At Home

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With Mass Home Care

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Al Norman, Editor

Baker Takes Elder/ Disabled Cuts Off The Table

It all happened very quickly.

Five days after being informed of proposed cuts to key elderly and disabled programs, a coalition of nearly 70 aging and disability rights groups delivered a letter to Governor **Charlie Baker**, asking that the cuts be rescinded. Four days after the Administration received the letter, **Marylou Sudders,** Secretary of the Executive Office of Health and Human Services, told advocates that the cuts were "off the table."

On a conference call with EOHHS on February 4th, advocates were told by the Administration that the following cuts were being proposed in the MassHealth program:

• The Personal Care Attendant program (PCA) will have its eligibility level raised from two activities of daily living (e.g. bathing, eating, dressing, walking, toileting) to three activities of daily living, making it harder of elders or individuals with disabilities to get into the program. Savings: $2 million

• The Adult Foster Care (AFC) and Group Adult Foster Care (GAFC), which provide personal care and 24/79 housing, will have its eligibility level raised from 1 ADL to 2 ADLs. Savings: $1 million in savings to AFC, and $2 million in savings to GAFC.

• When an Adult Foster Care family is gone from

the home for vacation of family business, the "Alternative caregiver days" are eliminated, so there is funding to pay for a back up caregiver. Savings: $1 million in savings to the AFC program

In addition, Governor Baker filed a supplemental bill that would have given him the power to "restructure benefits" for 12 major line items of MassHealth spending, representing $13 billion worth of services, from HIV and breast cancer treatment, to in-home services to the elderly and disabled.

Concerned advocates convened quickly, and drafted a letter to the Governor and his human services staff challenging the wisdom of these cuts, and asking the Governor to strike the section of his supplemental bill that would transfer unilateral control over vital MassHealth services to low-income,disabled individuals to the Executive branch.

Photo: IUPAT District Council 35

Here is the letter to Governor Baker, which was drafted by the human services groups:

Dear Governor Baker:

We are writing to express our deep concerns over your proposed emergency FY 15 9C supplemental legislation, HB49- "An Act Addressing the Fiscal Year 2015 Budget Shortfall," which if passed in its current form will have widespread and significant impacts on tens of thousands of low-income residents of Massachusetts who depend upon vital MassHealth services for their well-being.

Section 7 of HB49 gives the Executive Branch unilateral authority to manage MassHealth "by restructuring benefits" in a dozen major MassHealth line items, affecting children, adolescents, families, elders, individuals with disabilities, HIV patients, and breast cancer patients and impacting mental health, behavioral health, substance abuse, managed care, dental care, health subsidies to small businesses, primary medical care, personal care attendants (PCAs), and adult foster care (AFC) services and programs, without legislative oversight or control. These line items represent approximately $13 billion in public investments in the health of low-income populations in the Commonwealth.

We understand the importance of managing the MassHealth programs, but section 7 of HB49 gives the Executive Branch open-ended power to change health and supportive services benefits to MassHealth recipients which will have a tremendous fiscal impact, and will result in a loss of federal match dollars that are attached to many of these services, without even obtaining legislative approval. Billions of dollars in taxpayer investments in these services will be affected by this blanket authorization.

We cannot support such a transfer of power away from the General Court to the Executive Branch, especially when it concerns the lives of many people with disabilities in the Commonwealth. There need to be checks and balances to ensure that the mission of MassHealth to care for people in the least-restrictive setting is not transformed— that homelessness and institutionalization are not increased, as may result from planned cuts to PCA and AFC services. As Governor, you have very difficult decisions to make regarding the budget and the well-being of Massachusetts. But we, as advocates for low-income beneficiaries, are obliged to raise our concerns to lawmakers over plans that we think will harm the people we serve. For this reason, we respectfully request that you reexamine Section 7 in HB 49 and how this will impact the lives of many people who have a disability.

Section 7 of HB49 is overly broad, and not in the best interest of the Commonwealth of Massachu-

setts. We urge you to strike this section from your legislation, and work with the General Court to put forward specific, detailed plans for any restructuring of MassHealth benefits. We stand ready to work with you to better manage the taxpayer investment in MassHealth services, but let us do that in a deliberate and transparent process."

In his budget plan statement, Governor Baker said his cuts were "considered carefully," and would protect " critical services for people." On January 20th, when he first confirmed the FY 15 budget deficit, Governor Baker said, "The long story short: the deficit is about $765 million, spending seems to be the primary issue here, tax revenue's about where people thought it would be, and we will obviously make these decisions as we go forward with great sensitivity and careful judgment."

EOHHS Sec.Marylou Sudders, ANF Sec. Kristin Lepore, Photo: Bill Henning, BCIL

Mass Home Care was among the first in line to congratulate the Governor publicly when he decided not to use his "9c" powers to cut elderly home care. But as more budget details emerged, it became clear that there were $6 million in other cuts to the PCA, AFC and GAFC programs.

Secretary Sudders asked leaders from the advocacy groups to come to her office on February 13th to discuss the cuts. Early on in that meeting, Sudders announced that the $6 million in cuts were "off the table for FY 15, and for FY 16."

Sudders noted, however, that the Administration wanted to develop "a different structure for the delivery of MassHealth services."

Sudders said the Administration would hold a "series of public discussions." "It's not our intent to redesign the system from the Corner Office," she added. "This has to be a community conversation." Sudders said EOHHS has "a little blueprint" for redesigning MassHealth, but the work would be done through a public process. Sudders told the advocacy groups that she understood the value of these programs, and was sympathetic to their purpose. "I was a Personal Care Attendant once," she noted.

State Could Improve MassHealth Long Term Care

As the Baker Administration focuses on changing how MassHealth delivers billions of dollars on health care services, the elder advocacy group Mass Home Care, a network of 30 non-profits that helps seniors live independently at home, released a report on February 18th. entitled *The Long Term Services Challenge*, which says Massachusetts could better coordinate its long term services---while at the same time reduce the overall cost of care to state and federal taxpayers. Instead of concentrating on doctors and hospitals, the Mass Home Care report focuses on "post acute care" that is often non-medical in nature—the care at home that keeps people out of emergency rooms and hospital beds.

"The Blue Cross Blue Shield Foundation recently called long term services a 'looming crisis,'" said Mass Home Care President **Dan O'Leary**. "Community care is one of the few state programs that has an immediate Return on Investment. When we keep an elder at home today, that's one less bed we have to pay for in a nursing facility today."

This study, which was shared with Governor **Charlie Baker** in January, estimates that Massachusetts spends about $3.7 billion annually on long term support services. According to the Health Policy Commission, per capita health care spending in Massachusetts is the highest of any state in the nation. The Commonwealth has a higher proportion of its population enrolled in Medicare and Medicaid

than the national average. In 2011, the rate of residents in nursing facilities in Massachusetts was 46% greater than the U.S. average. That same year, a study by AARP found that Massachusetts ranks 40th in the nation for the percentage of low income residents who end up in nursing facilities without first receiving community-based care that might have kept them at home.

Hospitals in Massachusetts discharge patients into nursing homes at a rate 8% higher than the U.S. average. 80% of the residents in Massachusetts nursing facilities are elders. "Most health care reform focuses on acute care issues," the Mass Home Care report says. "Less-discussed are the challenges of long term supports and services (LTSS). Many health entities are not at risk for long term services costs, which are seen as 'downstream' of hospital and medical care—and therefore someone else's problem."

The report notes that Massachusetts has a higher proportion of its population enrolled in Medicare and Medicaid than the national average. Across the U.S., the Medicare and Medicaid populations have greater health care needs and spending levels than those in commercial insurance. 5% of patients account for nearly half of all spending among the Medicare and Medicaid populations in Massachusetts. Significant savings can be captured by focusing on high-cost patients, and high-cost patients generally have more clinical conditions than the rest of the population. The presence of multiple conditions, such as behavioral health and chronic medical conditions, increases spending.

About 55% of all LTSS spending in Massachusetts is considered community-based. But there are at least two dozen states that spend a far higher percentage of their LTSS dollars in the community than Massachusetts.

The Mass Home Care report quotes the state's Health Policy Commission: "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."

Community-based LTSS has had a dramatic impact on lowering the use of skilled nursing facilities in Massachusetts, saving taxpayers as much as $853 million per year, according to Mass Home Care. Between FY 2000 and FY 2014, the number of nursing home patient days paid for by MassHealth fell by 4.5 million days (-34%).

Among the reforms in *The Long Term Services Challenge* are the following:

• Expand the federal Community Care Transition Program of Coaches to help high-cost patients become more engaged in self-managed care, reduce ER admissions and hospital readmissions. Coaches are conflict-free---not owned by medical providers.

• Improve care transition coordination between ASAPs, insurers and hospitals to reduce the rate of discharges to skilled nursing facilities (SNFs)

• Reduce the average length of stay (ALOS) in SNFs through more aggressive pre-admission and post-admission screening and discharges

• Use federal Balancing Incentive Payment (BIP) funds to fill in some of the gaps in community-based services, such as Transition Coaches, Medication Technicians, and other LTSS programs.

• Raise the income eligibility thresholds for home care and MassHealth as a focused strategy to serve the "lower middle class" and maintain them in the most integrated, least costly setting.

• Restore and enhance the existing statutory role of the Executive Office of Elder Affairs as the manager overseeing a coordinated system of home care and MassHealth LTSS.

• Expand the presence of relocation workers in SNFs to help residents to return to the community. In FY 14, a total of 2,545 elders were relocated from SNFs back to the community. Approximately 90% of these discharges are individuals on MassHealth.
• Create a Community-Based Mental Health counseling service. In FY 13, 11.2% of the home care caseload (5,048 elders) expressed "a feeling of sadness or being depressed" that "life was not worth living, that nothing mattered," or that they "would rather be dead."
• File a 1915i amendment which uncouples home and community based services from nursing facility level of care, thereby expanding the number of elders eligible to attract federal matching funds. 1915i will bring in millions in new federal matching funds for elders in the home care program who currently do not attract FFP because they are not considered nursing facility level of care.
• File a Community First Choice 1915(k) amendment to provide home and community-based attendant services to Medicaid enrollees with disabilities under their State Plan. This option provides a 6% increase in Federal matching payments to States for expenditures related to this option.
• Expand the DMH Medication Technician program which allows a trained technician to assist consumers in their home with medication reminders, cueing or prompting. It allows increased medication adherence to reduce the use of costlier medical settings.
• File a 1915c waiver to create 24/7 residential "small homes" program for up to 4 disabled individuals who need round the clock care to remain living in the least restrictive setting.
• Allow spouses as caregivers in the Personal Care Attendant (PCA) and Adult Foster Care (AFC) program. 17 other states allow spouses as caregivers. The State Senate unanimously passed legislation to allow spouses as caregivers last June. The Administration can do this by regulatory action.
• Allow individuals who need cueing and supervision to receive Personal Care Attendant services, not just those who need hands-on care, and end discrimination against people with cognitive instead of physical disabilities.

"Attention is finally shifting from medical care to whole care," O'Leary said. "What happens outside the doctor's office—especially for high cost patients in transitions—is as important as what happens inside the office. We're ready to work with Governor Baker to make this 'whole person care' agenda work for seniors and taxpayers," O'Leary said.

Note: As of February, 2015, there are 44,290 elders receiving home care assistance. 39% of them (17,104) are nursing facility eligible, but are in the community instead. 46% (20,333) are on MassHealth. 73% (32,470) are women. Their average age is 80. 57% live alone, 80% are unmarried. The average client spends 2.6 years in the program

Dramatic Drop In Food Stamp Recipients

In late January, a group of food stamp advocacy groups, including the Northampton and Amherst Survival Centers, and the Food Bank of Western Massachusetts, wrote to **Marylou Sudders**, the Secretary of the Executive Office of Health and Human Services (EOHHS) about "widespread problems" facing food stamp (SNAP) recipients, due to "modernization" initiatives taken by the state's Department of Transitional Affairs (DTA), which oversees the SNAP benefit in Massachusetts.

According to advocates, SNAP enrollment from September of 2013 to September of 2014 in the Commonwealth dropped by 7.3%---an "alarming" decline of 65,000 recipients---which one media story said translated into a loss of $106 million in federal funds, or $8.8 million per month. "This is a huge loss of dollars coming into the state," **Elizabeth Silver**, a Northampton lawyer who signed the SNAP letter, told *The Greenfield Recorder*. "We all know how those funds flow right back into the economy."

The group's letter charged that DTA's modernization programs "almost certainly have a role" in the decline in SNAP enrollment. In February of 2014, DTA rolled out an "Electronic Document Management Center (EDMC) system that created a centralized document center in Taunton, MA, for all SNAP case files. Advocates charge the document center produced "error-prone data," and a "significant backlog" of documents. More than 86,000 documents were unprocessed, the bulk of which were 6 days old, or older.

Another concern was the DTA's new centralized phone system, which replaced the "assigned caseworker" system for beneficiaries. An 800 number replaced the case workers with "a random worker in a random office somewhere in the state" answering calls. The advocates say that SNAP applicants find it difficult to speak to a live person, with very confusing phone prompts, no way to leave a message, and callers often disconnected. In addition, once a recipient gets through, their case records are incomplete or missing. Community groups also complained that worker responses are "erratic, with different outcomes depending on the DTA worker, which suggests a lack of sufficient worker training." Consumers trying to walk-in to local DTA offices often face a 2 or 3 hour wait.

One elderly SNAP beneficiary wrote to Franklin County Home Care: "I just received a letter stating that my Food Stamps have stopped because I did not meet the deadline. However, I sent everything in (with exception of any possible medical bills because I was going to have to change my Part D Plan (and did not know if I would have any), on December 31, 2014. I did meet the deadline. Now all I get is disconnected when I call and I am notified 2 days before you stop my Food Stamps. I am eligible, I know I am. Any suggestions about how I can get in touch with a person?"

Pat Baker, an advocate with Mass Law Reform, specializing in food stamp beneficiary rights, told advocates: "The recent DTA changes in the SNAP application and recertification process, coupled with an extraordinary surge in demand for verifications from recipients) is very troubling - particularly difficult for seniors as well as persons with disabilities, limited English speakers and persons with limited phone access (e.g. the so-called "free" phones that run out of minutes). Thousands of individuals in MA are also not getting through the Assistance Line." Baker added. "We reported to USDA another case of a 90 year old senior whose SNAP benefits were also terminated for failure to verify medical expenses at recertification. Medical expenses are an optional deduction, and she was otherwise eligible for a substantial SNAP benefit. The problems are endless and quite discouraging."

The advocates conclude that the "modernization" plans did not have "proper testing, sufficient resources and training for the DTA field staff, and sufficient resources to implement modernization smoothly." The group says these hastily implemented plans "have caused thousands of low-income residents…to lose access to their lifeline benefits."

Obama's FY 16 Budget: Ending Nursing Home Bias

One of the leading elder

advocacy groups in America, the National Council on Aging (NCOA) says that President **Barack Obama's** FYI 16 budget "presents a mixed bag for seniors."

The President's budget invests in a number of core aging services programs and calls for eliminating the sequester, the automatic across-the-board cuts to discretionary programs that are slated to take effect again this year. "However, it is disappointing that the request once again includes Medicare proposals that negatively affect beneficiaries," NCOA says.

Photo: HCAF

One of the most anticipated innovations in the Obama budget proposes several Medicaid improvements to stimulate more home and community-based services:

• A new pilot program for "comprehensive" Medicaid long-term services and supports would authorize up to five states over eight years to design programs that remove the institutional bias and streamline existing programs. According to *Forbes* magazine, this plan "could be a major step towards ending Medicaid's long-standing bias in favor of nursing homes."

• Additional state flexibility on eligibility for the Community First Choice Option would allow states to extend eligibility to certain individuals who qualify for nursing facility services (individuals with incomes up to 300% of SSI) in more administratively efficient ways.

• Two proposals to provide additional state flexibility in the 1915(i) Home and Community-Based Services State Plan Option would remove administrative burdens to permit states to expand eligibility to certain individuals who meet needs-based criteria and allow states to provide full Medicaid to individuals accessing 1915(i) services.

The President's FY16 request proposes significant new funding for Older Americans Act Title III programs, including:

• $38.5 million more for Supportive Services and Senior Centers

• $19.9 million more for Congregate Nutrition

• $20 million more for Home-Delivered Nutrition

• $20 million for a new nutrition modernization demonstration program which "would support competitive grants to translate research into evidence-based models states can use to implement more efficient and effective home-delivered and congregate nutrition programs"

• $5 million more for the National Family Caregiver Support Program

• $15 million for a new Family Support Initiative, for the "development and expansion of promising and evidence-based state and local approaches to supporting the largest provider of our nation's long-term care: families"

• Additional caregiver support with more than double funding for Lifetime Respite.

The Administration continues its commitment to national funding for elder justice, with another $21 million requested for Adult Protective Services (APS). Mandatory funding to maintain the investment in Aging and Disability Resource Centers (ADRCs) didn't materialize last year, but the Administration is now proposing to restore those resources at $20 million, entirely from discretionary funding. Falls prevention, Chronic Disease Self-Management Education, Alzheimer's Disease demonstrations and outreach, and State Health Insurance Programs (SHIPs), are level-funded in the President's budget request for the Administration for Community Living (ACL), which used to be known as the Administration on Aging.

The President's proposed Medicare budget includes net savings of $423 billion over 10 years. There are 5 proposals that would increase Medicare beneficiary out-of-pocket costs for new beneficiaries by about $84 billion over 10 years and significantly more in the following 10 years. The biggest cost shift ($66.4 billion over 10 years) would further increase Medicare Parts B and D premiums based on income, which could eventually impact beneficiaries with incomes of about

$50,000, according to NCOA. The group is "particularly disappointed" in proposals that would increase out-of-pocket health costs for sicker, lower-income seniors:
• Starting in 2019, a new $100 Medicare home health copayment, which would primarily affect lower-income women with functional impairments
• Starting in 2017, doubling brand-name prescription drug copayments and reducing generic copays for beneficiaries with incomes below 150% of poverty, which could be particularly troublesome for sicker seniors who need more medications
• Starting in 2017, gradually increasing Medicare Part B deductibles by $75, which would make it more expensive for beneficiaries to see their doctors
• Imposing a 15% premium penalty for seniors with first dollar Medigap supplemental insurance policies, including the most popular plans F and C, which would increase annual out-of-pocket costs by about $250 on average.

Beneficiaries with incomes between 100-200% of poverty are not protected against these costs and already spend an estimated 26% of their income out-of-pocket on health care – more than any other demographic group. The Administration did not propose to make the Medicare low-income protection Qualified Individual (QI) program permanent, but would only extend it from March 31, 2015 to December 31, 2016. However, the budget does include proposals to accelerate by three years the closure of the prescription drug coverage gap and improve Medicare appeals.

In a press statement dated February 3, 2015, a spokesman for the ACL said the President's FY 16 budget "will help ensure that older Americans enjoy not only longer but healthier lives. The Budget makes a number of commitments to enhance, advance, and create opportunity for older Americans, especially in the four focus areas of the 2015 White House Conference on Aging: retirement security, healthy aging, long-term care services and supports, and elder justice."

According to ACL, the President "will oppose any measures that privatize or weaken the Social Security system and will not accept an approach that slashes benefits for future generations or reduces basic benefits for current beneficiaries. The President's budget also "expands retirement opportunities for all Americans to help families save and give them better choices to reach a secure retirement. As many as 78 million working Americans - about half the workforce - don't have a retirement savings plan at work. Fewer than 10 percent of those without plans at work contribute to a plan of their own."

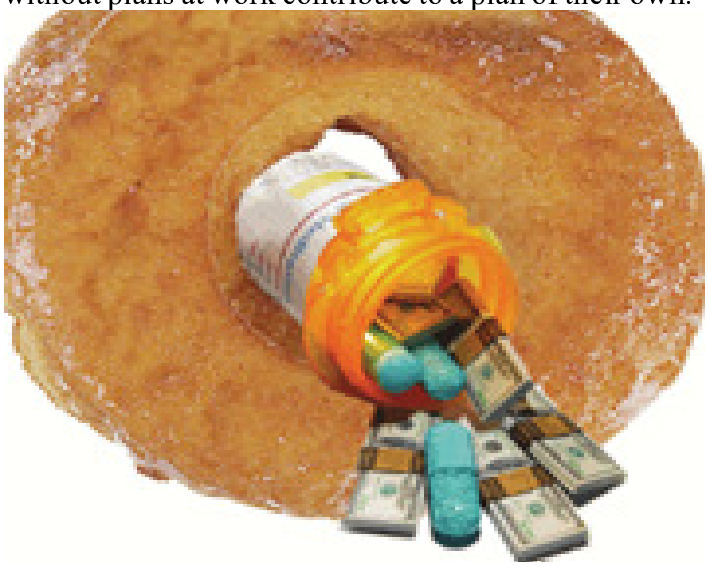


Photo 1st. Cardinal Medicare

To provide relief from increased prescription drug costs, the Budget proposes to close the Medicare Part D donut hole for brand drugs by 2017, rather than 2020, by increasing discounts from the pharmaceutical industry. The $60 million increase in nutrition services over the 2015 enacted level will buy 208 million meals for over 2 million older Americans nation-wide, helping to halt the decline in service levels for the first time since 2010. In addition, the Budget helps provide supportive housing for very low-income elderly households, including frail elderly, to allow seniors to age in a stable environment and help them access human services.

To ensure older individuals and people with disabilities receive services in the most appropriate setting, the President's budget proposes expanded access to Medicaid home and community-based long-term care services and supports. The Budget expands and simplifies eligibility to encourage more States to provide home and community-based care in their Medicaid programs, and proposes expanding and improving the "Money Follows the Person" Rebalancing demonstration, which helps States provide

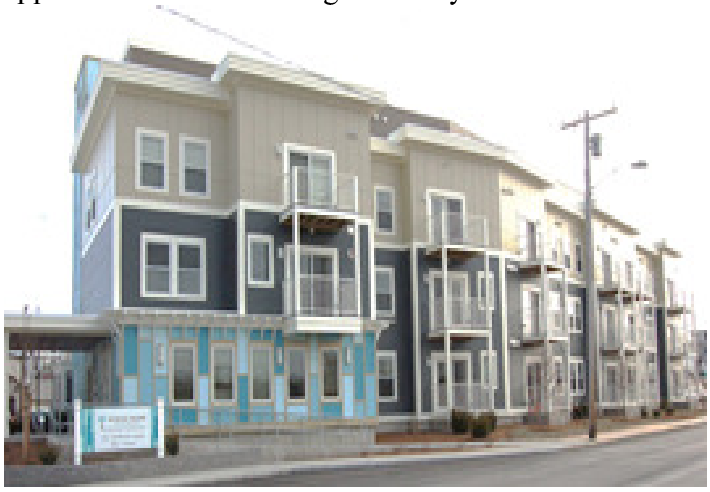
opportunities for older Americans and people with disabilities to transition back to the community from institutions.

The Budget also includes a comprehensive long-term care pilot for up to five States to test, at an enhanced Federal match rate, a more streamlined approach to delivering long-term care services and supports to provide greater access and improve quality of care.

The White House Budget also includes increased discretionary resources for the Aging and Disability Resource Centers (ADRCs) program, which make it easier for Americans nation-wide to learn about and access their health and long-term care services and support options. ADRCs support State efforts to create consumer-friendly entry points into long-term care services at the community level,

The Family Support Initiative will assist family members supporting older adults or people with disabilities across the lifespan. It will complement nearly $50 million in new resources for existing aging programs that are already providing critical help and supports to seniors and their caregivers, such as respite and transportation assistance. To support evidence-based interventions to reduce elder abuse, neglect and financial exploitation, the Budget includes $25 million in discretionary resources for Elder Justice Act programs authorized under the Affordable Care Act. These resources will support standards and infrastructure to improve detection and reporting of elder abuse; grants to States to pilot a new reporting system; and funding to support a coordinated Federal research portfolio to better understand and prevent the abuse and exploitation of vulnerable adults.

The President's FY 2016 budget request for the Department of Transportation (DOT) includes $18.4 billion—a $7.4 billion increase over FY 2015 enacted levels—for the Federal Transit Administration (FTA), which supports mobility programs for seniors and people with disabilities. Funding for these programs under Section 5310 would receive a $6 million increase in FY 2016 for a total of $264 million. FTA also funds The National Center on Senior Transportation to provide technical assistance on best practices for non-governmental organizations and public agencies and seed grants that demonstrate creative approaches to increasing mobility for older adults.



Feldman Seaside Apartments, Wintrhop

In the housing field, the President's budget provides a total of $455 million for the Housing for the Elderly (Section 202) and $177 million for Housing for Persons with Disabilities programs (Section 811), which would be a boost in spending for both programs (increases of $35 million and $42 million, respectively). The Section 202 funding level includes $365 million for existing operating subsidy contracts, $77 million for housing service coordinators, and $10 million for new awards to supportive housing models that coordinate with HCBS.

In senior employment programs, the OAA Title V Senior Community Service Employment Program (SCSEP) remains in the Department of Labor. Advocates wanted it moved to ACL. The program would be level-funded at $434 million in FY 2016. The President proposed continuing current levels of $202 million for the three programs under the Senior Corps umbrella—RSVP (formerly the Retired Senior Volunteer Program), the Foster Grandparent Program (FGP) and the Senior Companion Program (SCP). The Administration did not propose a dramatic restructuring of the Senior Corps program that was included in last year's budget request—relocating FGP and SCP to other areas of the Corporation for National & Community Service (CNCS) and cutting RSVP—but the President's budget does include proposed changes to the program to ensure that grants are competitively awarded and programs are evidence-based.

Two former AoA Title II demonstrations have secured mandatory funding: the Chronic Disease Self-Management Program (CDSMP), which received $8 million for FY 2015, and Elder Falls Prevention, which received $5 million in FY 2015. The President has recommended continuing these investments in FY 2016 at the same levels, administered by ACL.

Another program included in the President's budget is the Alzheimer's Initiative, which provides total funding of $14.7 million to fund both Alzheimer's outreach and awareness campaign activities and long-term services and care caregiver support programs.

"Taken together," says ACL, "these and other initiatives in the Budget will help to change the aging landscape in America to reflect new realities and new opportunities for older Americans, and they will support the dignity, independence, and quality of life of older Americans at a time when we're seeing a huge surge in the number of older adults."

In the coming weeks, Congress will hold hearings on the President's recommendations. A formal budget resolution is then prepared by budget committees in each chamber in March. A congressional budget resolution sets the total level of spending authority and revenues, with specific allocations to each major budget category. This non-binding plan, if adopted by April 15, then guides the appropriations committees, as well as tax and finance panels, for the rest of the year. According to n4a, "Congress rarely gets fully on the same page, with one or both chambers failing to pass a resolution. However, this year, with Republicans in charge of both the House and the Senate, hopes are high for an agreed-upon budget resolution. If passed by both chambers, budget leaders will have the authority to send 'reconciliation instructions' to the committees with jurisdiction over taxes and mandatory programs, which could mean major changes to those programs and revenue streams."

In late spring and through the summer, the House and Senate Appropriations Subcommittees of jurisdiction make the specific programmatic determinations for each discretionary line item. This takes several months to move through committee. Like all other legislation, the House and Senate must agree on appropriations bills. Achieving agreement further lengthens the process. Although appropriations bills are supposed to be finalized by October 1, this deadline is usually missed.

Older Americans Act Bill Filed in U.S. Senate

Photo: Sen. Lamar Alexander. Huffington Post

In related federal action, the U.S. Senate Health, Education, Labor and Pensions (HELP) Committee leadership re-introduced in late January a bipartisan compromise bill to reauthorize the Older American Act. Although the Older Americans Act is required under law to be reauthorized every four years, the law has not been reauthorized by Congress since 2007.

The new bill, S. 192, is largely the same as the bill that received Senate Committee approval in the 113th Congress, but it includes a funding formula compromise to address funding issues that stymied progress last year, according to the National Association of Area Agencies on Aging (n4a).

On January 20, HELP Committee Chairman **Lamar Alexander** (R-TN), Ranking Member **Patty Murray** (D-WA), Senator **Bernie Sanders** (I-VT) and Senator **Richard Burr** (R-NC) introduced the Older Americans Act Reauthorization Act of 2015 (S. 192). The new measure is very similar to S. 1562, which was the bill considered last Congress to reauthorize OAA. The current bill adds a new provision to address the funding formula agreement, and it would authorize the Act for three years. The funding formula compromise al-

ters the current hold harmless provision, which protects state OAA funding from falling below FY 2006 levels. N4a says that the FY 2013 sequester did not override this provision, leading to double-digit cuts for many of the fastest-growing states and lower-than-average cuts for the states with slower growing aging populations. Absent increased funding for the Act overall, Senators struggled to respond to the concerns of the fastest-growing states without directly reducing funding to other states.

Under the proposed funding compromise, the hold harmless provision would be replaced by an alternative calculation that stipulates that for the next three fiscal years (FY 2016–FY 2018), no state would receive less than 99% of what it received in the previous year. In FY 2019, unless Congress acts to update the law again, the hold harmless resets so that no state shall receive less than 100% of what it was allocated in FY 2018.

Provisions in the new reauthorization bill do address definition updates for elder justice, Aging and Disability Resource Centers, and a new emphases on evidence-based health and wellness programs and coordination of human services transportation. The Act would take an important step toward better ensuring quality home care by directing the Assistant Secretary to develop a consumer-friendly tool to assist older individuals in choosing home and community-based services.

Mass Senior Action Rallies for Medicare Savings Eligibility

MassHealth operates a joint federal-state program that assists seniors in paying for Medicare health costs, though seniors such as Mattapan resident **Edna Pruce** say the state's restrictions are too burdensome. "We must open the doors to MassHealth," Pruce, a resident of Mattpan, told the *State House News*. Pruce attended a Mass Senior Action Council rally at the State House. According to Pruce, "Once you turn 65, you can have no more than $11,670 in income and no more than $2,000 in assets" to qualify for MassHealth.

The Medicare Advocacy Project (MAP) notes that Older Americans who prepared for retirement find that their savings and life insurance policies are "working against them" for Medicare savings eligibility. Alabama, Arizona, Connecticut, Delaware, Maine, Mississippi, New York, Vermont and the District of Columbia have all eliminated asset limits. Connecticut, Maine and D.C. have raised their income limits, according to MAP.

Senior Action said Senator **Dan Wolf**, a Harwich Democrat, and Rep. **Denise Garlick,** a Needham Democrat, have filed bills that would ease the eligibility restrictions in Massachusetts.

"Thousands of seniors struggle to pay for their healthcare," Senior Action says, "many cut back on other necessities to pay for needed care. While Medicare provides a foundation for health security, the large out-of-pocket costs and coverage gaps make it difficult for many to afford the care they need." MSAC's legislative campaign is called "Bridge the Gap."

"MassHealth provides a wrap-around to Medicare for low-income beneficiaries, helping to fill the gaps. Twelve states have increased the Medicaid asset limit for seniors above the federal minimum," Senior Action says. "Massachusetts has not."

Mass. Health Policy Commission: Wasteful Health Spending

The Health Policy Commission (HPC) has estimated that 21 to 39 percent of healthcare spending in Massachusetts ($14.7 to $26.9 billion based on 2012 spending) can be considered wasteful, based on national estimates of spending that could be eliminated without reducing the quality of care patients receive.

Many opportunities for waste reduction exist, including reducing overuse of unnecessary tests and diagnostics and enhancing administrative simplification efforts on the provider and payer side. These findings were part of the HPC's *Cost Trends Report for 2014*.

Readmissions and avoidable ED visits represent areas for improvement in Massachusetts. Both require multi-faceted solutions, likely involving a combination of aligned financial incentives, provider commitment to change, and effective patient \

engagement. Community collaborations are particularly important for reducing avoidable ED visits.

Overall, Massachusetts' Medicare readmissions rates are higher than the national average and the Commonwealth ranks ahead of just four states and the District of Columbia on readmission rates (the composite average of the 30-day readmission rates for heart attack, heart failure and pneumonia). The most notable initiative is CMS' Medicare Hospital Readmissions Reduction Program (HRRP), which began reducing Medicare payments for hospitals with excess readmissions for certain conditions on October 1, 2012. The magnitude of the penalty is based on the extent to which a hospital's readmission rate exceeds the national average, after an adjustment for patients' clinical characteristics. The maximum penalty is a 3 percent cut in Medicare payments for all patients of a given hospital, not just those readmitted. This year, the penalty will apply to payments from October, 2014 through September, 2015. In Massachusetts, 55 hospitals, representing 80 percent of all hospitals in the Commonwealth, will be penalized. Massachusetts has the eighth-highest average hospital penalty percentage in the nation, suggesting the potential to improve clinical performance.

In 2014, the Massachusetts Hospital Association (MHA) defined a statewide target of a 20 percent reduction in preventable readmissions by 2015, in line with the goals of the national Partnership for Patients. However, despite participation in these promising intervention programs, risk-adjusted readmission rates in Massachusetts remain relatively high, as evidenced by the Commonwealth's penalties and rankings. One challenge in motivating significant change is that when seeking to reduce readmissions, hospitals face conflicting financial incentives; as readmissions increase revenue for the hospital, and training staff and implementing new programs incur costs to the hospital. While avoiding the HRRP penalty may offset the lost revenue for some hospitals, the financial trade-offs likely vary by hospital. These considerations suggest that other incentives for change are needed besides penalties. The healthcare system needs further adoption and enhancement of payment and care-delivery reforms that promote care coordination and high-quality patient outcomes.

Promising approaches combine integrated care delivery — such as patient-centered medical homes (PCMHs) and Accountable Care Organization (ACOs) — with aligned payment incentives, such as global or episode-based payments. In addition to payment incentives, public health interventions and social support services are necessary components for addressing drivers of readmissions. Patients living in low-income neighborhoods are 24 percent more likely than others to be readmitted, after demographic characteristics and clinical conditions were adjusted for. Research documenting socieconomic and environmental disparities in readmission rates indicates the importance of including investment in community drivers as part of any comprehensive solution for reducing readmissions.

High rates of ED use may be an indicator of both sub-optimal care and inefficient delivery. When patients seek care at the ED for conditions that are non-emergent, treatable in primary care settings, or avoidable, healthcare resources are inefficiently and inappropriately utilized. Based on national data, Massachusetts ranks 20th in the U.S. for the highest rate of ED visits per 1,000 residents, and Massachusetts residents use the ED 12 percent more than the U.S. average. In 2012, avoidable outpatient ED visits accounted for almost half (48%) of total ED visits. While growth in visits for most categories of ED use remained relatively flat between 2010 and 2012,

visits for behavioral health conditions (including mental health and substance use disorders) grew sharply, at about 5 percent a year, totaling about 6 percent of all ED visits in 2012.

MassHealth has adopted a number of innovative programs that strengthen the outpatient care system, including implementing the One Care program, which provides patients with an independent long term services coordinator who can coordinate a broad array of services needed by the most vulnerable members.

According to the Health Policy Commission, post acute care offers a significant opportunity for reducing wasteful spending. Following discharge from an inpatient hospital, a variety of post-acute care (PAC) settings are available to patients needing nursing or rehabilitative care. Previous Health Policy Commission (HPC) research found that the rate of discharge to PAC services in Massachusetts is more than double the U.S. average, even adjusting for differences in patient characteristics. PAC use in Massachusetts is higher than in the U.S. across all payer types, for both home health use and institutional setting use. Overall, in 2011, only 58 percent of patients in Massachusetts had a routine home discharge following an inpatient stay, compared to 70 percent of patients nationwide. This trend of lower rates of routine home discharge following an inpatient stay was consistent across all payers in Massachusetts. For Medicare patients, rates of discharge were higher for both home health care and institutional care. Annual Medicare spending in Massachusetts for PAC totaled an estimated $1.85 billion in 2012. Medicare spending averaged $4,900 per home health discharge and $15,500 per institutional PAC discharge. If Medicare patients in Massachusetts had the same PAC use distribution as in the U.S. overall, health care savings in Massachusetts would total almost $400 million a year, or about 22 percent of total Medicare PAC spending in Massachusetts. Even adjusting for age, Massachusetts has higher rates of people living in nursing homes, which would also impact PAC discharge patterns, in that a nursing home resident with a hospitalization would have to be discharged back to an institutional setting. However, rates are higher among Medicare, Medicaid, and commercial payers, and PAC use rates in Massachusetts are still twice as high as in the U.S. overall, adjusting for multiple risk Factors. Therefore, differences in practice patterns appear to play a driving role. Factors influencing providers' referral decisions and practice patterns include institutional culture and individual provider practice, the availability of PAC facilities or open beds in a given market, the hospital's or family's proximity to PAC providers, patient preference and ability to self care, availability of family caregiver support, and relationships among providers, such as when a hospital prefers to discharge its patients to PAC providers with whom it has system affiliation or contractual relationships.

Introducing a common tool to be used by hospitals for discharge planning would require upfront investment in training staff and ongoing resources in staff time, but could ultimately provide valuable assistance in improving discharge patterns to optimize patient outcomes, patient satisfaction and value of care. These new requirements present an important opportunity to improve discharge planning and patient care. Providers should use the new data to innovate on improving discharge planning and patient outcomes, as well as evaluating and sharing best practices.

For a particular patient, discharge to a skilled nursing facililty, IRF, or long term chronic hospital might be the right option for the patient's needs. However, given the relatively high cost of institutional PAC services (SNFs, IRFs, LTCHs) and the goal of ensuring that patients are in the least restrictive setting necessary for the desired outcome, payers and providers should strongly consider adopting evidence-based tools to improve discharge planning, especially to target use of institutional settings to only the most appropriate patients.

The healthcare system in Massachusetts, like the U.S. overall, is characterized by a high concentration of spending on a small percentage of patients, where one-fourth of all patients represent close to 85 percent of total medical expenditures. In the commercial adult and Medicare populations, persistent HCPs—defined as patients who are in the top 5 percent in total medical spending for three consecutive years—represent less than one percent of their populations, but account for roughly 10 percent of commercial spending from the top three commercial payers (average total spending of $66,635 per patient) and nearly six percent of total Medicare spending (average total spend-

ing of $93,759 per patient) over the three years. Controlling for clinical, regional, and demographic characteristics, several clinical conditions were found to predict persistently high total costs among commercial adults and Medicare populations. Some were "catastrophic" illnesses, like cancer, while others were chronic conditions such as arthritis, asthma, and diabetes, along with behavioral health conditions, including serious and persistent mental illness (SPMI), substance use disorder, and other mental health conditions. While catastrophic illnesses tend to be most predictive of persistently high costs, chronic medical conditions and behavioral health conditions tended to be the most prevalent among HCPs. For chronic conditions more generally, each additional condition was associated with a 50 to 60 percent increase in the odds of being a persistent HCP (or 1.5 for commercial and 1.6 for Medicare.) Patients with one or more behavioral health diagnoses have higher medical care expenditures and greater care needs, highlighting the need for increased attention to the way behavioral health conditions are identified and treated. Effective integration can create efficiencies in care delivery and improve outcomes.

Home Health Agency Turns to House Calls

"The U.S. healthcare system is in the midst of the most dramatic period of change in recent memory," says **David Rehm.** "Almost overnight, there has been a shift from volume to value. Quality, cost and outcomes are the critical factors driving this transformation."

Rehm is the President & CEO of HopeHealth, a non-profit healthcare organization, which delivers an array of medical care, care management and support services throughout eastern Massachusetts. The HopeHealth services include: Hope Hospice; Hope Palliative Care; Hope HouseCalls; Hope Dementia & Alzheimer's Services; Hope Care for Kids; Hope Community Care.

Rehm recently told *AT HOME* how HopeHealth is addressing some of the health care cost drivers in Massachusetts:

"It has never been more important for healthcare organizations to utilize the available resources to achieve optimal outcomes — not only for individual patients — but also for the entire population of patients for whom they are responsible. All of this is taking place in an environment that is increasingly consumer driven. The users of our healthcare system are more informed and more involved with their healthcare decisions than ever before.

Some of these changes came as a result of the Affordable Care Act (ACA). Longstanding concern with the rising cost of healthcare for consumers, employers and government are also key drivers. A major focus is concern over the combined effect of the Baby Boomer population, with rising costs on the Medicare and Medicaid systems that will become an even larger part of our nation's healthcare spend.

David Rehm. Photo: HopeHealth

For healthcare providers like HopeHealth, the recent changes to the Medicare system are particularly impactful. The ACA created a multi-year program of Medicare payment reductions that were amplified by federal budget sequestration, adding a two percent reduction. Simultaneously, there are new initiatives that focus on quality and patient outcomes, directly impacting providers' Medicare revenue. Medicare providers are committed to a multi-year initiative to find operating efficiencies while investing in new systems that can monitor and improve the quality of the care we deliver. Innovation is an essential component of strategic planning, as well as our day-to-day operational reality.

Fortunately, there are significant opportunities for cost reduction through the achievement of better patient outcomes. Recent attention focused on a relatively small number of patients that drive the majority of healthcare costs. Ten percent of patients consume 65% of our healthcare spend, while only five percent account for 45% of this spend. These are patients with serious illness, the majority of whom have multiple chronic, incurable conditions. Patients with five or more chronic conditions see ten or more different physicians annually, taking multiple medications prescribed by several different providers. Their care is fragmented, complex and often poorly coordinated. For example, one of the leading causes of hospitalization of these patients is adverse medication interaction. HopeHealth has been dedicated to the care of this seriously ill population for our entire thirty-four year history. We have been serving the terminally ill through our hospice program which provides comprehensive, team-based and coordinated care for the patient and their family. Recently, we began seeking new avenues to leverage our core competencies to benefit a broader population of patients with serious illness.

Our Hope HouseCalls service is one example of an innovative approach. Primary care physicians bring preventative care to the homes of those with medical and/or cognitive conditions that make it difficult, or even impossible, to regularly access office-based physician care. For this population, delivering care in the comfort and safety of their home is the most cost-effective and care-effective model. The house call model has been gaining increased recognition across the country for its potential to dramatically reduce emergency room visits and unnecessary hospital admissions and readmissions. According to the American Academy of Home Care Medicine, the cost avoidance of one emergency room visit more than pays for ten physician house calls. And, house call visits prevent associated costs such as special transport and lost caregiver productivity, while greatly improving customer satisfaction.

In Massachusetts, there are reported to be 120,000 individuals 65 and older who have Alzheimer's disease. Through our Hope Dementia & Alzheimer's Services program, we provide an array of services to this rapidly growing population of patients and their heavily burdened caregivers. Our newest service for this population is Specialized HouseCalls, which provides counseling, emotional support, education, behavioral management, care plan development, and home safety planning. Delivered by licensed, independent social workers, the service is designed to address the issues these caregivers experience on a daily basis.

These are just a few examples of the type of innovation that can succeed, despite increasing challenges. In order to meet the full range of healthcare needs in this changing environment, it's essential that all sectors of the healthcare system collaborate. We need to adapt and adjust effectively while our core reimbursement rates are being reduced. We're serving patients in an environment where we have to be cost-effective while focusing on our broader mission of enhancing quality of life. With creativity, courage, and collaboration, we're finding the two are not mutually exclusive."

Elder Lobby Day on Beacon Hill

Monday, March 2, 2015

11 AM, Nurses Hall, State House

Health Care, Economic Security & Independence At Home

Sponsors: AARP Massachusetts, Home Care Aide Council, Home Care Alliance,Jewish Community Relations Council/ Boston, Mass Association of Independent Living Centers, Mass Association of Older Americans, Mass Council of Adult Foster Care Providers, Mass Councils On Aging, Mass Home Care, Mass Senior Action Council, 1199SEIU United Healthcare