelihood of nursing facility placement by a factor of three, and that these institutional placements are likely to occur at a much younger age. The results are costly for the individuals who find themselves in avoidable nursing home placements, as well as for taxpayers---as nursing home placements are considerably more expensive than community-based care.

The BIP funds would be used to create a statewide network of mobile mental health and aging services anchored in the ASAP network, partnered with local mental health providers to offer in-home assessment, counseling and home-based treatment.

Mass Home Care was one of the groups signing onto the Mass Aging & Mental Health Coalition proposal to the General Court and Gov.-elect Baker.