At Home

August, 2015

With Mass Home Care

Vol 28 #8

Al Norman, Editor

photo: 1199 SEIU

PCA Workers Get $15/ Hour by FY 19

35,000 Personal Care Attendants will see their wages jump 30 cents an hour this month, to $13.68 per hour, and by July 1, 2018, PCAs will be receiving a first-in-the-nation hourly wage of $15, according to the 1199SEIU United Healthcare Workers East.

PCAs are paid with MassHealth funding, and the union bargains with the PCA Workforce Council. The state-funded home care program, and the home care aides who work in that program, are not part of this collective bargaining agreement.

"We are grateful to the members and leadership of 1199SEIU for their good faith in a successful process that will ensure PCA's receive appropriate compensation for the special and unique work" they perform, Governor **Charlie Baker** said in a statement. "More than 35,000 PCA's provide highly specialized care for seniors and individuals with disabilities that allow them to stay in their homes, and we look forward to continuing to build on this constructive relationship," Health and Human Services Secretary **Marylou Sudders** told the State House News.

Here is the press release that was issued by the

SEIU on June 26th:

"Tears of joy streaked the faces of cheering home care workers assembled in their Dorchester union hall on Thursday afternoon as a decades-long struggle for recognition and a living wage culminated in a historic moment of celebration.

According to an agreement reached in contract negotiations between the 35,000 home care workers of 1199 SEIU United Healthcare Workers East and the administration of recently elected Massachusetts Governor Charlie Baker (R), Massachusetts Personal Care Attendants (PCAs) are poised to become the first in the nation to achieve a statewide $15 per hour starting wage.

Upon reaching the agreement, workers called off the fifteen-hour picket they had planned to begin at the Massachusetts State House on the morning of Tuesday, June 30th. Instead, caregivers are planning a celebration of this milestone and nation-leading achievement of a $15 standard at 4:00 p.m. on the State House steps the afternoon of June 30th.

"This victory, winning $15 per hour, it means we are no longer invisible," said **Kindalay Cummings-Akers**, a PCA from Springfield, MA. Cummings-Akers cares for a local senior and became a union activist at the onset of the campaign. She was also a member of the statewide PCA negotiating team that reached the agreement with the Baker administration. "This is a huge step forward not just for home care workers, but also toward ensuring the safety, dignity, and independence of seniors and people with disabilities," she added. "We are a movement of home care workers united by the idea that dignity for caregivers and the people in our care is possible. Today, we showed the world that it is possible."

"Massachusetts home care workers are helping to lead the Fight for $15 – and winning," said 1199SEIU Executive Vice President **Veronica Turner.** "We applaud Governor Baker for helping to forge this pathway to dignity for PCAs and the tens of thousands of Massachusetts seniors and people with disabilities who rely on quality home care services to remain in the community or in the workforce. As the senior population grows, the demand for home care services is increasing. By helping to ensure a living wage for these vital caregivers, Governor Baker is taking a critical step with us toward reducing workforce turnover and ensuring that Massachusetts families can access the quality home care they need for their loved ones."

"It is a moral imperative that all homecare and healthcare workers receive $15 per hour, and Massachusetts is now a leader in this effort," said 1199SEIU President **George Gresham**. "Extreme income inequality is a threat to our economy, our bedrock American values and our very democracy. With a living wage, we can ensure more compassionate care for homecare clients, and better lives for homecare workers and their families. We applaud this bold step by Governor Baker towards a better future for our communities in Massachusetts and our country overall."

The home care workers' journey began in 2006 when they banded together with senior and disability advocates to pass legislation giving Personal Care Attendants the right to form a union – a right they previously had been denied because of an obscure technicality in state law.

After passing the Quality Home Care Workforce Act to win that right and introduce other improvements to the home care delivery system in 2007, the PCAs voted to join 1199SEIU in 2008 through the largest union election in the history of New England. 1199SEIU is the fastest-growing and most politically active union in Massachusetts.

Prior to the legislative and organizing campaigns, PCA wages had stagnated for years at $10.84 per hour. In a series of three contracts since forming their union and through several major mobilizations, rallies, and

public campaigns, the PCAs achieved a wage of $13.38 on July 1st, 2014.

Last year, the Massachusetts home care workers also united with the burgeoning Fight for $15 movement and the local #WageAction coalition, helping to kick off the $15 wage effort in the Bay State with rallies in Boston, Springfield, and Worcester on June 12, 2014.

Home care workers took to the streets again on April 14, 2015 as part of a massive Fight for $15 mobilization that drew thousands to the streets of Boston. That Boston-based action served as the kickoff for similar coordinated protests in more than 200 cities and 50 countries across the globe.

Caregivers say they are excited that the picket action they had planned for their current contract expiration date of June 30th can now serve as a celebration of this achievement and the spirit of cooperation that made it possible.

Mass Home Care Photo

"This is an inspiring moment for home care workers, but also for our children – and our children's children," said a beaming **Rosario Cabrera**, a home care worker from New Bedford, MA whose children Kendra, age 14, and Daniel, age 12, were with her at the negotiating session as workers cheered the new agreement with the Baker administration. "I am so proud that I can show my children and someday tell my grandchildren that I was part of this moment in history, that I was part of a movement for social justice. We want all home care workers to win $15 per hour – and to do it first in Massachusetts fills us with pride. It is evidence of what people can do when we organize and negotiate in good faith to reach common ground."

"Not only is this going to help the PCAs, but this is going to help us as consumers because it's going to be easier to hire an attendant now that they can receive a dignified living wage," said **Olivia Richard**, age 31, a paraplegic consumer who lives in Brighton, MA. "In the past, consumer employers have had issues with getting PCAs simply because the wage wasn't enough. This is going to make a huge difference in our lives, as well."

In negotiations, workers and the Baker administration reached an agreement extending the current collective bargaining agreement and establishing a commitment that all PCAs statewide will receive a starting rate of at least $15 per hour by July 1, 2018. Workers will receive an immediate 30 cent raise effective July 1, 2015, a portion of which will be paid retroactively once the contract is ratified.

A new round of discussions will then begin no later than January 1, 2016 to solidify details on the series of wage increases that will elevate PCAs to the $15 mark by the agreed upon date of July 1, 2018. Meanwhile, PCAs across the state will vote by mail ballot on ratifying the contract extension and the terms therein, including the commitment to establish a statewide minimum $15 starting rate.

Mass Home Care Seeks Wage Parity For Home Care Workers

The increase in PCA wages will have an impact on other wage sectors of the elder care industry. On July 6, 2015, Mass Home Care sent a letter to the Executive Office of Elder Affairs regarding two related workforce impacts that now need attention. During FY 16 budget discussions, the state legislature decided not to increase appropriations for the ASAP workers, and rejected an effort to increase salaries for the home care aides. Uneven wage levels in the home care field can have a destabilizing effect on the home care workforce.

Here are excerpts from the Mass Home Care letter:

"The good news that Personal Care Attendants are on a track to receive $15 and hour by July 1, 2018 raises several related wage issues in the home care system:

1. A significant wage gap will open up between the PCA worker and the home care aides who both perform very similar personal care services. We are concerned that if home care aide wages do not begin to rise to keep pace with PCA wages, that home care aides will either want to become PCAs, or leave the home care workforce to seek better wages. This month, the PCA wage will rise to $13.68 per hour, while many home care aides are earning $11 or less. This has a destabilizing impact on the home care aide workforce that elders are depending upon.

2. The wages of PCAs will begin to approach the wages paid to ASAP care managers. According to an independent salary survey that Mass Home Care commissioned in January, 2015, the average starting salary for a home care manager was $34,255, or $13,162 below comparable positions. A PCA working 40 hours per week would earn $31,320.

We must develop some considered response to the impact on these other workers in the home care system. Home care aides and ASAP care managers are deserving of wage increases to help them remain economically secure, and to keep these occupations financial sustainable.

We would like to work together with the Baker Administration to identify the options we have to achieve some level of wage parity for the home care workforce in Massachusetts.

We are prepared to meet with you at your soonest opportunity to begin to formulate a plan to deal with the wage challenges facing our direct care workers."

FY 16 Budget Conference Committee: Elders Deflated

The FY 16 budget released by the Joint Conference Committee on July 7, 2015 was a major letdown for elder home care advocates. "Our aspirations were popped," said **Al Norman** of Mass Home Care. "We felt a sense of deflation of our hopes." Advocates went into the Conference Committee with the Senate budget roughly $10 million higher than the House side---and emerged on the other side of the Conference committee with only $2 million left. 80% of the higher Senate appropriations were lost.

Here are some of the line item results:

• An outside section in the Senate budget which would have leveraged up to $6.25 million in federal dollars to open up home care supports for "near poor" disabled seniors was not included in the budget.

Mass Home Care photo

• The major success for advocates is the increase in Enhanced Home Care funding (9110-1550) by 11.4%--an additional $7.17 million to keep elders who are nursing home eligible living in the community. This will not translate into much new growth, however, because demand for this program is already at this funding level.

• Funding to pay Adult Foster Care families for "respite" days has been restored (4000-0600), so that "MassHealth shall maintain the same respite benefits for adult foster caregivers that were in affect January 1, 2015."

• The basic home care program (9110-1630), which serves the most seniors, will rise by only 1.6%, or $1.7 million, a compromise between the House and Senate numbers.

• The account that pays for the frontline care managers and RNs, will not increase at all, marking the sixth year in a row that this item has seen no increase. This ASAP account is now $5 million lower than it was in FY 09.

or -12% below levels 8 fiscal years ago.
• Protective services for elders suffering from abuse or neglect will rise by $337,476, or a 1.5% increase.
• No increase in funding for meals on wheels/nutrition (9110-1900) over FY 15 levels.

Norman said policymakers must come to grips with the demographic changes that will overtake the state if we don't invest in care at home. "We need to take the savings we're creating from lowered institutional use, and shift it over to home care. The pressure is only going to increase to give people care where they want it---at home."

"Federal money that could have let us keep more seniors out of nursing homes was left on the table," Norman concluded.

Fallon Total Care Reluctantly Pulls Out of One Care Plan

"We regret to inform you," the four page letter began, "that Fallon Total Care will no longer pay for your health care and prescription drugs as of October 1, 2015."

Roughly two years earlier, on Sept. 3, 2013, Fallon Total Care (FTC), a wholly-owned subsidiary of Fallon Community Health Plan (FCHP),, announced that as of October 1, 2013, it would begin offering coverage as a Massachusetts "One Care" plan for adults between the ages of 21 and 64 who are dually eligible for both Medicare and Medicaid. Fallon Total Care promised "an integrated approach to coordinating behavioral health, medical care and community support all in one plan — providing members with more benefits than traditional Medicare and MassHealth combined."

In its first press release announcing the One Care Plan, Fallon Total Care said: "As a health care services leader with a history of providing coordinated care and coverage for individuals eligible for both Medicare and Medicaid, Fallon Community Health Plan has long believed in the concept of integrated care. Through Fallon Total Care, we've leveraged our experience and knowledge and have developed a member-centered model of care designed to provide choices and encourage collaboration, and built specifically for the unique needs of One Care members…With FCHP's experience and innovation, Fallon Total Care is well poised to move beyond the traditional care management structure and integrate medical, behavioral and community based care," said **Mary Ritter,** President and CEO of Fallon Total Care. "Fallon Total Care will work to make a positive difference for each individual as we become part of the solution in health care reform in Massachusetts."

21 months later, on June 17, 2015, Fallon Total Care announced that it was leaving the One Care plan. FTC told the media their continued participation was "not economically sustainable." The decision to leave the plan was estimated to affect 5,475 people in Hampden, Hampshire and Worcester counties. "After careful consideration and a thoughtful, comprehensive assessment of our experience," FTC said in a statement to the media, "we have decided reluctantly to end our participation in the commonwealth's One Care demonstration program," effective Sept. 30.

The financial concerns at Fallon over the economic sustainability of the One Care program were due, in part, to the fact the 3 plans---Commonwealth Care Alliance, FTC, and Tufts Health Plan/Network Health, have collectively lost $54.28 million from October of 2013 through March of 2015. This loss is before the application of "risk recovery payments" to the plans from Medicare and MassHealth. Risk-sharing is designed to mitigate the impact of plan losses.

State officials began quickly to develop some talking points to tell FTC plan members. "MassHealth is committed to the One Care program," they told the media. "We will work with Fallon Total Care members to ensure a smooth transition and continuation of coverage either under another One Care plan or through MassHealth and Medicare directly," said **Michelle Hillman**, spokeswoman for MassHealth, in an emailed statement. "MassHealth believes in the long term that

we will see positive results from the One Care model."

Massachusetts was the first state in the nation to launch an integrated dual-eligible plan sponsored by the federal government's Centers for Medicare & Medicaid Services and the Commonwealth's Executive Office of Health and Human Services to address enrollees' full range of medical and behavioral health needs.

In one draft talking point, MassHealth explained to Fallon members: "If you are currently enrolled in Fallon Total Care, you can keep getting coverage from Fallon through September 30, 2015. You will have choices about what your coverage will be next. Members currently enrolled in Fallon Total Care will be receiving information in the mail from Fallon Total Care, as well as from MassHealth and Medicare well before FTS coverage ends to let you know what your choices are and what the next steps are to make sure you make as smooth a transition as possible….Right now, you don't need to take any action. Your coverage through Fallon Total Care will continue through September 30, 2015. And your eligibility for MassHealth and Medicare will not change as a result of FTC's closure…Other One Care plans are available in the counties where Fallon Total Care is now. By the end of September, you'll need to consider one of these choices.If you do not wish to enroll in another One Care plan, you can return to your original coverage through MassHealth Fee-For-Service and Medicare, including Medicare Part D (prescription drugs).

Members of FTC can leave the plan before September 30th. They can choose another One Care plan in their county before then, or go back to getting their health care and drug services from MassHealth and Medicare. Members may need to find a new doctor if they decide to enroll in another One Care Plan. Because their doctor may not be part of that Plan's provider network.

Roughly a month after Fallon's withdrawal announcement, disability rights groups urged the company to slow down its termination schedule. The group Disability Advocates Advancing our Healthcare Rights (DAAHR) wrote to Fallon Total Care to request that it extend its transition period from September 30th to December 31st. "We respect that there are serious financing challenges," DAAHR wrote, "and that Fallon is within all of its contractual rights to act as it is doing. However, to reduce potential harm to the 4,500 people enrolled in the plan and support continuity of care we urge Fallon Total Care to make this three month extension…We are certain that Fallon feels an obligation to ensure the continuity of care and to safeguard the health of those who enrolled in your One Care plan. In consideration of the care needs of these individuals, we hope you will extend the transition period through December 31, 2015."

White House Conference On Aging: Neglecting Social Security

On July 13, 2015, a scaled-down White House Conference on Aging was convened in Washington, D.C. Congress refused to provide any funding for the event, so the once-in-a-decade event relied more on a network of "watch parties" across the country, where groups of elder advocates streamed the Conference on the internet.

In a "Discussion Guide" sent out by the White House, people attending a viewing session were asked to think about the following questions:

•In your experience, what are the most empowering parts of aging?

•What should we be thinking about now to prepare our families, communities and country for the next decade to support older Americans and their families?

•How can the government work with the private sector to expand opportunities for older Americans and their families?

•What are the best ways for multiple generations to stay connected?

•What are your strategies for taking part in healthy activities?

•What are ways you would like to get more involved in

your community?
•If retired, have you enjoyed new opportunities for volunteerism, business ventures or public service?
•What advice would you give to someone trying to plan for a secure retirement?
•How has new technology changed your aging experience?

The National Association of Area Agencies On Aging (n4a) gave the WHCOA a number of recommendations that Mass Home Care supports:

"In order to achieve many of the goals outlined in the WHCOA Health Aging policy brief, including managing chronic conditions; optimizing physical, cognitive and behavioral health of older adults; and helping people live safely and comfortably in their own home and stay engaged and connected to their communities as they age we believe the following recommendations should be a priority of the Administration and Congress.

•Improve Care Transitions and Care Coordination: by Better Integrating the Aging Network and Community-Based Organizations: AAAs have demonstrated their ability to partner effectively with health care systems and state quality improvement organizations to administer care transition programs that result in seamless transitions for consumers from acute care settings to home. This results in improved health outcomes and fewer re-hospitalizations. with AAAs and other community-based organizations to more efficiently and safely facilitate patient transitions from acute health care settings back to the community and home.

•Encouraging CMS's Center for Medicare and Medicaid Innovation to **seed new partnerships between the medical community and the Aging Network** to recognize that the majority of health happens at home and in the community. Specifically, we recommend that a role for AAAs and community-based organizations be more specifically included in CMMI pilots around models such as Medical Homes, Medicaid Health Homes and new demonstration projects that better coordinate care to dually eligible individuals. The Affordable Care Act (ACA) established the Community-based Care Transitions Program (CCTP) to improve care for high-risk Medicare beneficiaries being discharged from the hospital to prevent unnecessary re-hospitalizations and avoidable health care costs.

•Encouraging the Administration and CMS to explore options to **make care transitions activities reimbursable under Medicare** and incentivize hospitals to work with the program, which is administered by CMS. As part of the Partnership for Patients, community-based organizations must partner with hospitals. AAAs have taken the lead in this initiative: AAAs played a key role in approximately 90% of sites. More than 100 AAAs received initial CCTP funding.

But there was much that the WHCOA left off its agenda. With the backdrop of Social Security's 80th Anniversary this year, some advocates found the WHCOA agenda a missed opportunity. **Eric Kingson**, co-director of Social Security Works and co-chair of the Strengthen Social Security Coalition, blogged on *The Huffington Post* one week before the WHCOA that the

Eric Kingson

event "seems destined to be little more than an exercise in benign neglect of the growing economic problems of today's and tomorrow's seniors." Kingson called on the 200 or so Conference delegates to sound the alarm "on the retirement income crisis facing working Americans," and to push for "benefit increases in Social Security."

"Conference delegates would do great service by urging politicians and the press to avoid characterizations of Social Security, Medicare, Medicaid and related protections as 'entitlements'," Kingson wrote. "The WHCOA delegates should highlight the precarious economic circumstances of today's seniors; that most

seniors are not living on easy street… Annual Social Security benefits average just $16,000 in 2015. A small percentage of seniors is wealthy, but many more live in poverty or near the margin of economic insufficiency. Nearly half (48%) of seniors are economically vulnerable when 200% of the New Supplemental Poverty Measure is used as the standard…Most American workers face a personal retirement income crisis. Absent expanding Social Security, they will be unable to maintain their standards of living when they grow old."

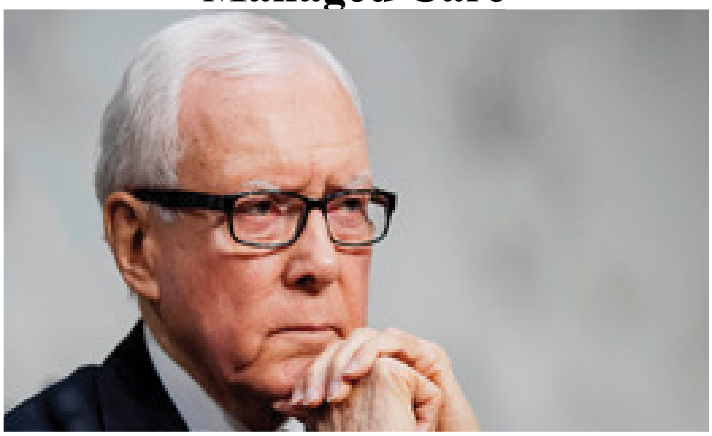
Kingson notes that the extended recession of 2008 "furthered the deterioration of retirement prospects for countless individuals…many people in their 40s and 50s have been balancing substantial losses of 401(k), IRA and other savings, pension protection, housing equity, and job security with the rising cost of health care and college tuitions. The National Institute on Retirement Security estimates that 38.3 million working-age households (45%) do not have any retirement savings. Even among working households with retirement savings." Kingson argues that expanding Social Security revenue options are supported across all political groups, and the system could be enhanced by asking millionaires and billionaires to pay the same rate by raising the payroll contribution cap, currently set at $118,500 for 2015.

Social Security works wants the WHCOA delegates to push for the expansion of Social Security, including: modest across the board increase in monthly benefits; larger minimum benefit payments for low wage-workers; caregiver credits to offset some of the cost of caring for children, ill or family members with disabilities; use of the more accurate Consumer Price Index for the Elderly (CPI-E) to calculate COLAs. Eligibility for many other programs, like the Massachusetts home care program, are tied to the CPI used by the Bureau of Labor, which does not adequately measure the cost of living for elderly individuals—very different than the index now used based on urban workers' food costs. "If the goal is to strengthen economic security, WHCOA delegates should make clear that the richest nation at the richest time in the world's history should make a down payment to provide greater retirement income security for today's and tomorrow's seniors," Kingson says.

Advocates also noted that the issue of Long Term Services and Supports was downplayed at the WHCOA event, and the pre-event that took place in Boston. Although there was an afternoon workshop on LTSS, the summary report from the Boston session (see July, 2015 *At Home*) carried only two sentence on the subject: "The long-term services and supports breakout session's priorities focused on consumer choices in accessing quality medical and social services resources. Additionally, the participants agreed that workforce development was a priority."

This decade's WHCOA may have been scaled down—but the LTSS and retirement income crisis facing older Americans is only scaling up.

Improving Medicaid Managed Care



Senator Orrin Hatch

On June 19, 2015, Mass Home Care submitted testimony to the Congressional Chairs of the U.S. Senate Committee on Finance, U.S. Senator **Orrin Hatch** and U.S. Senator **Ron Wyden**, regarding ways to improve care for patients with chronic conditions.

Here are excerpts from that testimony:

"We submit the following comments regarding policies to improve care for patients with chronic conditions:

1. Creating integrated, independent, conflict-free care coordination across settings

In January of 1987, Representative **Claude Pepper** (D-FL) introduced H.R. 65, the Medicare Part C: Catastrophic Health Insurance Act. This legislation amended Medicare to add a new part C entitled

"Program for Comprehensive Catastrophic Coverage, and Certain Preventive Benefits." Pepper's bill extended traditional Medicare coverage to provide, among other new benefits, "comprehensive long-term care services provided in the least restrictive environment."

Because this legislation never was signed into law, any discussion on the subject of improving Medicare's provision of services to individuals with chronic care needs must begin with the stark admission that Medicare cannot integrate care across settings because its scope of coverage barely addresses LTSS needs at all.

As **Howard Gleckman** of the Urban Institute recently pointed out: "While older people with chronic conditions do need improved medical care, they also need better social supports, personal assistance, access to services such as transportation, and safe and affordable housing. Improving delivery of medical care without including social supports is like pumping air in a flat tire without first fixing the puncture….Those high cost enrollees don't just have multiple medical conditions. They also have functional limitations and often cognitive impairment. And often, it is the combination that drives high costs, not chronic illness alone…. without the services and supports to help address their functional limitations, even better coordinated medical care won't make huge improvements in their quality of life, and it may not save much money.

Medicare was never designed to address what one physician has called "the ambush of social circumstances" that can have a major impact on individuals coping with multiple chronic conditions: lack of adequate housing, lack of adequate income, lack of accessible transportation, lack of proper diet and nutrition, etc. But as Gleckman reminds us:

"But remember that senior with heart disease, diabetes, and arthritis. Even with the best, well-coordinated medical treatments, how well is she going to do without an aide to help her get started in the morning, assistance taking her many meds, or a ride to the doctor? Without a grab bar in her shower, she could very well fall. And with very few exceptions, none of Medicare's managed care models provide any of those services."

Dr. **Joanne Lynn** of the Center for Elder Care and Advanced Illness, Altarum Institute, has described the fragmented, episodic approach we have taken with post acute care, and suggested a better path:

"A more reliable and efficient care system for frail elders must be integrated across multiple programs (e.g., Medicare, Medicaid, Older Americans Act [OAA], federal housing, and similar state and local initiatives) and service setting siloes (e.g., hospitals, nursing homes, home care, and housing modifications) that constitute health care and supportive and environmental services….[and] brings together health care practitioners, social services personnel, and organizations working on housing, transportation, and other community-based services in order to serve a complex population of older adults with chronic conditions and functional limitations."

Howard Gleckman

In Massachusetts, there is considerable precedent in the use of "conflict-free care management"—agents acting independently of the managed care organization. There is a well-established practice at the federal and state level in this kind of independent care coordination within the Medicaid program. Any managed care organization can benefit from this conflict-free care coordination.

In a 2010 report, the Center for Health Care Strategies stated: "One of the hallmarks of having a successful long term care program is the implementation of a needs assessment system that is independent of the agencies that directly provide services. This increases

the likelihood that consumers are being assessed objectively, and that services are being provided to meet consumer needs rather than provider needs."

Over the past decade, Massachusetts has moved forward to adopt an independent conflict-free care coordination framework for the provision of LTSS, both in accepting new federal financial incentives, and within state statute. Massachusetts has 11 years of experience with integrating medical and functional funding streams and settings for the elderly through the Senior Care Organizations (SCO) program. This insurance plan for dually eligible people age 65 and over is able to travel across the barrier of acute and post acute care by combining Medicare and Medicaid capitations---creating, in essence, the kind of unified insurance coverage that Congressman Pepper envisioned. The benefit plan in the SCO program reflects the bio/psycho/social needs of a "whole care" approach to care.

Congressman Claude Pepper

The SCO plan currently has 38,000 enrollees, and is operated by 5 separate plans, both for-profit and non-profit. It is voluntary enrollment, which allows members to "opt out" and return to traditional Medicare and Medicaid fee-for-service.

One of the unique features of this plan is that every senior with "complex care" needs has a Geriatric Support Services Coordinator (GSSC) on their team, who is not owned by the SCO, and functions as their independent agent for LTSS purpose. Under M.G.L. Chapter 118E, s. 9D, the GSSC is defined as:

"Geriatric support services coordinator, a member of a senior care organization primary care team who is employed by an aging services access point, is qualified to conduct and is responsible for arranging, coordinating and authorizing the provision of appropriate community long-term care and social support services… ASAPs under contract with SCOs shall employ geriatric support service coordinators, who shall be members of the primary care team and shall be responsible for: (i) arranging, coordinating and authorizing the provision of community long-term care and social support services with the agreement of other primary care team members designated by the SCO."

It is important in any Medicare reform plan that there is the capacity and funding necessary to provide such care coordination across all settings. The Massachusetts home care program, which receives $250 million in state and federal funding, has used non-provider, conflict-free ASAPs as its care coordinator since its inception in 1973. ASAPs are responsible for: (1) providing information and referral services to elders; (2) conducting intake, comprehensive needs assessments, preadmission screening and clinical eligibility determinations for elders seeking institutional and community care services from Medicaid or the home care program(3) arranging, coordinating, authorizing and purchasing community long-term care services called for in the comprehensive service plan; and (4) monitoring the outcomes of and making periodic adjustments to a service plan in consultation with service and health care providers. Under M.G.L. Chapter 19A, 4B, ASAPs are independent from providers:

ASAPs shall not provide direct services except for case management; information and referral, and protective services as defined in regulations of the home care program…and the Older Americans Act, as amended…Except for the direct services provided by ASAPs pursuant to this section, no ASAP shall have a direct or indirect financial ownership interest in an entity that provides institutional or community long-term care services on a compensated basis.

More recently, in October of 2013, Massachusetts statute created a second duals plan for people aged 18 to 64, the "One Care" plan, with enrollment of 17,600 members. This integrated Medicare and Medicaid plan also features on the core team an "Independent

Long Term Support Coordinator (ILTSC). This care coordinator cannot be owned by a One Care plan. ASAPs and Independent Living Centers function as the ILTSC agent for plan members.

At the federal level, the Centers for Medicare and Medicaid Services (CMS) requires conflict-free case management policies in states using Medicaid funds from the Balancing Incentive Program, Community First Choice (1915 k), and 1915(i) state plan amendment. It is also part of the Money Follows the Person requirements.

The CMS definition of conflict-free case management includes the following principles::

• Clinical determination of need is separated from direct service provision.

• The independent assessment is based on the individual's needs and strengths.

• Case coordinators are not related to the individual being assessed, their paid caregivers, or anyone financially responsible for the individual.

• A person-centered assessment including behavioral health, which will take into account the individual's total support needs as well as the need for the HCBS to be offered.

• The assessor must be independent; that is, free from conflict of interest with regard to providers, and to budgetary concerns.

• The person who assesses care needs does not provide the services to meet those needs

Conflict-Free Case Management exists in the following federal statutes:

• Balancing Incentive provisions in the Affordable Care Act

• Community First Choice provisions in the Affordable Care Act

RECOMMENDATION: Mass Home Care strongly urges the Senate Finance Committee to pursue the requirement for integrated, independent, conflict-free care coordination across settings in any managed care plan that covers LTSS.

2. Expand the use of independent Care Coordination For Transitional Care

According to a 2011 study of care coordination models for dually eligible beneficiaries by Emory University, there is a growing body of evidence that has identified the key functions performed by health plans and successful comprehensive team based care coordination models in managing chronically ill patients. The key design features of effective care models include:

• Coordination of care for all covered Medicare and Medicaid services

• Utilizing a team based approach and a capitated payment from Medicare and Medicaid.

• Approaches that provide a whole-person focus on preventing disease and

• managing acute and mental health services tailored to the needs of dually eligible beneficiaries over age 65 and those under 65 with disabilities who reside in the community and in institutions.

• Medical advice from a care coordinator available 24/7.

• Assessment of patient risk and development of an individualized care plan

• Medication management, adherence and reconciliation

• Transitional care

• Regular contact with enrollees

• Centralized health records

• Close integration of the care coordination function and primary care (and specialist) physicians

The use of care transitions coordination in Massachusetts is a firmly-established model. Over the past several years, a number of CMS care transitions efforts, led by community-based ASAPs, have reduced preventable hospital readmissions.

The Community-based Care Transitions Program (CCTP), created by Section 3026 of the

Affordable Care Act, has tested models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program.

Care transitions occur when a patient moves from one health care provider or setting to another. Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—are readmitted within 30 days, at a cost of over $26 billion every year. Hospitals have traditionally served as the focal point of efforts to reduce readmissions by focusing on those components that they are directly responsible for, including the quality of care during the hospitalization and the discharge planning process. However, it is clear that there are multiple factors along the care continuum that impact readmissions, and identifying the key drivers of readmissions for a hospital and its downstream providers is the first step towards implementing the appropriate interventions necessary for reducing readmissions.

The CCTP, launched in February 2012, runs for 5 years. Community-based organizations (CBOs) use care transition services to effectively manage Medicare patients' transitions and improve their quality of care. In Massachusetts, the CBOs are Aging Services Access Points (ASAPs). They are paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and of implementing systemic changes at the hospital level.

The CCTP Project in Massachusetts produced the following outcomes:

• One CCTP project has enrolled 3,782 hospital patients on Medicare into their Transition Coaching program. For the period December 1, 2012 to July 31, 2014, this Care Transitions project reduced the hospital readmission rate from 25% for this target population to 19.5%---a decrease of 37% in the readmissions rate.

• Another CCTP project using trained transitions coaches supported by tablet-based software enrolled community-based Care Transitions Program patients, and after six months, found that a subset of admissions they were tracking saw hospital readmissions dropped from 24% to 14%--a 39.6% reduction. There was a net savings to Medicare of $567,071 during the six months. (Source: AHRQ)

• As of March, 2015, two of the CCTP projects are in the top 8 performing projects in the country. One project has served over 10,000 patients since mid-2012. This site targeted patients at high risk of readmission and has achieved more than a 50% reduction in the 30-day Readmission Rate among its CCTP Participants.

These Care Transitions outcomes have demonstrated that independent, community-based care coordination entities, the ASAPs, are an evidence-based approach that can result in substantial reductions in the readmissions rates at their hospital partners. Massachusetts has the advance of an existing LTSS care coordination infrastructure capable of achieving impressive outcomes.

As the Massachusetts Health Policy Commission has noted: “Transitional care focuses on improving care transitions – such as when a patient is discharged from a hospital into a post-acute care setting – through better in-hospital planning and post–discharge follow-up. Such efforts target acute hospital and ED use and health status decline, emphasizing coordination and close clinical management among all involved parties. Care management activities can also play a role in better coordination of care for high-cost patients across multiple conditions. In addition, other geographically targeted programs have focused on high-cost patients dealing with socioeconomic challenges. This strategy,

popularly referred to as "hot-spotting," often targets patient populations with interventions that convene providers and community groups to solve problems in a more holistic manner. While some of the factors driving high-costs are clinical, others are socioeconomic, such as education, and delivery system-related, such as fragmented care or high-priced providers."

As one health plan noted: "Their [health coaches] job is to help patients with health needs that are not medical — diet changes, tracking down the right supportive socks, finding free senior transportation vans that can transport them to office visits or exercise classes."

The Care Transitions benefit also includes access to community living coaches who can focus on non-medical social factors that impact health care, and evidence-based wellness programs, which are now widely lead by ASAPs to increase patient engagement and education on managing chronic diseases. The Healthy Living Center of Excellence, sponsored by an ASAP and medical provider, has created a integrated and coordinated statewide network of providers for evidenced based wellness programs. By working with health care insurers, physician groups and other health care providers they can help to identify high risk members and refer to locally lead programs.

RECOMMENDATION: Medicare and Medicaid should provide funding for community-based, independent care transitions coordinators based on the CCTP project model found in section 3026 of the Affordable Care Act.

3. Expand and fund self-management as a key component in the improvement of health outcomes associated with chronic disease.

The ASAPs and AAAs in Massachusetts are actively involved in disseminating chronic disease self-management programs as part of a statewide Healthy Living Center of Excellence, which was initiated by one of our member agencies, Elder Services of Merrimack Valley, and Hebrew Senior Life. There has been very little focus by health plans, including Medicare and Medicaid, on the role of the individual in proactively managing their health conditions and taking more responsibility for improving their personal behaviors that will result in improved health outcomes and lower costs. Most consumers have received no training in self-care and chronic care management. There are many self-management trainings now out in the community, and they represent the most innovative models of patient- and family-centered care, because they actually engage members in maintaining their own wellness. Greater focus should be paid to the dissemination of models of chronic disease self-management education (CDSME) to more Americans of all ages, in groups, in one-on-one settings, and online programs.

We recommend support for Medicare beneficiaries to have access to evidence based self-management programs for chronic disease, pain management, fall prevention and physical activity. We believe this will result in improved quality of care, improved disease management and lower per capita costs. Mass Home Care supports Medicare funding for the Stanford Chronic Disease Self Management Program (CDSMP) for older adults with chronic disease. Research studies have demonstrated positive changes in self-efficacy, health behaviors, physical and psychological health status, and symptom management as well as reducing per capita costs of health care.

the healthy living Center of Excellence

The Center for Medicare and Medicaid Innovation (CMMI) should be directed to develop and test Integrated Self-Care Planning (ISP), to integrate primary care and community service providers to help older adults and their caregivers reach personal goals for aging well.

Mass Home Care also recommends that Medicare billing codes for Chronic Care Management (CCM) services include the provision of chronic disease self management education (CDSME). Community providers should be able to bill for those members who attend a CDSME workshop either in-person or online at the recommendation of their physician.

RECOMMENDATION: We urge the Chronic Care Workgroup to recommend CDSMP and CDSME be provided by community based organizations to all health care providers, organization and systems as the fundamental self management approach for Medicare beneficiaries with one or more chronic diseases.

BIP Report Card

On July 10, 2015, the Office of Long Term Care Services and Supports (OLTSS) issued its first Balancing Incentive Payment (BIP) Stakeholder's Newsletter. BIP Project Director, Ken Smith, told advocates: "We plan to include our progress with the BIP call center, website development, and the BIP public awareness plan."

BIP refers to federal funding that is provided to states whose share of overall LTSS spending was less than 50% on community-based care, and thus more than 50% on nursing homes. When the Commonwealth applied for this federal funding several years ago, the Commonwealth was below 50% community care. In total, the Commonwealth has received roughly $122 million in added reveue from the BIP program.

According to the BIP newsletter, "Massachusetts has not only achieved, but has also exceeded BIP's 50% requirement for funding community based care versus institutional based care. To date, approximately 65% of the MassHealth LTSS budget funding has been awarded to support services in the community.

Federal funding is being used to create a new Call Center and Website. As of October 1, 2015, Massachusetts will offer a statewide toll-free telephone number and website for individuals seeking community LTSS. Customer service representatives will be trained on how to complete the referral process with the caller in order to make an appropriate referral to one of the Aging and Disability Resource Centers (ADRC) that specializes in the service needs identified by the caller. Massachusetts has partnered with the University of Massachusetts Medical School to support this initiative.

BIP funds will also be used for a Public Awareness Campaign. In the coming months, Massachusetts will conduct an awareness campaign to let the public know about the BIP program. Specifically, the campaign will increase the visibility of Community LTSS services and also increase the visibility of entities that support LTSS services such as ADRC and state agency partners. The public awareness campaign will also highlight the upcoming fall launch of the website and the call center.

The BIP grant has also allowed Massachusetts to hire eight new Community Based-LTSS financial eligibility specialists and three complex case eligibility specialists. The eligibility specialists will alternate their time between the local ADRCs and the MassHealth Enrollment Centers. This added staffing capacity is designed to help MassHealth applicants navigate the complex eligibility process and assist in aligning the timing of functional determinations with financial determinations.

According to data obtained from the Massachusetts Comptroller's office, the Commonwealth has earned $122.65 million in BIP funding for the 15 month period April, 2014 through June 2015. The first $16 million in BIP funding was used for "structural" items listed above, like developing a call center, website and new benefits specialists, and ensuring that all intake systems are run on a conflict-free care management model. But of the remaining $106 million, around 80% of the funding that was made available for home and community based services was spent on non-elderly populations, and only 20% for the elderly. Yet the worst rebalancing problems are with elderly programs, where nursing facilities expenditures have been the dominant form of care. Since the year 2000, nursing facility patient days have plummeted by -34%.

Mass Home Care's recent effort to raise the income eligibility for the home care program would have come out of this federal BIP funding---but the FY 16 budget Conference Committee did not approve it.

GAO Study: 90% of Elders Who Need Meals Don't Get Them

A study conducted by the federal Government Accounting Office (GAO) recently at the request of U.S. Senator **Bernie Sanders** (I-Vt.) found that nearly 4 million low-income seniors – more than 1 in 5 – do not know where their next meal is coming from.

Sanders posed this question to the GAO: "What is known about older Americans' reported need for home and community-based services like those funded by the Older Americans Act, and the potential unmet need for these services, based on national survey data?

U.S. Senator Bernie Sanders

The GAO found that fewer than 10% of low-income seniors who needed a meal delivered to their homes in 2013 received one. One in three low-income seniors age 60-69 is what the government defines as "food insecure," yet fewer than 5% receive a meal at home or at a senior center. Elderly people with a disability, minorities and seniors living on less than $10,000 a year were even more likely to be hungry.

The GAO study updated findings from a 2008 report on the unmet need for Older Americans Act services. First passed by Congress in 1965 and this year celebrating its 50th anniversary, the Older Americans Act provides essential services for seniors like nutrition programs, job training, caregiver support, transportation, and protection from abuse and financial exploitation. The GAO report noted that while the number of older adults has increased from 56 to 63 million, funding provided to states has gone down since 2009. "An estimated 27% (about 16 million) of older adults from all income levels report difficulties with one or more daily activities, indicating they may need home-based care, the GAO found. "Two-thirds or more of these older adults either receive no help, or receive help with some, but not all, of their difficulties—either formally from sources such as Title III programs and Medicaid or informally through family members. Specifically, between approximately 67 and 78% do not receive help with all identified difficulties, depending on the number and type of difficulty."

The GAO reported that more older adults receive professional help than did in 2008 among those who have difficulty with three or more basic activities such as bathing or walking (about 19% in 2008 compared to an estimated 30% in 2012). About one in five adults age 65 and older potentially need transportation services. An estimated 20% of people 65 and older (about 8.5 million) are potentially at-risk for needing transportation services like those provided by Title III programs, according to the GAO analysis of 2012 data.

Senator Sanders has called for the reauthorization of the Older Americans Act and has advocated for increased funding for Older Americans Act programs. "The demand for these programs is great and in many areas of the country vulnerable seniors are on waiting lists for services that they desperately need," Sanders wrote in a letter signed by 32 other senators. The letter was sent to the Senate appropriations members who later this year will set funding levels for senior programs.

"A nation is judged by how it cares for its most vulnerable including the elderly and children. It is not acceptable that millions of elderly in this country are living in poverty and struggling to feed themselves," Sanders said. "Instead of giving tax breaks to billionaires we should be expanding nutrition programs and other services for seniors," the Senator added.

Funding for the Older Americans Act programs is not sufficient to meet the needs of seniors who require help with daily activities. The report found that 16 million (27%) older adults from all income levels report difficulties with one or more daily activities. More than two-thirds of these seniors do not get the help they need.

Sanders is an original co-sponsor of legislation that would reauthorize the Older Americans Act.

Mass Home Care's

2015 Network Conference

"New Visions For Long Term Supports"

Alice Bonner

Secretary of Elder Affairs

Daniel Tsai

Assist. Secretary EOHHS

Tuesday, Sept. 29, 2015

Holiday Inn in Boxborough

20 Workshops/ RN and SW CEUs

REGISTER ONLINE & PAY BY CREDIT CARD:

https://www.eventbrite.com/e/mass-home-cares-2015-network-conference-new-visions-for-long-term-supports-registration-17482128517