At Home

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With Mass Home Care

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Al Norman, Editor

Budget Amendments Seek Funds for Home Care

On April 15, 2015, the House Ways and Means Committee released its FY 16 budget. The HWMs budget cut 4 key elder home care accounts by a total of $4.7 million below Governor **Charlie Baker's** proposed FY 16 budget. The key cuts came in the following accounts:

• -$3,092,614 cut (-3%) in the basic home care purchased services account (9100-1630)

•-$642,000 (-30%) cut in the account that pays for congregate housing (9110-1660)

•-$871,884 (12%) cut in the elder nutrition meals on wheels account (9110-1900)

• -$180,000 (1%) cut in the Prescription Advantage account (9110-1455)

•-$4,786,496 TOTAL CUTS below Governor's budget.

The only significant increase over Governor Baker's budget was in the Council on Aging account, which rose by $1.68 million, a +12% increase in COA funding. The largest elderly cut—over $3 million---came in the home care purchased services account. A cut of this magnitude would foreclose the opportunity to continue the "intensive care management" program, which works with elders with behavioral health needs who are resistant to accepting services, putting at risk their options for living independently at home.

Dan O'Leary, President of Mass Home Care, said advocates began immediately to line up House sponsors for a series of amendments to restore the lost funds:

• An amendment by House Chair of the Elder Affairs Committee, Representative **Denise Garlick** of Needham,

to restore $3 million to the home care services account.
• An amendment by Representative **Chris Walsh** of Framingham, a member of House Ways and Means, to add $5 million to the Aging Services Access Points account for personnel and operations costs for the 27 agencies who manage the home care program statewide. This personnel line item funds care managers, RNs, and other direct care staff, and is now 12% lower than it was in FY2007.
• An Amendment by Second Assistant Majority Leader **Paul Donato** of Medford, to restore $871,884 in elder nutrition funding. Donato's amendment would add nearly 140,000 meals on wheels back into the nutrition budget.

Rep. Denise Garlick

The Home Care Aide Council reports that a $3 million wage increase for homemakers in Massachusetts was not included in the House Ways and Means budget. This fund would build on last year's successful campaign that passed a $6.1 million wage add-on for the workers who go into the homes of the elderly to provide personal care supports. The Council says that Representative **James O'Day** of West Boylston, who spearheaded the wage campaign in FY 15, has filed an amendment to appropriate $3 million from the Community First Trust Fund for a FY16 Homemaker Salary Reserve. This request will support essential workers by providing an annualized wage and benefit increase of approximately 32 cents an hour to over 26,000 homemakers and personal care homemakers across the state.

Mass Home Care's goal is to restore some of the cuts made below Governor Baker's budget. "Our efforts to keep people living at home have saved taxpayers $853 million this year alone," O'Leary noted. "We have helped drop nursing home use by 34% compared to the year 2000. It's a smart investment to expand funding for community care, and it attracts extra federal matching money. We need to focus on some of the most complex care clients who need a robust system of supports in order to avoid institutional care. This is what the Governor's funding level would have allowed us to do." O'Leary said Mass Home Care will pursue the issue of raising the income eligibility level for the home care program when the budget moves to the Senate.

The House is expected to begin the FY 16 budget debate in the week of April 27th.

Mass Food Stamp Decline Raises Concerns

Massachusetts is losing over $9.5 million per month in federal SNAP nutrition dollars according to research from the Massachusetts Law Reform Institute.

Since the spring of 2014, low income households and the anti-hunger agencies that serve them have faced significant access barriers in getting--and keeping--SNAP benefits. The access barriers are the direct results of the state's hastily implemented "business modernization."

In mid April, Mass Home Care and the Massachusetts Councils on Aging (MCOA) sent a joint letter to the Department of Transitional Assistance expressing concerns that the drop in SNAP enrollment was a very serious issue for low-income seniors.

According to MLRI, "Massachusetts has created an impenetrable bureaucracy coupled with unfiltered, erroneous data matching; extreme verification demands; and automatic case closings without worker review. Food pantries have reported a spike in demand for emergency food, and families are losing direct certification for free school meals. The

SNAP participation rate in Massachusetts is declining at a much faster rate than the rest of the country. The individual SNAP participation rate in Massachusetts is declining at 8 times the national average. Household SNAP participation rate is declining at 7 times the national average. Between December 2013 and December 2014, the number of SNAP recipients in Massachusetts fell by 8.8% --a drop of 77,140 individuals in a 12 month period. The national average decline for individual recipients during the same time period was 1.1%.

USDA data shows the average SNAP benefit per individual in Massachusetts is $123 per month. With a decline of 77,140 individuals, the Massachusetts economy is losing over $115 million in food benefits annually. According to the USDA's Economic Research Service, every $1 in SNAP creates an economic stimulus of $1.72, so Massachusetts is losing $200 million per year in economic activity.

MLRI says the precipitous SNAP participation drop in Massachusetts is due to a number of factors:

• Erroneous data matching: In the spring of 2014, the Department of Transitional Assistance (DTA) changed its data matching process resulting in thousands of erroneous SNAP denials/closings. Incorrect data matches result in clients having to prove they no longer work at businesses (sometimes from months or years in the past); correct erroneous wage matches of non-countable income including earnings of children, training stipends, college work study and income already reported to the state. DTA's computer system was automatically issuing wage match notices and automatically closing cases without SNAP worker review to determine if requested documents were sent in or even needed. As of March 23, 2015, DTA has temporarily stopped the automatic mailing of letters to clients about wage matches-- but the system is far from fixed and thousands of clients have been hurt in the past year by this policy.

• Documents Not Processed: Documents are put in the case record but not processed in a timely way, resulting in denials and case closures. Clients are asked to send in documents multiple times. Food pantries and other community organizations are reporting that documents sent to the DTA "Document Management Center" are not being acted on or reviewed by SNAP workers. SNAP applications and renewal forms filed are frequently not acted on until advocate contacts DTA. Many SNAP workers do not know how to find on-line SNAP applications and clients are told to re-apply. Food pantries report high amount of application denials for "lack of verifications" already sent to DTA.

• Ineffective Phone and Staff Capacity to Communicate with SNAP Clients: The DTA Assistance phone line was built to handle 6-7,000 calls per day, but DTA Central reports it was receiving between 20-25,000 calls per day--meaning many phone calls were dropped or callers could never get through the line. Clients are not receiving pre-scheduled DTA phone calls for the required application interview. It continues to be very challenging for clients to get through the DTA Assistance Line to get an interview or ask questions. Clients must call multiple times to get through, using up valuable cell phone minutes. The DTA Assistance line automatically hangs up when too many people are calling in, making it impossible for low wage workers and clients with no regular phone access to get through.

• Families, Seniors Turned Away from Local DTA Offices: Since October 2014, DTA offices have refused to accept hand-delivered documents. Clients who are anxious that the state receive their paperwork and attempt to hand deliver them are routinely told they must "mail documents to Taunton" or they can "wait 2-3 hours" to

hand a document to a DTA worker. Despite repeated requests, DTA has refused to amend the process to permit a drop off policy where a clerk simply date stamps and ships paperwork to the DTA Document Center. Walk-in clients are often not screened for expedited (emergency) SNAP benefits upon first contact, in violation of federal law, and instead handed paper applications to mail on their own. Walk-ins are also sometimes told to leave and call DTA Assistance Line for help with their case.

• Lack of Adequate Staff Training: Six months into "Business Process Redesign" or modernization, inadequate staff training continues to be an issue. Community organizations report that many DTA workers do not understand basic policy, demand incorrect documents and erroneously deny or close cases that get reopened by superiors with some advocacy. Many DTA workers do not appear to understand how to find and work on a new application or documents submitted to the DTA Document Center. Many workers refuse to assist clients in gathering required information, in violation of federal SNAP law.

In a March 15, 2015 letter to Governor **Charlie Baker,** The Greater Boston Food Bank explained the SNAP challenge facing elders: "Each day, many are forced to make difficult choices between buying enough nutritious food to stay healthy and paying for critical bills such as medical, housing and utility expenses. GBFB currently assists seniors to apply for these benefits through our SNAP Outreach program, and we have seen a significant amount of their cases closed for erroneous reasons. Seniors in particular are vulnerable because they live on fixed incomes while costs of living increase. They cannot keep up. For many, purchasing food becomes the last priority. By not having enough to eat and sacrificing nutrition, their health is further jeopardized, which perpetuates the financial challenges they already face. The negative health benefits that seniors face can take a toll, but we also know that this situation is remediable through participation in effective programs such as SNAP. In many ways, SNAP serves as a safety net for many seniors by ensuring that they are protected from the harmful effects of food insecurity. The GBFB told the Governor about the case of a 78 year old man who "submitted his application and all necessary documents in the beginning of December. He completed his phone interview and was told he was all set, yet never heard anything further from DTA. He recently contacted our SNAP Outreach Coordinator inquiring about his application. We learned his application was never 'wrapped up' by the case worker and due to the new system structure; it was never looked at again---until our Outreach Coordinator inquired. The client reported he had frequently tried to follow up via the DTA hotline and was unable to get through. Had he not been connected to an advocate, he would have missed out on the $194 per month he desperately needs." The Food Bank wrote about another case of an 80 year old woman whose benefits were shut off in January. "The elder was unaware that her case had been closed until she went to the grocery store to use her card and was told there was no money on it," GBFB wrote. "This was an upsetting and mortifying experience for this client..After investigating, we learned that her case was listed as closed due to lack of recertification and that she had to reapply because her case had been closed for more than 30 days… it was confirmed that the client had indeed submitted her recertification in December, but it was never processed. In turn, she should never have been made to reapply and her case should have never been closed. This client almost lost out on $776 in benefits due to the disorganization and inefficiency of this new system."

According to GBFB, "DTA has created a system that is too difficult to navigate and information verification requires excessive demands that has

no bearing on current eligibility. The decision to rush into a major modernization redesign in 2014 coupled with what appears to be extreme demands for verifications of out-of-date information and automated case closures due to unfiltered data matching, is extremely troubling. Requiring families to provide documentation for jobs worked in the past is not only excessive and unnecessary, but impacts health and causes confusion among a population that is already weary of taking advantage of these programs due to fear and pride."

"We urge the Baker Administration to investigate the thousands of SNAP case closures in Massachusetts," the Greater Boston Food Bank wrote, "to end automatic closures of cases due to data matching, and to look to other means tested programs for guidance on successfully enrolling and retaining eligible participants. We bring this information to your attention because we are concerned about the lasting impact it will have on the health of our very vulnerable senior citizens."

Thomas G. Massimo, acting director of the Department of Transitional Assistance, told *The Boston Globe* that these concerns were serious enough to suspend the automatic mailing of the computer-generated letters.. The letters are now reviewed by staff before going out. Massimo said the new data system saved about $12 million in food stamp overpayments to 100,000 households, but it is unclear how many of those households were entitled to the benefits. "I don't know that any of them are in error," Massimo said. "We are concerned with making sure we're not putting artificial barriers in the way of clients, but we do have a program integrity obligation as well."

State Rep. **Ellen Story**, D-Amherst, told the *Springfield Union-News* that she was "appalled" to hear of the issues stemming from the DTA's changes. Story said she plans to send a letter to state administration detailing the problem. "I think that the governor and the new [Secretary of Health and Human Services Marylou Sudders] don't have to take any responsibility for this, so hopefully they will not be defensive and they will fix it," she added.

As part of the FY 16 budget debate on Beacon Hill, the House of Representatives will have before them an amendment, filed by Representative **Marjorie Decker** (D-Cambridge), a member of the House Ways and Means Committee, which would bar DTA from denying or terminating food stamps or cash benefits if the household has sent documents to DTA and DTA has not yet determined the effect of the documents on eligibility. Decker's amendment would also require DTA to offer households the option of authorizing DTA to obtain information from third parties such as employers to obtain documents relevant to eligibility.

Bonner Named New Secretary of Elder Affairs

EOEA Secretary Alice Bonner

The state's Executive Office of Elder Affairs has a new Secretary. **Alice Bonner,** PhD, RN was appointed on April 17th as Secretary of Elder Affairs. Bonner brings 30 years of experience working on behalf of older adults in the Commonwealth. "The fastest growing segment of the population includes those age 85 and older. It is critical we have a strong leader who will listen to and meet the needs of these and all older adults and their caregivers" said Secretary of the Executive Office of Health and Human Services, **Marylou Sudders**. "Dr. Bonner's deep commitment, particularly around affordable housing, transportation, nutrition services and dementia care are

vital to ensuring choice and autonomy for older adults."

Bonner has held a longtime interest in the care of older adults. She is an Associate Professor at the School of Nursing in the Bouve College of Health Sciences at Northeastern University. Prior to that, she served as a deputy associate regional administrator for the Northeast and director of the Division of Nursing Homes for the federal Centers for Medicare and Medicaid Services (CMS) at the US Department of Health and Human Services. She also worked as Bureau Director of Health Care Safety and Quality at the Massachusetts Department of Public Health and served as Executive Director for the Massachusetts Senior Care Foundation, a nursing facility-led group.

While at CMS, Bonner led a national initiative to improve dementia care. She has served on a number of national panels related to the National Alzheimer's Strategic Plan and other policies. Among her honors: the **John L. Mackey** Award for Excellence in Dementia Care from Johns Hopkins (2014), **Cernoria Johnson** Memorial Advocacy Award from the Consumer Voice (2013) and the Columbia University-Presbyterian Hospital School of Nursing Distinguished Alumni Award for Health Policy. Bonner's 30-year career as a clinician, researcher, educator and policy-maker has focused on models of care that promote optimal health, autonomy and quality of life for older adults.

Bonner received her undergraduate degree from Cornell University, her nursing degree from Columbia University, her Masters in Gerontological Nursing from the University of Lowell and her PhD in Nursing from the University of Massachusetts, Worcester. "I am extremely grateful to Governor Baker and Secretary Sudders for the opportunity to work with them to promote EOEA's mission: to ensure the independence and wellbeing of older adults, their families and caregivers," said Bonner, who will begin her new role at EOEA on June 1. "I look forward to hearing from the individuals EOEA serves including those living at home, in senior housing, assisted living, nursing homes and other settings, as well as people in state government, our stakeholders and partners."

The state's share of elderly population will rise to 26% by 2030. The Executive Office of Elder Affairs provides support services, information, options counseling, and education/training to assist older adults in making decisions about health care, housing, jobs, nutrition, volunteering and lifestyle. EOEA contracts with 27 Aging Services Access Points (ASAPs) and 23 Area Agencies On Aging to implement many of its community based programs.

MassHealth Has New Head, New Restructuring Plans

MassHealth Assistant Secretary Dan Tsai

The MassHealth insurance program has new staff and a new mission.

On January 22, 2015, Governor **Charlie Baker** announced that he had appointed **Daniel Tsai** to manage the $15 billion MassHealth program. Tsai, formerly a partner at McKinsey & Company, assumed the new role of Assistant Secretary in the Executive Office of Health and Human Services. MassHealth was previously run by a Director.

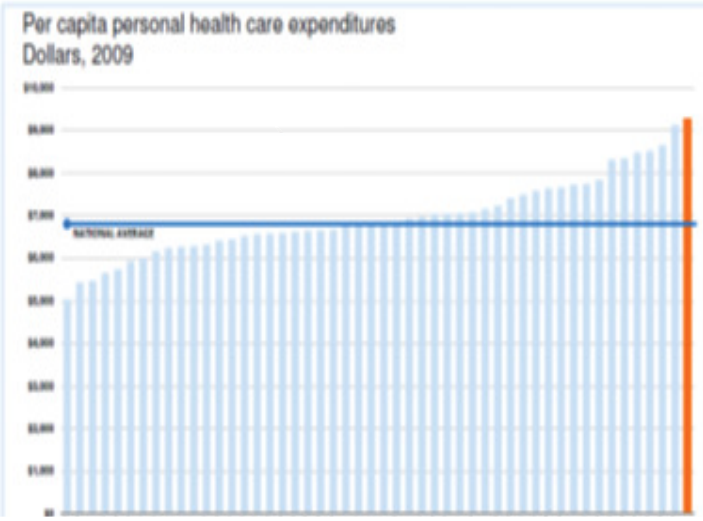
"Massachusetts has long been a leader in healthcare reform, but we must always look for ways to improve on how we serve those in need and ensure our residents have the information needed to find affordable coverage," said Governor Baker in a press statement. "I am confident in Daniel's ability to fill this new and expanded role as Assistant Secretary to facilitate further cooperation among

agencies who assist and care for our Medicaid population.

"I believe deeply in the mission of MassHealth and the important services it provides for our most vulnerable populations," Tsai said. "I am humbled and honored to have this opportunity to work with Governor Baker and Secretary Sudders to enhance the voice of these individuals in state government."

At McKinsey, Tsai worked in the company's Healthcare Systems and Services practice, co-leading the firm's Medicaid service line. He has significant experience designing and implementing innovative, state-wide payment systems for Medicaid, Medicare and Commercial populations, and has worked closely with multiple Medicaid programs, private payers, and Fortune 50 health services companies. Tsai regularly leads workshops and conference sessions on health care payment and care delivery strategies and holds an A.B. in Applied Mathematics and Economics from Harvard.

Massachusetts spends more on health care than any other state



MassHealth provides access to critical, affordable and quality health care to the Commonwealth's most vulnerable populations in the communities where they live. MassHealth serves 1.7 million low-and moderate-income members, and individuals with disabilities, or approximately one in four Massachusetts residents. Through grants and demonstrations, MassHealth seeks to enhance the ability of hospitals and community health centers to more efficiently and effectively deliver integrated health care services to the MassHealth members they serve.

The Baker Administration also revealed more about its restructuring plans for MassHealth and new staffers added to the MassHealth team. The Executive Office of Health and Human Services (EOHHS) announced on April 16th changes to the organization that will support the move toward a more patient-centered and accountable system of health care. "This is an important step to creating a sustainable Medicaid program and improving how we serve the state's most vulnerable residents," said **Marylou Sudders**, Secretary of EOHHS. "These changes will put the emphasis on improving the effectiveness and quality of care provided."

Under the restructuring, a new unit at MassHealth will shift MassHealth from the current fee for service payment system to new payment models focused on keeping people healthy and lowering costs. "Our top priorities for MassHealth include improving customer service, moving towards more accountable and coordinated care for patients, better integrating behavioral health and other supportive care, and finding ways to better manage our existing programs," said Dan Tsai.

The new position of Chief of Behavioral Health and Supportive Care is filled by **Scott Taberner**, who formerly was the Chief Financial Officer at the Massachusetts Behavioral Health Partnership. Taberner will head up reforms to better coordinate and integrate care for behavioral health, physical health and long-term services and supports for elders and persons with disabilities.

MassHealth also has a new Chief Financial Officer, **Matthew Klitus**, a principal at Boston-based CBDI and an experienced healthcare investor. Klitus will oversee MassHealth's strategic direction and performance and will have responsibility for improving the overall efficiency and management of the MassHealth program. Klitus also worked at Bain Capital, focused on healthcare services investments.

Ipek Demirsoy, Policy Director for Accountable Care at the Health Policy Commission, has been appointed to lead MassHealth's care delivery and payment reform work. Demirsoy will have responsibility for launching new payment models, including Accountable Care Organizations, that improve care coordination, cost and quality of care for MassHealth members. Demirsoy previously worked with health systems and academic medical centers on health care transformation at McKinsey & Company.

Robin Callahan, currently the Deputy Medicaid Director of Policy & Programs for MassHealth, has been promoted to overall Deputy Medicaid Director and will have increased responsibility for day-to-day operations, including improving MassHealth's customer service and other operational and programmatic capabilities.

MassHealth expenditures were projected to increase 16% over FY15 numbers to $16.9 billion. By maximizing new revenue opportunities, addressing gaps in eligibility processes and finding administrative efficiencies, the Baker Administration's MassHealth budget for FY16 caps spending growth at 5.6% to a total of 15.3 billion—slowing down the rate of grown by roughly two-thirds.

The Impact Of $15 Wage Floor in the Home Care Industry

According to a recent report by the National Employment Law Center (NELC), the number of home care jobs in the United States is projected to grow five times faster than jobs in all other occupations. According to the Bureau of Labor Statistics, the country will need one million new home care workers by 2022.

NELC says that thousands of home care workers have taken to the streets in recent months, adding their voices to the growing call for a $15 hourly wage. "Home care workers, who provide critical in-home support to older adults and people with disabilities, make a compelling case for higher wage standard" the NELC report says. "Like the fast-food industry where the campaign for $15 originated, home care is growing at a rapid rate but remains marred by poverty-level wages. Low wages have profound implications beyond the workers and their families, driving alarmingly high turn over and burn out, jeopardizing critical services, and straining the home care system just as more and more Americans come to rely on its services."

"Stabilizing the home care system through higher wages and better conditions is not only fair; it eases worker reliance on public benefits and allows recipients of home care services to stay in their homes and out of more costly institutional care. And when low-wage workers like home care workers experience a wage hike, they spend most of that increase on basic necessities like food, housing, and clothing, contributing to their local economies and spurring economic growth. A $15 wage for home care workers is the right thing to do—for the workers and their communities."

NELC says revenues in the home health industry have grown 48% over the past 10 years. In contrast, when adjusted for inflation, average hourly wages for home care workers have declined by nearly 6% since 2004. "At this rate, home care workers' earnings will be worth less than $18,000 (in 2013 dollars) when this workforce reaches its predicted growth to nearly three million in 2022."

A significant number of home care workers rely on public assistance because their earnings are not enough to make ends meet. Among home care workers, nearly 50% live in households that receive public assistance benefits such as Medicaid, food stamps, and housing and heating assistance. With the creation of a $15 wage floor, the average home care worker would receive approximately 50% more in her hourly wage rate, an approximate increase of more than $8,000 in yearly earnings. The home care workforce as a whole would see about $16.5 billion in additional yearly earnings. NELC estimates that the increased consumer spending from additional earnings in the home care sector would generate new economic activity of between $3.9 billion and $6.6 billion. On average, for each of the two million home care workers, this would translate to approximately $2,000 in new economic activity, as workers spent their earnings in their local communities. This economic activity would create between 29,000 and 50,000 jobs outside the home care

industry. Raising wages would benefit a workforce that is primarily women of color. 89%, or more than 1.7 million home care workers, are women. 30%, or 600,000, are African American, and 16%, or 320,000, are Latino.

The elderly population is growing at record levels. Every day, 10,000 baby boomers turn 65. By 2050, the elder population is expected to more than double, from about 4 0 million to 84 million. Approximately half of the senior population needs help with activities of daily living. A recent policy paper by the AARP noted that the majority of long-term services and supports are provided by family members, but that the supply of family caregivers is unlikely to meet the projected demand brought on by the aging baby boomer population. The report found that in 2000, there were seven potential caregivers aged 45-64 for every person 80 years or older. By 2030, the report predicts, this ratio will drop to 4:1 and again to 3:1 in 2050. A decent wage would help stabilize a workforce that currently has high turn over because of low wages and irregular hours.

Home care will be increasingly critical to our long term care system, not only because it is the preferred form of services for a rapidly expanding number of consumers, but also because it is cost-effective. For more than a decade, the states have been shifting their long term care spending away from more costly institutional care, such as nursing homes, and toward home care. Home care workers are already saving state, local and the federal government around the country billions of dollars. Improving worker pay will help ease the turn over and recruitment problems that have prevented states from rebalancing the long term care system by expanding the use of home care.

"Transitioning the fast-growing home care industry to a more stable, higher wage staffing model is essential if our nation is to meet the long term needs of both the caregiving workforce and our aging population," the NELC report concludes. "Fortunately, in recent years we have seen some of the first steps towards rebuilding wage and job standards, and paving the way for a $15 wage. For example, after years of advocacy by worker and consumer advocates, the U.S. Department of Labor in 2013 finalized rules extending federal minimum wage and over time protections to the workforce, while domestic worker bills of rights have won greater state wage protections and industry standards in several states and spurred campaigns in others. Several states and cities have recognized that raising. wages for workers employed in such publicly funded programs also saves public funds by easing workers' reliance on public benefits and stemming the tremendous financial and human cost of recruiting and retraining what has been a constantly churning workforce."

States have passed reforms such as New York's Wage Parity Act, which raised compensation for Medicaid-funded home care workers to $14 per hour in wages and benefits. The fight for a $15 wage has raised expectations for what workers can achieve and has inspired many workers and supporters to join the fight." Since fast-food workers took the streets in New York City in 2012, the NELC adds, "several cities have proposed or enacted $15 minimum wages. $15 wage for the home care industry will ensure that all home care workers across the country earn a decent wage that supports their families and communities and helps stabilize a workforce that growing numbers of Americans will be counting on to deliver dependable, quality care in the years to come."

Observation Status Bills Reintroduced in Congress

For the last several years, Congressional lawmakers have been trying to address the problem

of "Observation Status" in the hospital, which can affect both what Medicare beneficiaries pay for hospital stays, and their coverage of subsequent care in a nursing facility. A person who has been classified as "observation status" in a hospital will be unable to receive Medicare payment for the front-end part of the nursing home costs—because Medicare requires a prior 3 day hospital stay for its nursing home benefit.

For the last several sessions of Congress, bills have been introduced to try to fix the problem for Medicare beneficiaries by counting all time spent in observation toward the three-day prior hospital stay requirement. On March 23rd, alongside Center for Medicare Advocacy Executive Director **Judith Stein**, Congressman **Joe Courtney** (CT) announced the reintroduction of the Improve Access to Medicare Coverage Act of 2015 (H.R. 1571). As the Congressman stated, "My bill would fix this problem by counting all days spent in the hospital—whether admitted or on 'observation'—toward the three-day requirement to qualify for Medicare coverage."

Rep. Joe Courtney

In a press release announcing the filing of his bill, Congressman Courtney said: "For seniors on Medicare, coverage of rehabilitative care after a stay in the hospital can be a financial lifesaver. Because of the rising number of 'observation status' stays in the hospital, hundreds of thousands of seniors each year are left to pay out-of-pocket for the full cost of doctor-prescribed skilled nursing care—which can amount to tens of thousands of dollars. Since I began this effort in 2010, I have heard from families and advocates all over the country,

The "observation status" problem creates very significant out-of-pocket costs for necessary, doctor-prescribed care, Courtney noted. "While Connecticut requires hospitals to notify patients of their status, most other states do not—meaning that patients and their families often do not learn that they do not qualify for coverage until they are being discharged from the hospital, and have little recourse to appeal the decision."

First introduced in 2010, the Improving Access to Medicare Coverage Act received broad bipartisan support in the 113th Congress, and wide-ranging support from national advocacy groups, including AARP, the American Medical Association (AMA), the American Health Care Association (AHCA), the American College of Emergency Physicians, and the Connecticut-based Center for Medicare Advocacy.

The day after Rep. Courtney filed his bill, similar legislation in the Senate (S. 843) was filed by U.S. Senator **Sherrod Brown** of Ohio. "The last thing seniors should worry about after being hospitalized is their Medicare coverage. But far too many seniors don't know if their hospitalizations are under observation status, only to find out after that Medicare won't cover their nursing home stays," said Brown.

Another sponsor of the bill, Senator **Susan Collins** of Maine, said: "As Chairman of the Senate Special Committee on Aging, encouraging action on issues important to seniors remains one of my top priorities. I'm proud to support legislation that helps protect seniors from the severe financial consequences many older Americans are currently incurring from the increased usage of observation stays. This bipartisan bill…will help insulate older Americans from undue out-of-pocket costs and ensure that they get the care that they need."

The "Doc Fix" Gets Fixed

The National Association of Area Agencies on Aging (n4a) reported in early April that members of Congress have taken on some major priorities

affecting the elderly, including passage of a long-term legislative fix to Medicare's Sustainable Growth Rate (SGR) bill, which headed off a 20% reduction in physician reimbursement rates. The SGR was enacted by Congress in 1997 to control Medicare cost growth but lawmakers stepped in to delay the cuts as they accrued each year. Rather than permanently fix the problem Congress has instead spent $150 billion in 17 short-term fixes since 2003. The most recent patch is scheduled to expire on April 1, which would leave physicians with a 21% cut in Medicare payments

Included in a health care "extenders" package that is part of the current SGR formula law were some wins and disappointments for the elderly. "The good news," said n4a, is that Congress proposed a two-and-a-half year extension of the so-called MIPPA funding through September of 2017, for a totral of $71 million for Area Agencies on Aging, State Health Insurance Plans, and Aging & Disabilities Resource (ADRC) programs, providing outreach and enrollment assistance for low-income beneficiaries.

Originally created in the Medicare Improvements for Patients and Providers Act (MIPPA), updated in the Affordable Care Act and the fiscal cliff deal of January 2013, and extended under the SGR "patch" that passed last year, these outreach and enrollment activities performed largely by the Aging Network have had no permanent source of funding.

The SGR laws passed over the last two years have provided a convenient source of continued funding. Under the new SGR law, MIPPA funding is renewed, with SHIPs getting $33.5 million, AAAs $22.5 million, and ADRCs getting $15 million for outreach. The MIPPA funding, however, was not made permanent, so advocates will have to take up this issue again in FY 2017.

The SGR law also makes funding for the Qualifying Individuals (QI) program permanent. The QI program helps to bolster the financial security of Medicare beneficiaries between 120 and 135% of the federal poverty line by paying for monthly Part B premiums. Together these programs are essential to ensuring that the country's most vulnerable seniors receive health care by improving access and covering premium payments often out of reach for low-income older Americans.

N4a says that funding for the ADRCs was not included in the SGR law, and that they have asked Congressional leadership to replace at least the $10 million in mandatory investments made through the Affordable Care Act that expired at the end of FY 2014. The ADRC network stands to lose two-third of its annual federal funding if these investments are not continued in 2015. The 113th Congress maintained $6 million in discretionary appropriations in FY 2015, but was unable to bridge the $10 million gap in mandatory funding with discretionary appropriations.

N4a had hoped that the health care extenders package in the SGR would prove a convenient vehicle to continue this funding and bridge this funding gap, but these investments were not included in the final deal. N4a says "a decade of improvements and advancements in building this national network will be undermined."

The SGR plan largely reflects the bipartisan Senate Finance Committee bill introduced—but not passed—last year to permanently fix the flawed formula and overhaul the Medicare reimbursement system, but the measure has met opposition in identifying acceptable offsets (i.e., ways to pay for) for the 10-year, $200 billion cost. Currently, the $70 billion in offsets include cost-shifting to higher income Medicare beneficiaries.

After the "doc" fix was signed in the House, the AARP released the following statement:

"AARP applauds the House for its bipartisan work on the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2) that permanently

replaces the Sustainable Growth Rate (SGR) formula. However, we remain concerned that Medicare beneficiaries are unfairly shouldering more than their fair share of the cost of the SGR "Doc Fix," and we urge further improvements as the bill moves to the Senate. "AARP has long supported a permanent solution to the SGR so that Medicare beneficiaries can rest assured that they'll be able to continue seeing their physician each year," said AARP Executive Vice President **Nancy LeaMond**. "We also support the move towards greater use of quality measures and reporting and increased care coordination, among other improvements in the new physician payment formula designed to enhance value in Medicare."

While AARP commends the House of Representatives for working together in a bipartisan fashion on this SGR bill, we are concerned that Medicare beneficiaries will now face higher out-of-pocket costs, including higher premiums and reduced coverage through certain Medicare Supplemental (Medigap) plans. The typical senior on Medigap is not wealthy—nearly half have annual incomes of less than $30,000. AARP wants a permanent solution to the SGR formula, one that achieves a balanced and fair solution for all stakeholders—Medicare beneficiaries, physicians and other health care providers, insurers, and drug companies. AARP is ready to work with the Senate to improve this important bill."

While the price of ending the Sustainable Growth Rate formula is steep, the Congressional Budget Office says it's cheaper than doing nothing, because the status quo would cost $900 million more than the proposed reforms over the next 10 years. The bipartisan bill, H.R. 2, would increase direct spending by $145 billion from 2015–2025. It would also generate about $4 billion in offsetting revenues over the period, the CBO said in a letter to House Speaker **John Boehner**, who issued a statement which said that H.R. 2 "will save taxpayers money and put the nation's budget on a more sustainable path."

President **Barack Obama** told the Associated Press, "I have my pen ready to sign a good bipartisan bill." On April 16th the President got his chance: he signed the bill passed by the House of Representatives on March 26 and by the Senate on April 14 that permanently repealed the SGR formula for Medicare physician payment. The President praised the bipartisan nature of the legislation, cobbled together in the House by Speaker John Boehner (R-Oh.) and Democratic Leader **Nancy Pelosi** (D-Calif.) for negotiating the terms of the legislation. He further said that "It also improves it [physician reimbursement] because it starts encouraging payments based on quality, not the number of tests that are provided or the number of procedures that are applied but whether or not people actually start feeling better. It encourages us to continue to make the system better without denying service," he added. The new law averts what would have been a 21% cut to Medicare physician payment, replacing it with 0.5-percent "updates," or physician payment increases, in 2015, 2016, 2017, and 2018. The new program will

be called the Merit-based Incentive Payment Program, or MIPS. Physicians will also be able to opt for an alternative program involving slightly higher payments in return for participation in certain Alternative Payment Models, or APMs. MIPS targets four key areas: quality, resource use, clinical practice improvement (including care coordination and improvement activities), and the meaningful use of electronic health record technology.

But besides the new SGR law, Congress still has to address a full slate of must-pass legislation, including annual appropriations negotiations to determine federal funding levels for FY 2016 and reauthorizing the Older Americans Act. Unless Congress repeals the current budget caps—which looks unlikely given initial budget

blueprints—appropriations levels will be capped roughly at FY 2015 levels of $493 billion for non-defense programs, including Older Americans Act funding.

N4a is advocating to restore OAA funding to at least pre-sequestration FY 2010 levels, but they are also supporting President Obama's budget where is exceeds FY 2010 levels, including significant increases to Title IIIB Supportive Services, IIIC Nutrition, and IIIE Family Caregiver Support programs, as well as the Administration-proposed increases to ADRCs and Elder Justice funding.

Congress also must deal with reauthorization of the Older American's Act, which has been in somewhat of a holding pattern. The current OAA reauthorization bill, S. 192, was placed on the Senate calendar in February, but with a very packed Senate schedule, it is uncertain when the Senate will be able to consider this bill.

Markey: Medicare Vouchers "A Disaster Waiting To Happen"

In March, both the House and Senate budget committees in Congress released and passed their budget resolution plans on party-line votes. If Congress can come together to approve one unified FY 2016 budget resolution, appropriators will then begin their months-long process to identify specific discretionary program allotments, including funding for the OAA.

Even though budget resolutions are non-binding, the documents publicly outline the majority party's funding priorities not only for the upcoming fiscal year, but for years into the future. Just like the Obama Administration's budget released earlier, released Congressional budgets are largely messaging documents. However, with majorities in both chambers, Republicans are particularly well-poised this year to attempt to implement some of the budget recommendations outlined in their resolutions.

The House Budget proposal especially would have sweeping ramifications for older adults and echoes concepts espoused in the past few years of House budgets. Overall, the House budget includes $5 trillion in spending cuts, and proposes to achieve a balanced budget within the next ten years. Many of these proposed cuts target programs for low and middle-income Americans, including older adults. The House budget would continue to slash Non-Defense Discretionary (NDD) programs, which include funding for the OAA, by $759 million below already devastating sequestration levels. Under House Budget Committee Chairman **Tom Price's** (R-GA) plan, by 2025, NDD programs would be cut by a third from FY 2010 levels, adjusted for inflation. The House budget addresses heath care spending by completely repealing the Affordable Care Act (ACA) and rolling back Medicaid expansion. It would also radically restructure Medicaid by converting the program to a block-grant structure. This restructuring would cut nearly $1 trillion over the next decade from the program. Combined with the Medicaid expansion repeal, Medicaid cuts outlined in the House budget total approximately $1.8 trillion over the next decade, and would privatize Medicare for future retirees by restructuring the program to a voucher system, where participants would receive vouchers to purchase insurance through the private market.

U.S.Senator Ed Markey

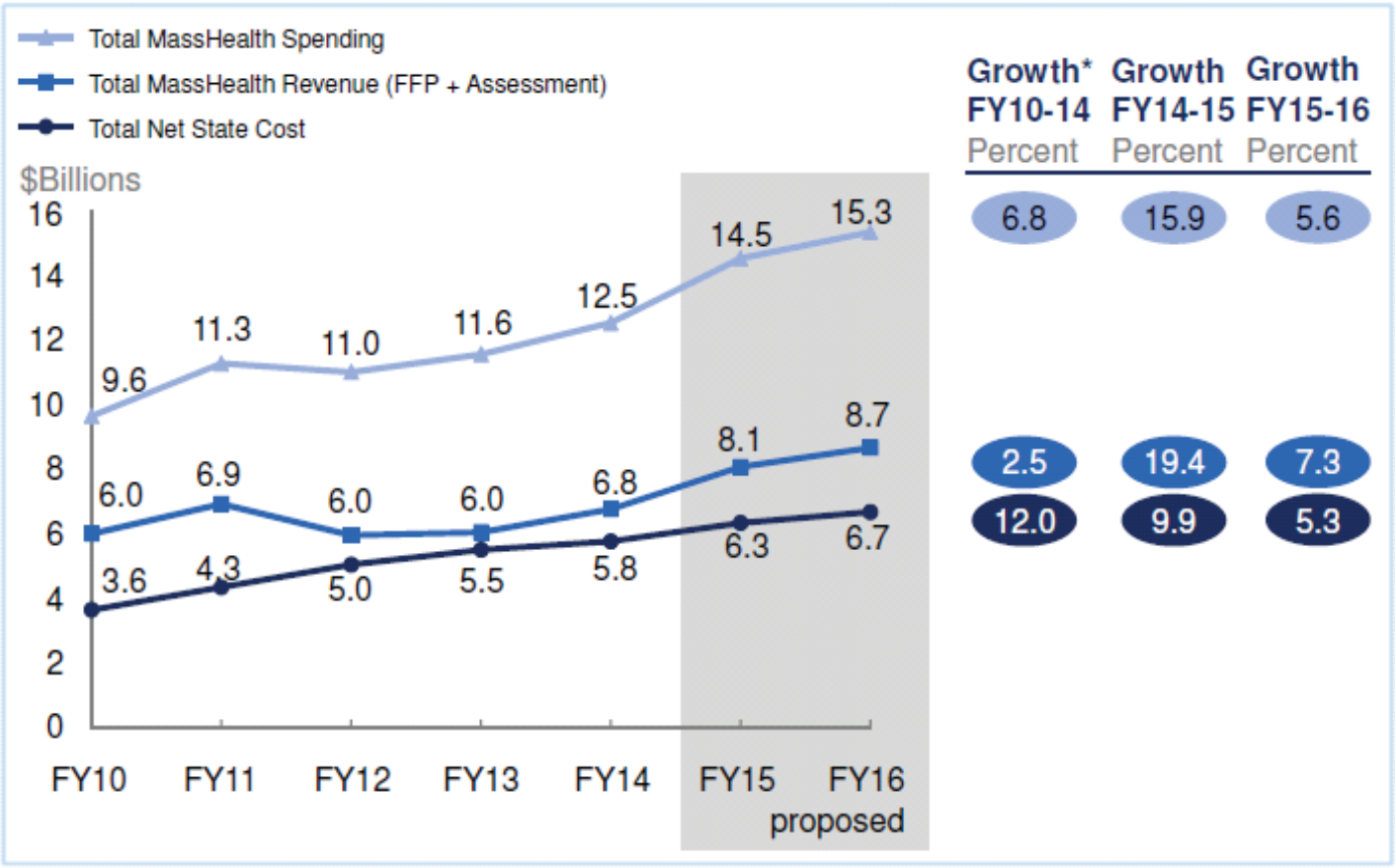
In a letter sent out by the Markey Committee, Massachusetts Congressman **Ed Markey** said: "The Republican budget would take away Medicare's guaranteed benefits and give seniors a coupon instead. This is a disaster waiting to happen -- join me and my colleagues and speak out against the GOP attack on Medicare. Giving seniors a voucher for health insurance is not going to work. How can I be so confident? Because

Medicare was created to address the fact that private insurers wouldn't cover senior citizens at any price. Coupons are not going to pay for something insurers refuse to sell. We have had this discussion many, many times before -- and the new Republican majority is insisting that we have it again. Let me be clear: I will not stand by and let the Republicans break the promise of Medicare."

The Senate's budget proposal largely mirrors the House plan in proposing sweeping spending cuts to achieve a balanced budget in ten years. Overall, Senate Budget Committee Chairman **Mike Enzi's** (R-WY) plan would cut spending by $4.5 trillion over ten years, including reducing NDD program funding by $236 billion through 2025. Under Chairman Enzi's plan, by 2025 NDD funding would be at least 24% below 2010 levels, adjusted for inflation.

The budget proposal would also repeal the ACA and would block-grant Medicaid. Neither the House nor Senate budget proposals make structural changes to Social Security, but both plans argue that cuts in non-defense program, including the OASA, are necessary to preserve Social Security. Additionally, both plans achieve a balanced budget within 10 years through decreasing spending only. Neither proposal uses revenue increases as part of a balanced approach to long-term deficit reduction.

MassHealth is currently unsustainable



*Represents the Compound Annual Growth Rate (CAGR): the year-over-year growth rate of an investment over a specified period of time
SOURCE: MassHealth