At Home

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Al Norman, Editor

Sen. Barbara L'Italien , Mike Festa prepare to testify

Advocates Push Again For Spouse As Caregivers

At a State House hearing on Beacon Hill June 16th, advocates for the elderly and disabled pushed for legislation that would allow MassHealth members to hire their spouse to be paid to provide for their personal care. Unlike 17 other states, Massachusetts regulations allows many family members to be paid as caregivers—but not spouses. A similar bill in 2014 was passed unanimously by the State Senate, but never reached the Governor's desk

Mass Home Care Executive Director **Al Norman**, who helped filed the original spousal pay bill, said it was "time for the state to pass "family-friendly legislation," and give families the freedom to choose their own caregivers.

Norman was joined at the hearing by AARP Massachusetts State Director **Mike Festa,** who told the Children and Families committee "AARP believes public LTSS should give meaningful support to families and friends who provide them. Both existing LTSS programs and any new national program should support—not necessarily replace—the care that families and friends currently give. In a person- and family-centered approach, the needs and situation of family caregivers are assessed and addressed.

"We know families and friends need access to assistance so they are not unreasonably burdened and can continue to provide care," Festa added. "Caregiver assistance should include education and training, counseling, legal consultations, respite care, adult day services, programs that help individuals pay relatives and friends who provide care, and other types of help." According to a recent survey conducted by AARP, most Massachusetts registered voters age 45 and older believe that being cared for at home with caregiver assistance is the ideal situation when basic tasks of life become more difficult due to aging or illness. This same survey found that there is widespread support among registered voters age 45 and older for changes in the Personal Care Attendant program; 86% say they would support allowing spouses to serve as paid personal care attendants for their loved ones."

Norman and Festa testify at spouses hearing. AARP photo

The legislation also was endorsed by Boston College Professor of Social Work, **Kevin J. Mahoney,** who has led the National Resource Center for Participant Directed Care. "Based on our research," Mahoney wrote, "I can assure you that spouses, even when they are paid, continue to provide hundreds of unpaid hours of support, and participants benefitted from having a caregiver who was there because of their relationship and love for the participant."

Also testifying in support of the bill was State Senator **Barbara L'Italien** (D-Andover), one of 52 lawmakers who cosponsored H. 70. "This bill will save the state money by keeping people living independently at home, and out of nursing homes." Her comments were supported by State Representative **James O'Day** (D-West Boylston), who until recently was the House Chairman of the Elder Affairs committee. State Representative **Aaron Vega** (D-Holyoke), who sits on the Children and Families Committee, noted that many ethnic groups strongly prefer care from relatives, like Hispanics and Asians.

Norman quoted from a 2012 study of California's spousal pay program which found "no financial disadvantage to Medicaid and some quality and cost advantages (particularly the much lower rate of preventable hospital stays among elderly recipients) from allowing spouses to be paid providers. This argues in favor of honoring recipient and family preferences for paid spouse providers."

The California study also found that people who had spouses as caregivers had better care outcomes; they had a higher level of satisfaction with their care, and with spouses as caregiver, they used less services. Researchers found no evidence of "induced demand" for care, the so-called 'woodwork effect.' Monthly Medicaid expenditures were lower with spouses than with non-relative providers, because states generally do not pay spouses for 'general household chores,' so less hours of care are necessary to pay for. "There were no financial disadvantages," the study concluded, "and some advantages to Medicaid in terms of lower average Medicaid expenditures and fewer nursing home admissions when using spouses, parents, and other relatives as paid providers. This argues in favor of honoring the recipient's and family's preference for such providers." Medicaid expenditures were lower among those with spouse providers ($770 for elders) and highest among those with nonrelative providers ($1,388). Expenditures among those aged 65 years or older are lower, in part, because more of these recipients have Medicare as their primary payer for hospital, physician, and other health care.

According to Mass Home Care, the Veteran's Administration allows vets to hire their spouse for their personal care. "The V.A. treats veterans as adults, and they let them pick anyone they want to provide for their care," Norman said. "This is a personal decision the state should not impose on families."

PCA Workers Picket For $15 Per Hour

The "purple shirts" will be in front of the Massachusetts State House on June 30th, looking for $15 an hour for Personal Care Attendants (PCAs), and an end to "poverty wages."

The people inside the purple shirts are Personal Care Attendants, and members of 1199 SEIU healthcare workers union which represents them. The PCA workers are on a campaign for a "fair contract and a real living wage" from the PCA Workforce Council, which must negotiate a contract with the workers. PCAs voted to unionize several years ago. This workforce provides personal care services to thousands of low-income Baystate residents who want to live independently at home. “PCAs provide dignity and independence to people with disabilities and seniors,” says 1199 SEIU, “but are forced to live in poverty and on government assistance.”

The SEIU is calling on Governor **Charlie Baker** to agree to a fair contract. “Tell him to respect seniors and people with disabilities by agreeing to a fair contract with PCAs, including a real living wage of $15 an hour.”

SEIU will be holding a 15 hour picket on June 30th, from 7 am to 10 pm at the State House. The community rally will begin at 4pm.

SEIU issued the following statement about their current wage negotiations with the state:

“35,000 Personal Care Attendants across Massachusetts provide support in the homes of close to 30,000 elders and people with disabilities. By supporting people with bathing, eating, dressing, and other daily activities these workers are enabling our family and community members to live independently and with the dignity these deserve.

Meanwhile these same workers are stuck in poverty, faced with impossible decisions every day. At the rate of $13.38/hour PCAs struggle to put food on the table, get their own healthcare needs met, pay housing and heating bills, and pay for their children’s activities and clothing.

PCAs organized with 1199SEIU, the healthcare workers union, in 2007 after working with elder and disability advocates to pass a law enabling union representation. Since joining with 1199SEIU, PCAs have made significant gains including 23% raises and a $1 million training fund and new orientation program.

PCAs reentered negotiations in the spring 2015, joining the national movement for Fight for 15 and proposed a pathway to $15 over a three year period. In addition, PCAs have proposed a modest paid time off benefit (currently they have no paid days off), some additional health and safety protections, and funding for health insurance for PCAs who are currently not covered by any state subsidized plan.

After 2 negotiations, the Workforce Council – with direction from the Baker administration – has made no formal proposals but has made it clear they are looking for a short term contract with little gains in wages and a cut to the training and orientation program.

Personal Care Attendants simply want to be able to provide quality care to local families while also be able to care for their families - without relying on food stamps or other government benefits just to survive. And in order to provide quality care they need training and orientation. The state is moving in the wrong direction not only by not lifting wages but by proposing cuts to the new training and orientation programs that will help PCAs provide care to our family members. Governor Baker needs to hear from Massachusetts elder advocates in support of fair wages and quality training and orientation for PCAs. The workforce is the backbone of our longterm care system in Massachusetts and without a fairly compensated, well trained workforce, elders will be in jeopardy.

As the contract expiration approaches on June 30, PCAs are gearing up for a 15 hour picket in front of the Massachusetts State House from 7AM-10PM. Please join us at 4PM for a rally to support $15 for Personal Care Attendants and a fair contract. And please call Governor Baker at 617-725-4005 to make your voice heard.”

Waiting For the FY 16 Budget

House and Senate budget negotiators say they will have a new FYI 16 state budget in place by July 1st, but elder advocates say that more than $10 million in elder funding hangs in the balance on the final outcome of the Conference Committee report.

Mass Home Care has shared with conferees 4 priority areas that are on advocates’ shortlist of programs to support. Here are the major items that Mass Home Care is recommending: **1. 9110-1630: HOME CARE SERVICES FOR "HARD TO SERVE" ELDERS.** This is the account that pays for personal care services for the elderly, like bathing, dressing and eating. The Governor recommended $106.67 million for this account. The House came in at $103.57 million, and the Senate version matched the Governor's figure of $106.67 million. The Senate budget contains roughly $3.1 million above the House version to allow the home care program to continue to assist "hard to serve" elders who are resistant to help. Mass Home Care supports the Senate budget version.

2. 9110-1633 HOME CARE PERSONNEL AND OPERATIONS: This is the account that pays for personnel and operations expenses for the 27 Aging Services Access Points (ASAPs). The Governor and the House recommended $34.68 million for this account, which is a cut of roughly $866,677 million below the FY 15 appropriation for this account. The Senate funds this line item at the FY 15 appropriation, adding back in the funds cut by the Governor and the House. Eight years ago, in FY 08, this account was funded at $39.87 million, which is 12% higher than the FY 16 Senate version. This account, which pays for frontline care managers and RNs, has been level-funded for 7 years. Mass Home Care commissioned an independent salary study of ASAP salaries, which found that care manager and RN salaries at the ASAP agencies were "below market rate" compared to existing salaries in the field. Mass Home Care supports the Senate version of this line item.

3. Outside Section 105K. RAISING HOME CARE INCOME ELIGIBILITY. This outside section uses $6.25 million in federal funds to expand the home care income eligibility limit from $27,000 to $35,000, the first time there has been an adjustment to the base level since the mid-1970s. This will allow some lower middle income families to get home care that they cannot afford without partial subsidy. The House budget has no outside section to raise home care income eligibility.

The Senate outside section would commit up to $6.25 million in federal funds to raise home care eligibility to 300% of the federal poverty level. It requires the Executive Office of Elder Affairs to produce a report by October 1, 2015 that would project enrollment and costs for this wider eligibility opening, and report on ways to pay for these services using other revenue sources, such as the federal 1915i state plan amendment to MassHealth that is projected to provide the Commonwealth with $20 million in new revenue for serving current home care clients. Home care advocates note that the 1915i amendment has already been submitted to the federal government, and requires no new activity at the state level to collect another $20 million for home care annually. The base home care income eligibility has not been adjusted since the program was founded in 1974. In the 1980s, a cost of living adjustment was added---but the base amount was never changed. Today, an elder in Massachusetts with a $35,000 annual income and a need for one hour of personal care per day, would spend 26% of their income on home care alone. These older individuals are unlikely to be able to afford such care, and will pass up the support. This puts them in a "no care zone" financially unless their home are can be subsidized. The Senate budget would allow such lower middle income elders to get home care services at a reduced cost. The Senate Outside Section 105K is the top Mass Home Care priority in the Conference Committee.

4. 4000-0600. RESTORING 'RESPITE DAY' PAYMENTS TO ADULT FOSTER CARE GIVERS. The Senate budget for FY 16 includes language in this account to restore "respite" day payments to primary caregivers in the Adult Foster Care (AFC) program, which were cut in April by the Baker Administration as a 9c cut. This allows caregivers to receive a stipend for days when they take a 'break' from their 24/7 responsibility for caregiving. Under the AFC program, caregivers take an elder into their home and provide them with 24/7 supervision and supports. Many of these seniors would otherwise be in a nursing facility. Up until April, these primary caregivers were allowed to take up to 14 days per year in "respite" days, when they conduct their own personal business away from the home, and bring in a back-up caregiver who gets a stipend while the main caregiver is away. Since April, the state has taken away these "respite day" payments as a cost-saving move. Mass Home Care supports the Senate budget version, which restores these payments to the caregivers.

One Care Plan: Where Are the LTSS Coordinators?

In May, a citizen's advisory group formed by MassHealth to help oversee the managed care health care program known as "One Care," reported findings on a "member experience" survey of enrollees in the MassHealth program who joined this plan.

There are currently close to 18,000 members in the One Care program, which launched in October of 2013. The enrollees are all on Medicare and Medcaid, and are referred to as "the duals." Although the One Care program is targeted to individuals between the ages of 18 and 65, the program is permitted to serve people who turn 65 and stay in the plan. This overlaps an existing duals managed care program, known as Senior Care Organizations (SCOs), which began 11 years ago, and has a population of 38,000. In both plans, there is statutory language allowing enrollees to have an independent Long Term Care Support coordinator to assess their need for long term services. Aging Services Access Points (ASAPs) are one of the independent LTSS Coordinators available to members.

The One Care Implementation Council, as it is known, released the results of its "One Care Early Indicators Project Workgroup" survey. The Workgroup, which includes several members of the Implementation Council and state employees, released survey findings that reflect those of an earlier indicators report---reinforcing the concerns of advocates that most people in the One Care plans to date are not engaged with their independent LTSS agent.

A total of 6,000 One Care members were surveyed, and roughly 1,800 responded. The survey conclusions include the following:

- Many One Care members are unsure whether they want and/or have been offered a LTS Coordinator and whether they want/need LTSS services.
- 39% said they needed/wanted a LTSC, and 20% said they were not sure.
- Many members were unsure if they need/want or had been offered a LTS Coordinator. Only 42% said they had been offered a LTS coordinator. 23% said they were not offered an LTSC, and 30% were not sure.
- Only 44% of those who were offered a LTSC actually met with one, which means only 18% of those surveyed had actually met with a LTSC—82% had not.
- Only 38% of members said they had an individual care plan.
- 34% said they had an unmet LTSS need for services.
- 26% said they had a need for personal care, but 25% of those said their need was not being met. Fewer members than anticipated reported working with a LTS Coordinator.

These findings suggest a lack of understanding among members about LTSS and the benefits of working with a LTS Coordinator. There also may be a lack of availability of LTS Coordinators. The way that the One Care plan has been set up, primary care doctors and Care Coordinators on the One Care staff have a key role in connecting (or not connecting) members to LTS Coordinator services. The Workgroup also concluded:

- Members' needs for medical services are more consistently assessed and addressed compared to LTSS needs
- Many members are unsure whether they had an individual care plan and there is a need for greater attention to person-centered and member driven care planning

The Workgroup listed these recommendations:

- Educate members, effectively and in an on-going manner, about availability of LTSS and role of LTS Coordinator. Care Coordinators and PCPs are essential to these efforts, and therefore must be fully knowledgeable of and invested in the integrated care model. The Implementation Council, MassHealth and One Care plans can support broad member education in this area.
- Enhance capacity within Community-Based Organizations to ensure availability of LTS Coordinators.
- Ensure that LTSS needs are assessed and addressed. One Care plans and MassHealth must reinforce and continually manage toward this goal.

Mass Home Care, which has long been critical of the One Care implementation of the independent LTSC agent role, said that it is clear from this survey that the One Care plan has not successfully implemented state law provisions under Chapter 118E, 9F, which says that the LTSC: "shall participate in initial and ongoing assessments of the health and functional status of the member, including determining appropriateness for long-term care support and services, either in the form of institutional or community-based care plans and related service packages necessary to improve or maintain enrollee health and functional status;

Many members are not being told about the LTSC, fewer still ever meet with an LTSC, Mass Home Care said. Almost 4 in 10 members say they have no individual care plan. State law does not give One Care plans the right to filter out access to an independent LTSC. Members are not asked if they want to be assessed by a doctor for their medical needs---it is a requirement. Even-handed treatment of LTSS would warrant the same status for assessment for LTSS needs by an LTSC—it should also be a requirement.

"These are very serious deficiencies in the One Care plan,"said Mass Home Care Executive Director **Al Norman**. "This latest survey repeats findings from an earlier survey. Although EOHHS has said in the past that some of these deficits are 'actionable,' it does not appear that any corrective actions have had an impact."

"EOHHS should immediately instruct plans that ALL members need to have an initial LTSS assessment," Norman said, "to create a baseline metric of need for LTSS for each enrollee. From there, the member can choose if they want to receive LTSS services, but the initial assessment for LTSS needs should be as important as the initial medical assessment by a physician."

U.S.Senate Forms Working Group on Medicare Chronic Care

Senator Orrin Hatch

Anyone studying health care issues in America cannot miss the warning signs in the Medicare program—and the outstanding challenge of beneficiaries with chronic care diseases.

In mid May, a Congressional Committee overseeing the rollout of Medicare managed care, issued a request to health care professionals to submit creative ideas for how to improve care for Medicare beneficiaris with chronic care needs. Here are excerpts from the letter sent by the U.S. Senate Committee on Finance, chaired by Senators **Orin Hatch** (R-Utah) and **Ron Wyden** (D-Oregon):

"On May 15th, the United States Senate

Committee on Finance held a hearing entitled, “A Pathway to Improving Care for Medicare Patients with Chronic Conditions.” During that hearing, Chairman Hatch and Ranking Member Wyden announced the formation of a bipartisan, full Finance Committee chronic care working group, co-chaired by Senators **Johnny Isakson** (R-GA) and **Mark Warner** (D- VA). The working group will analyze current law, discuss alternative policy options, and develop bipartisan legislative solutions that will be presented to the Chairman and Ranking Member.

To guide and inform this effort, the Chairman and Ranking Member, with the co-chairs of the working group, are seeking recommendations and thoughtful policies from health care stakeholders based on real world experience and data-driven evidence that will improve care for this vulnerable population.

The impact of chronic disease on the Medicare program and those it serves are staggering:

- Treatment of chronic illnesses such as heart disease, diabetes, and cancer – just to name a few – now account for almost 93% of Medicare spending.
- According to Medicare Payment Advisory Commission (MedPAC) data, in 2010 more than two-thirds of Medicare beneficiaries had multiple chronic conditions while 14% had six or more chronic conditions.
- Beneficiaries with six or more chronic conditions accounted for 46% of all Medicare spending in that same year.
- The traditional Medicare fee-for-service program spent an average of $32,658 per beneficiary with six or more chronic conditions compared to an average of $9,738 for all other beneficiaries.

Left unresolved, this situation will only worsen. Researchers at the Centers for Disease Control and Prevention (CDC) report that an increasing number of adults between the ages of 45 and 64 – are living with multiple chronic conditions. These members of the Baby Boom generation will soon be aging into the Medicare program. Because utilization of health care services increases as a person’s number of chronic diseases climbs, this population trend signals even higher future Medicare program spending. Private sector health insurers have extensive experience in using disease management and care coordination tools to effectively target and better engage patients that have chronic conditions. The successful Medicare Advantage program has given beneficiaries the option to receive Medicare benefits from these private plans that have an incentive to manage patient care across all settings. As a result, 15.7 million beneficiaries – or 30% of Medicare participants – chose a Medicare Advantage plan in 2014.

Traditional fee-for-service Medicare has recently increased its focus on chronic care by implementing new billing codes in the physician fee schedule and by studying alternative payment models. Yet traditional Medicare still struggles to properly align incentives to providers who engage in labor and time intensive patient care coordination.

Representative Ron Wyden

Over the past decade, Congress routinely tasked the Centers for Medicare & Medicaid Services (CMS) with conducting various demonstration programs aimed at strengthening chronic care coordination, lowering hospital admissions, and reducing Medicare spending. These demonstration programs have, at best, shown mixed results which underscores the inherent limitations of traditional Medicare’s fee-for-service payment system – one that rewards providers for delivering increased volume of services, but doesn’t incentivize them to coordinate medical care.

Since the Affordable Care Act (ACA) became law, there has been an increased focus on programs like Accountable Care Organizations (ACOs) and Medical

Homes. Recent ACO related demonstrations have initially shown promise, but these payment initiatives are still relatively new. The data has yet to prove if ACOs – as they are currently structured – will improve quality and significantly reduce Medicare spending long-term.

Developing and implementing policies designed to improve disease management, streamline care coordination, improve quality, and reduce Medicare costs is a daunting challenge. But we are committed to tackling this urgent matter head on and finding ways to provide high quality care at greater value and lower cost without adding to the deficit. As the Finance Committee looks to develop solutions that improve health outcomes for Medicare patients with chronic conditions, we intend to proceed carefully. Stakeholder input is critical for the committee to work toward its goal of producing bipartisan legislation that can be introduced and marked up later this year. To aid the Finance Committee in bipartisan chronic care reform policy development, we request all interested public and private sector stakeholders submit their best ideas on ways to improve outcomes for Medicare patients with chronic conditions. In reviewing all submissions, we have three main bipartisan goals that each policy under consideration should strive to meet:

1.The proposed policy increases care coordination among individual providers across care settings who are treating patients living with chronic diseases;

2. The proposed policy streamlines Medicare's current payment systems to incentivize the appropriate level of care for patients living with chronic diseases; and

3. The proposed policy facilitates the delivery of high quality care, improves care transitions, produces stronger patient outcomes, increases program efficiency, and contributes to an overall effort that will reduce the growth in Medicare spending.

In addition, we request feedback on the following issue areas, which outline specific policy categories that the Committee plans to consider as part of its chronic care reform efforts:

1.Improvements to Medicare Advantage for patients living with multiple chronic conditions;

2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures;

3. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions;

4 The effective use, coordination, and cost of prescription drugs;

5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology;

6. Strategies to increase chronic care coordination in rural and frontier areas;

7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers; and

8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.

In response to this plea for "best ideas" for improving care to Medicare enrollees with chronic care needs, advocates around the country began circulating draft letters for the Finance Committee to review.

Feds Propose New Rules For Medicaid Long Term Services

While the U.S. Senate Finance Committee focused on Medicare chronic care needs, on June 1, 2015, the federal Department of Health and Human Services (DHHS) issued a 643 page proposed rule regarding a number of Medicaid health programs, including Medicaid Managed Long Term Services and Supports (MLTSS), found in 42 CFR Part 438.

In its introduction to the proposed MLTSS rules, DHHS says: "The current Medicaid managed care regulations were written at a time when a managed care delivery system was not frequently utilized for LTSS. With states using managed care to deliver covered services to populations with more complex needs, care coordination that is appropriate for individuals using LTSS becomes an important component of managed care." Managed Long-Term Services and Supports (MLTSS) refers to "an arrangement between state Medicaid programs and managed care organizations (MCOs), through which the MCO, receives a capitated payment for providing long-term services and supports (LTSS)."

MLTSS programs have grown significantly over the past decade and are expected to increase even more in the coming years. Recognizing this significant shift in delivery system design, in May of 2013, DHHS developed ten key principles inherent in a strong MLTSS program. DHSS is now revising the Medicaid managed care regulations to ensure that all MLTSS programs operate in accordance with these elements.

DHSS proposes this new definition of LTSS as "services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting." DHHS intends for community based services "to be largely non-medical in nature and focused on functionally supporting people living in the community." Individuals with chronic illness that may receive LTSS include individuals with mental health conditions and substance use disorders.

Among the MLTSS elements from 2013 are the following:

- **Stakeholder Engagement**: Successful MLTSS programs have developed a structure for engaging stakeholders regularly in the ongoing monitoring and oversight of the MLTSS program. Educated stakeholders, including beneficiaries, providers, and advocacy groups inform decisions as to what works and what does not in the managed care system, allowing the state to design systems that are responsive to the needs of stakeholders and to address any implementation issues discovered early in the process.

- **Support for Beneficiaries:** Support and education, including enrollment and disenrollment assistance and advocacy support services, are critical for all beneficiaries in a MLTSS program. States would provide a beneficiary support system, including choice counseling services to those with complex needs, such as those receiving LTSS. If the state does not permit participants enrolled in MLTSS to switch managed care plans (or disenroll to FFS), at any time, states should permit MLTSS enrollees to disenroll and switch to another MCO or FFS when the termination of a provider from their MLTSS network would result in a disruption in the enrollee's use of that provider. DHHS also incorporates a new section (§ 438.816) called Expenditures for Independent Consumer Support Services for Enrollees using LTSS that is modeled in part, on the current rules for enrollment broker services, including that the person or entity providing the service must meet independence and conflict of interest provisions applicable to enrollment brokers (§ 438.810(b)).
- **Person Centered Process:** Ensuring that beneficiaries' medical and non-medical needs are met and that they have the quality of life and level of independence they desire within a MLTSS program starts with person-centered processes including comprehensive needs assessments and service planning policies. This proposal would have an overall effect of shifting from a strictly medical, acute care focus to one that addresses all covered services.
- **Comprehensive, Integrated Service Package**: In instances in which a state managed care program

divides services between contracts or delivery systems, it is important that there is robust coordination and referral by the managed care plan to ensure that the beneficiary's service plan, which may include LTSS, is comprehensive and person-centered.

- **Participant Protections and Quality:** A quality system for MLTSS is fundamentally the same as a quality system for a state's entire managed care program, but should include MLTSS-specific quality elements. DHHS specifically proposes to include references to specific MLTSS quality considerations, and that the state includes the results of any rebalancing efforts by the MCO in its annual program review. These provisions are discussed in more detail in section I.B.6.b. of this proposed rule.

DHHS also includes these additional proposals:

- **Stakeholder engagement:** plays a critical role in the success of a MLTSS program. DHHS proposes that states create and maintain a stakeholder group so that opinions of beneficiaries, providers, and other stakeholders are solicited and addressed during the design, implementation, and oversight of the MLTSS program. Each MCO should also establish a regular process to solicit direct input on the enrollees' experiences through a member advisory committee, including a reasonably representative sample of the covered LTSS populations.
- **Independent Enrollment Brokers:** Enrollment broker means an individual or entity that performs choice counseling or enrollment activities, or both. Enrollment services means choice counseling, or enrollment activities, or both. The broker and its subcontractors meet the following conditions: (1) Independence. The broker and its subcontractors are independent of any or other health care provider in the State in which they provide enrollment services. A broker or subcontractor is not considered "independent" if it is an MCO or other health care provider in the State; is owned or controlled by an MCO, or other health care provider in the State; or if it owns or controls an MCO or other health care provider in the State. The broker and its subcontractor must be free from conflict of interest. A broker or subcontractor is not considered free from conflict of interest if any person who is the owner, employee, or consultant of the broker or subcontractor or has any contract with them; has any direct or indirect financial interest in any entity or health care provider that furnishes services in the State in which the broker or subcontractor provides enrollment services;

- **Choice Counseling:** Under § 438.2, Choice counseling is defined as the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care health plans and primary care providers. Choice counseling must be provided to all potential enrollees and enrollees who disenroll from a MCO. If an individual or entity provides choice counseling on the State's behalf under a memorandum of agreement or contract, it is considered an enrollment broker, and must meet the independence and freedom from conflict of interest standards.

In § 438.71 states are required to create a Beneficiary support system that provides support to beneficiaries both prior to and after enrollment in a MCO. This would include Choice counseling for all beneficiaries, training for network providers; assistance for enrollees in understanding managed care; and assistance for enrollees who use, or express a desire to receive, LTSS.

In § 438.208(c) , the State must implement mechanisms to identify persons who need LTSS, and may use State staff, the State's enrollment broker, or the State's MCOs, to identify these needs. Each MCO must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State as needing LTSS to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanism must use appropriate health care professionals or individuals meeting LTSS service coordination requirements of the State or the MCO. If the State require MCOs to produce a treatment or service plan for enrollees who require LTSS that are determined through assessment to need a course of treatment or regular care monitoring, the treatment or service plan must be developed by the enrollee's provider or individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any other health care professionals caring for the enrollee. The LTSS service plan must be developed by a person trained in person centered planning using a person-centered process and approved by the MCO, if this approval is required by the MCO. The service plan must also be reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee. DHHS also proposes amending paragraph (c)(2) of § 438.208 so that assessments for individuals in need of LTSS are comprehensive and are conducted by appropriate LTSS service coordinators having qualifications specified by the state or the MCO.

The proposed rules for MLTSS can be found at: https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered#h-57

Boston Hosts Regional White House Conference on Aging

On May 28, 2015, roughly 200 people attended an invitation-only White House Conference on Aging event in Boston at the **Edward M. Kennedy** Institute. The forum featured speeches by Health and Human Services Secretary **Sylvia Burwell**, who announced a new federal "Million Hearts" initiative, which seeks to prevent one million heart attacks and strokes by 2017. Burwell also announced a new Medicare and Medicaid Innovation Center project to help healthcare providers treat the whole health of their patients to improve heart health and reduce the risk for heart disease and stroke.

There were panels and breakout sessions on retirement security, healthy aging, long-term services and supports (LTSS), and elder justice. For Mass Home Care, one of the key issue of the conference was long term services. The WHCOA has written a policy brief on LTSS which does not directly address the major challenge facing Massachusetts over the future direction of Medicaid---the joint federal and state program that funds most LTSS in America. According to the WHCOA policy brief: "The largest source of long-term services and supports expenditures is Medicaid, funded at both state and federal levels, and estimated at $131.4 billion…Medicaid provides coverage for health care and long-term services and supports for individuals with limited financial resources…States are required to make nursing home care available under their Medicaid programs. However, Medicaid coverage of home- and community-based services is optional."

Boston WHCOA at Kennedy Institute

That last sentence pretty much sums up the problem in America today. Nursing facility care is an entitlement, home care is not. But there is an equally challenging problem that the WHCOA Brief does not mention: the medicalization of LTSS.

Governor **Charlie Baker's** Administration is working aggressively to introduce "Accountable Care Organizations" to control more than $3.7 billion in Medicaid LTSS funding. These ACOs are not just insurers---they are providers---like groups of hospitals or physician practices.. The medical establishment for years has used nursing facilities as the automatic default for patients who needed to move out of acute care settings. They have had little contact with community-based LTSS providers. In the home care system, for example, very few referrals for home care come from doctors. For many consumers, their first LTSS is a nursing facility. The ACO plan puts all Medicaid LTSS spending under the control of entities that have favored institutional care over community care.

In the past decade, Massachusetts has dramatically shifted care away from institutions---but this was the work of community-based groups, not the acute care providers. If Medicaid money is going to be controlled by health care providers, there will need to be some built-in protections for the consumer. One solution that we have pioneered in Massachusetts over the past decade is the use of an "independent agent" to ensure that Medicaid members have their LTSS needs assessed by someone who does not represent service providers. This "conflict-free care coordinator" is part of two large managed care programs in the Commonwealth that serve 55,000 elders and individuals with disabilities: the One Care and Senior Care Organizations.

Even today, LTSS is defined by what it can do for the medical system: reduce hospital readmissions, and lower Emergency Room visits. LTSS does not even have an agreed upon set of metrics to measure its success. This is because LTSS has been an after-thought. Yet "social determinants" have a big impact on wellness: adequate income, decent housing, good nutrition, accessible transportation. As one person said at the WHCOA in Boston: "Being able to go to the grocery store for fresh food is as important as taking your medications."

As the LTSS Policy Brief concludes: "delivering formal services and supports in home and community-based programs can improve the quality of care individuals receive as well as reduce health care costs."

Whole person care is not a matter for doctors alone. It takes an "Accountable Care Village" to keep people well. Non-medical, "social determinants" have a big impact on health care outcomes.

During the Boston WHCOA, without any advanced notice or fanfare, the White House announced that the official WHCOA will be held July 13th in Washington, D.C. It is not clear who will be attending this session, or how people got on the invitation list, but the voices of seniors and their advocates do not seem to be be part of the mix.

Mystic Valley Elder Services Merges With CRW

James P. Cunningham, Jr.

On June 9, 2015, Mystic Valley Elder Services and Chelsea Winthrop Revere Elder Services announced that the two organizations will merge operations on or about October 1, 2015.

The newly merged agency will operate under the Mystic Valley Elder Services name, and will continue to provide essential home- and community-based care and resources to older adults, adults living with disabilities, and caregivers residing in Chelsea, Everett, Malden, Medford, Melrose, North Reading, Reading, Revere, Stoneham, Wakefield, and Winthrop. Mystic Valley Elder Services will continue to coordinate home care services, Meals on Wheels, transportation, and enrichment opportunities for program participants and the community at large.

"The new Mystic Valley Elder Services will be an even more robust partner to the members of our eleven communities," said **Daniel O'Leary**, executive director. O'Leary is also the current President of Mass Home Care, and on June 15th was re-elected by his peers to serve a second one year term of office.

"This merger brings together the significant financial, intellectual, and human resources of two long-standing community institutions. Over the next several months, we will strengthen our newly centralized administrative offices, identifying resources that can be better spent on providing care and services to consumers across the region. We will streamline our operations so that more energy than ever can be focused on deepening our relationships with the individual community members of the expanded Mystic Valley region," he continued.

James P. Cunningham, Jr. who has served as CEO of Chelsea Revere Winthrop Elder Services for 39 years, is retiring at the end of June. "This union will ensure continuity of service for older adults in the Chelsea, Revere, and Winthrop communities," Cunningham said. "And our deeply knowledgeable staff will bring compassion and decades of expertise to the Everett, Malden, Medford, Melrose, North Reading, Reading, Stoneham, and Wakefield communities, further enriching the fine services they have received from Mystic Valley Elder Services over the past forty years." The boards of both organizations carefully studied the potential effects of this merger with an eye toward increasing quality of life for existing program participants as well as for those to come. O'Leary anticipates that the agency will continue to grow in size and resources both from a client and staff perspective over the next several years. "These agencies, both of which were created by the communities they serve, have faithfully addressed the needs of older adults and adults living with disabilities for decades," said Senator Sal DiDomenico (representing Everett and Chelsea) . "They are known individually among my constituents as organizations that act with integrity in all things, that bring wisdom and compassion to their services, and that elevate the needs and desires of the community members above all else. I take great pleasure at seeing them join forces and become an even more solid and expansive presence in the Mystic Valley region," he continued. The organizations will work to combine operations over the next several months with regard to personnel, finances, services, and vendor relationships. In the meantime, Mystic Valley Elder Services will begin to update print materials and the website in anticipation of the expanded service area and the influx of new staff. The union will be officially celebrated at the agency's 40th anniversary party on October 1 at the Montvale Plaza in Stoneham.

State Proposes $2 Million Rate Hike for Rest Homes

Rest Homes in Massachusetts have been described as one of the least understood, least funded resources in Massachusetts for the elderly and disabled. On May 21, 2015, the rest home industry made a direct pitch to the state for better funding. In a letter to **Marylou Sudders**, the Secretary of the Executive Office of Human Services, State Senator **Patricia Jehlen**, chairwoman of the Joint Committee on Elder Affairs, lead a group of lawmakers signing onto the issue of better rates for "Residential Care Facilities."

Here are excerpts from state lawmaker's letter:

Dear Secretary Sudders:

We are writing to request that the Executive Office of Health and Human Services move to promulgate regulations establishing updated rates of payment for residential care facilities (rest homes or RCFs) (101 CMR 204.00) utilizing cost data from 2010. Section 13D of Chapter 118E requires EOHHS to establish rates for nursing homes and rest homes by October 1st of each year, and in setting such rates, EOHHS must use base year reported costs that are not more than 4 years older than the current rate year. Unlike in prior years, the FY15 state budget does not include language allowing rates for RCFs to be set using older base year costs. To date, updated rates for FY2015 have not been established, and current rates are still based on reported costs from 2005. We ask that you lead EOHHS in complying with its statutory obligation to set rates of payment for residential care facilities.

Through the provision of three meals a day, medication administration/management, assistance with personal care and more in a community-based home-like environment, residential care facilities allow many individuals with chronic health and mental health needs the ability to continue living safely in the community, avoiding unnecessary nursing home placement or homelessness. Unfortunately, the Commonwealth is at risk of losing this critical component of our aging services infrastructure. In the past 10 years, 34 RCFs with more than 1,100 beds have closed.

With these closures, many of the residents have no choice but to relocate to nursing homes as their only available option. Today there are fewer than 80 freestanding RCFs that exist across the Commonwealth. One of the reasons facilities have closed is due to the fact that public rates of reimbursement have not kept pace with the actual costs of providing quality care.

Residential care facilities play a key role in enabling families with modest incomes to have access to much needed care and services in a supportive housing environment. At a time when we need to be ensuring the availability of appropriate care and services for our rapidly expanding elder population, as well as stable supportive housing environments for individuals with behavioral health needs in a community-based setting, it is critical that we do all we can to preserve and enhance this critical resource . We urge your immediate attention to take the necessary steps to ensure compliance with state statute and to support this important affordable supportive housing resource for those who need it.

Sincerely,

Senator Patricia Jehlen, et al.

While this letter on rest home rates was being drafted, the Executive Office of Health and Human Services was announcing a public hearing slated in Quincy, MA. for June 26th to present the emergency adoption of new rates for rest homes.

Under the EOHHS proposal, the amended regulation uses 2012 as a base year, with variable costs capped at the 85th percentile at $96.46 (or $101.63 with a 5.36% cost adjustment factor). Rates are being held harmless such that there are no rate decreases relative to current rates, EOHHS says. Rest homes with current rates below $70 will get a minimum of a $3 increase, and rest homes with rates greater than or equal to $70 and less than $90 get a $1 minimum increase. The proposed regulations went into effect on June 1, 2015, with an annualization for June only to account for rate increases for October through May. EOHHS says it is proposing this regulation and amendments to ensure that payment rates are consistent with efficiency, economy, and quality of care. It is estimated that annual aggregate state expenditures will increase by $1,935,030 as a result of these amendments.

Suzi Lawton, President and Advocate for the rest home group MARCH, The Massachusetts Association of Residential Care Homes, told AT HOME that she "thanks the Administration for the new rate proposals and hopes that other long standing policy issues will finally be addressed."

Lawton retired from running a rest home in 2006, but still advocates for the industry, The mission of MARCH is to encourage financial viability, support and advocacy and increase visibility and recognition of the cost effective quality care offered residents in a home-like setting within the long term care continuum. or residential care community.

Cueing Bill Takes Hearing

On June 16th, the legislature's Children and Families committee heard two bills that would allow people who need cueing, or supervision, to perform activities of daily living---like eating, bathing or dressing---to receive services through the personal care attendant (PCA) program.

H. 113 and S. 89, both would allow individuals with disabilities who need cueing to get into the PCA program, which is one of the largest MassHealth long term services programs in the Commonwealth. Enrollment in the PCA program went from roughly 5,800 members in 2000, to 30,000 members today. and roughly $500 million in expenditures. This program is open to people of all ages, including the elderly, younger adults with disabilities, and children with disabilities.

The average cost per member in the PCA program is approximately 32% of the cost of nursing home care. Under the PCA program regulations (130 CMR 422.000), a member is eligible to receive care only if they require "physical assistance" with two or more Activities of Daily Living.

"The current regs discriminate against a person because they happened to get the wrong disease, said Rep. **James O'Day** (D-West Boylson), chief sponsor of H. 113, with 32 other lawmakers. "A person suffering from Alzheimer's, or other form of serious cognitive impairment, who is unable to remember to do their activities of daily living, cannot get PCA support. We are putting people in jeopardy of needing nursing facility care."

The Senate version of the cueing bill, S. 89, was sponsored by Senator **Joan Lovely** (D-Salem). Mass Home Care testified in support of the PCA cueing and supervison bill.

Mass Home Care's 32nd Annual Meeting 6.15.15

Rep. Jeffrey Sanchez

Presidednt's Sauce

Sen. Stan Rosenberg

Sec. Marylou Sudders

Bernadette DiRe

Sec. Alice Bonner

Mark Messenger, Beth Gentleman

Linda George, Al Norman

James P. Cunningham, Jr.