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Al Norman, Editor

Dental Access Campaign Drills Down

A coalition of aging groups is supporting legislation on Beacon Hill that would make dental care for seniors more accessible.

According to the PEW Charitable Trust Dental Campaign, one of the groups supporting the legislation, many seniors in Massachusetts struggle to access dental care. Reasons include not being able to find a dentist that accepts public insurance, prohibitive cost of dental care or challenges in travelling to a dentist's office.

A person's ability to receive adequate dental care is largely determined by age, race, income, health needs, insurance status and zip code. If you are a senior living in the Berkshires or in South Boston, the reality is the same: it may be hard to get adequate dental care.

According to **Jeremy Crandall**, Senior Associate, Pew Dental Campaign:

• low income seniors are five times more likely to have lost all their teeth than seniors with annual incomes exceeding $50,000 (31% vs. 6%) in 2010. African-American seniors were twice as likely as white seniors to have lost all their teeth (30% vs. 14%).

• 59% of seniors (60+ years) in long-term care facilities had untreated decay and 34% had major urgent dental needs in 2009.

• 47% of special needs adults had untreated tooth decay in 2010. 31% of disabled adults in Massachusetts were missing six or more teeth in 2012, compared with 11%

of non-disabled residents.

• Most dentists in MA do not accept Medicaid. In FY 2013, only 21% of dentists licensed in Massachusetts were active providers (providers who billed more than $10,000 to MassHealth).

• As of 2014, Massachusetts had 61 federally designated dentist shortage areas; an estimated 244,000 people in those areas were not having their dental needs met. Residents from shortage areas were also less likely to see a dentist.

• 28% of Massachusetts adults with annual household incomes under $25,000 were missing six or more teeth, compared with only 6% in households with incomes over $75,000 in 2012.

• As of 2011, only 24% of Massachusetts residents had some type of dental insurance.

One effective, common sense solution to address the inequities, increase access to dental care, and improve the overall health of MA residents is passing legislation proposed by Senator **Harriette Chandler** (D-Worcester), who filed S. 1118, and Rep. **Smitty Pignatelli** (D-Lenox) who filed H. 249, that will authorize a new type of dental professional, the Advanced Dental Hygiene Practitioner (ADHP).

ADHPs are dental hygienists who – after completing additional training-–– are able to deliver basic but critically necessary care to underserved populations in the state. ADHPs will work under the general supervision of a dentist, using telehealth technology to share X-rays and patient records with the dentist and consult on complicated cases. This strategy will allow ADHPs to bring care directly to people in schools, nursing homes, and other community settings. ADHPs will deliver critical dental services like filling cavities, placing temporary crowns, and extracting loose teeth.

Proponents say that dental therapists provide quality care and improve access, based on evidence in other states. Similar practitioners in Minnesota have been providing preventive and basic restorative care in a variety of settings (private practices, community health centers, schools, nursing homes) since 2011. Evidence shows:

• Dental therapists have helped clinics decrease travel and wait times for some patients.

• Savings from the lower costs of dental therapists allowed clinics to treat more Medicaid or uninsured patients. One private practice that employs a dental therapist made an additional $24,000 in profit and served an additional 500 Medicaid patients in the therapist's first year.

• Similar providers have been practicing in Alaska for ten years, increasing access for 40,000 people living in rural communities, and Maine authorized them in 2014.

The ADHP bills have been referred to the Public Health Committee, and are expected to have a hearing soon on Beacon Hill.

State Opens Door To Remote Patient Monitoring

On September 2nd, Mass Home Care submitted testimony regarding a new draft of Home Health Services rates developed by the Baker Administration. Here are excerpts from the statement given by **Amy Jorud,** the Clinical Director at South Shore Elder Services.

"I am submitting this testimony today on the draft home health services regulations at 101 CMR 350 on behalf of the Mass Home Care Association, which represents the views of 29 Aging Services Access Points and Area Agencies on Aging across the Commonwealth.

We want to begin by applauding the Baker

Administration for creating a new home health service defined as "Remote Patient Monitoring" (RPM). This service, which has been promoted by home health agencies for many years, will allow home health providers to monitor a patient's health status remotely, using wired or wireless devices installed in the patients' homes to monitor their physiological conditions, based on data entered by the user. These devices send information collected in the home back to home health agencies for monitoring and response, if needed, by alerting clinicians to abnormal readings.

We are hopeful that adding RPM to the list of reimbursable home health services, that the state will also look at the concept of allowing our home care case managers to make home visits via telehealth monitoring, reducing monitoring costs, and allowing more care manager/client contact in less time with less miles traveled.

Since RPM is a new rate, we hope that the state will be open to receiving cost data from the home health industry regarding what adequate rates for the installation/removal and use of these devices should be. Is the proposed code rate Q3014 for installation at $50,and the removal fee $50—or is this one rate supposed to cover installation and removal? What assumption is behind a $10 rate for a RN remote monitoring visit per diem?

As for the home health rates themselves, Mass Home Care is concerned about how home health aide rates impact homemaker rates—and how these two rates compare to Personal Care Attendant rates. All these in-home support workers need to be viewed in wage context---not as unrelated jobs.

Under 651 CMR 3.01, the differences between a home health aide and a homemaker are clear:

• A Home Health Aide provides services provided to clients under the supervision of a registered nurse, or a speech, occupational, or physical therapist. This includes personal care; simple dressing changes that do not require the skills of a registered nurse; assistance with medications that are ordinarily self-administered and that do not require the skills of a registered or licensed nurse; activities that support the skilled therapies; and routine care of prosthetic and orthotic devices.

• A Homemaker provides services to assist a client with Activities of Daily Living and Instrumental Activities of Daily Living, which includes shopping, menu planning, meal preparation including special diets, laundry, and light housekeeping.

There is also a third employee classification available to MassHealth members similar to homemaker and home health aide: the Personal Care Attendant (PCA) which is defined at 130 CMR 422 as:

• A person…who is hired by the member or surrogate to provide PCA services [defined as] physical assistance with ADLs and IADLs provided to a member by a PCA in accordance with the member's authorized evaluation or reevaluation, service agreement, and 130 CMR 422.410.

These three positions all provide in-home personal care services. The home health aide works under the supervision of a nurse or specialty therapist, and is involved with some simple medical tasks, like dressing changes that don't require a nurse. The home health aide and the PCA are able to assist with self-administered medications.

Under the proposed regulations for home health services, service Code G0156, the services of a home health aide is reimbursed at the rate of $6.10 per 15 minutes, or $24.40 per hour. According to the Home Care Aide Council of Massachusetts, rate data analyzed from the Executive Office of Elder Affairs, reveals that almost 30% of all homemaker and personal care homemaker rates paid by ASAPs in 2014 were higher than the $24.40 home health aide class rate set by

MassHealth.

In the state home care program, because of recent wage hikes and salary reserves, the average rate of pay earned by homemakers is roughly $12.69 per hour. Again, according to Home Care Aide Council of Massachusetts research, the U.S Bureau of Labor Statistics data shows that as of the spring of 2014, the average wage earned by a home health aide in Massachusetts was $12.88 per hour, just barely higher than the average wage earned by a homemaker at $12.56. At the same time, the gross waged component for Personal Care attendants as of July 2014 was $13.38 per hour.

As of July, 2015, the gross wage component for PCAs is $13.68 per hour. This suggests that PCAs are now making considerably more than home health aides and homemakers. PCAs are slated to earn $15 an hour by July of 2018. The rates for homemakers and home health aides are very similar, and both of them are lower than the PCA.

On the one hand, it appears that homemakers in some instance are earning more than home health aides, and on the other hand, PCAs are paid significantly higher wages than homemakers. This leads to two conclusions:

1) The wage rate for home health aides should not be frozen, but should be increased

2) The wage rate for homemakers should not be allowed to remain significantly below that of PCAs.

Because the Commonwealth has committed itself to a multi-year upgrade of PCA wages, now is the time for the state to make a similar commitment to lifting the hourly wage for the homemakers and the home health aides, to create a wage scale that is relevant to the different levels of work performed, and to define a clear career ladder for the in-home workforce."

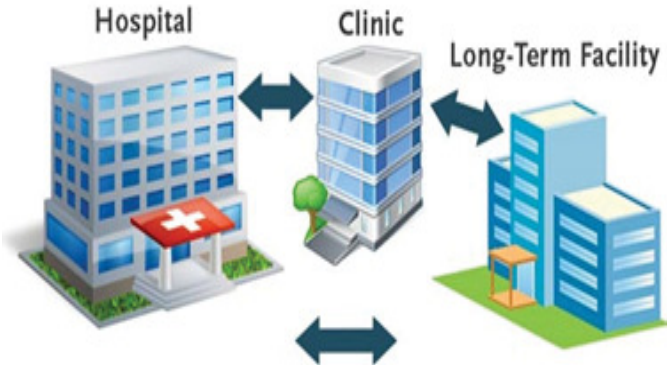
In their statement on the new home health aide rates, **Lisa Gurgone** of the Home Care Aide Council of Massachusetts said: "There is growing concern throughout the home care network that the average rate of pay earned by homemakers and personal care homemakers (currently set at $12.69 per hour) is bumping up against, and in some cases exceeding, the wages earned by home health aides paid through the Rate of Payment for Services of Home Health Aide in the Home Health Setting: Code G0156 proposed in these regulations. Home health aides are at the top of the Massachusetts home care aide career ladder, and yet, in a growing number of instances, home care agencies are being reimbursed at lower levels for providing these services… Right now, many of these workers move across the continuum – working as a homemaker or home health aide while also working as a PCA and/or certified nursing assistant (CNA). If these rate disparities persist, these essential workers may be forced to choose one model over the other, potentially limiting choice for consumers and reducing the capacity of providers to support clients requiring higher, more skilled home health aide services and supports…Therefore, the Council respectfully requests that an increase to the Rate of Payment for Services of Home Health Aide in the Home Health Setting: Code G0156 be added to these proposed regulations. It is now more important than ever for the Administration to establish an adequate rate structure that recognizes the essential role home health workers play in enabling elders and persons with disabilities to remain safely in their homes."

Medicare ACOs Produce $411M in Savings in 2014

A total of 353 Medicare Accountable Care Organizations (ACOs) generated more than $411 million in net savings in 2014, according to an analysis

from Healthcare Informatics. Many of those ACO managed care organizations did not generate enough savings to receive bonuses, according to the federal Centers for Medicare & Medicaid Services (CMS).

According to the CMS data, 92 of the 333 Medicare Shared Savings Program (MSSP) ACOs held spending $806 million below their targets and earned performance payments of more than $341 million as their share of program savings. In the Pioneer ACO program, which began with 32 ACOs in 2012, but is now down to 20 after several organizations dropped out, 11 organizations generated savings outside a minimum savings rate and earned shared savings payments of $82 million. In total, 103 Medicare ACOs, or 29 percent, received bonuses in 2014.



One View of Accountable Care Organizations

The data revealed that 15 out of the 20 Pioneer ACOs (75 percent) and 181 of the 333 (55 percent) MSSP ACOs generated some savings in 2014, meaning that 25 percent of those in the Pioneer program and 45 percent of MSSP ACOs generated no savings last year. As a whole, Medicare ACOs generated over $417 million in savings in 2013, a number slightly higher than what 2014 savings delivered.

In their third year, Pioneer ACOs showed improvements in 28 of 33 quality measures. ACOs with more experience in the program tend to perform better over time, CMS said. Of the 333 Shared Savings Program ACOs, 119 are in their first performance year in Track 1, which involves standing up the program without the financial risk associated with later tracks. Medicare Shared Savings Program ACOs that reported quality measures in 2013 and 2014 improved on 27 of 33 quality measures, according to CMS.

"These results show that Accountable Care Organizations as a group are on the path towards transforming how care is provided," said CMS Acting Administrator **Andy Slavitt.** "Many of these ACOs are demonstrating that they can deliver a higher level of coordinated care that leads to healthier people and smarter spending."

The organizations in the Pioneer ACO program showed improvements in 28 of 33 quality measures and experienced average improvements of 3.6 percent across all quality measures compared to performance year 2. Particularly strong improvement was seen in medication reconciliation (70 percent to 84 percent), screening for clinical depression and follow-up plan (50 percent to 60 percent and qualification for an electronic health record incentive payment (77 percent to 86 percent).

The number of beneficiaries served by ACOs is likely to continue to grow. Since the advent of the programs, the number of Medicare beneficiaries served by ACOs has consistently grown from year to year, and early indications suggest the number may grow again next year, CMS said.

Zero Social Security COLA Creates Medicare Controversy

The zero Social Security Cost of Living Adjustment coming this January may make the average Social Security recipient angry---but that's nothing compared to higher-income retirees who will see their Medicare premiums spike as a result of a quirk in the law.

According to an analysis from the Center for Retirement Research at Boston College, the zero COLA will freeze Medicare Part B for most retirees—but not for all. Here are excerpts from the Boston College report:

"Social Security is an extremely valuable source of retirement income. It is payable for life and benefits are adjusted to keep pace with inflation. No COLA is expected to be paid in 2016 because the CPI-W in the third quarter of 2015 will likely fall below the level in the third quarter of 2014.The anticipated lack of a

COLA has caused a flap in the Medicare program because higher Medicare Part B premiums cannot be passed on to most beneficiaries when they do not get a raise in their Social Security benefits. This flap also highlights the complicated interaction between Medicare premiums, which are deducted automatically from Social Security benefits, and the netbenefit. Because the system is not perfectly indexed, rapidly rising Medicare premiums undermine the ability of the elderly to maintain their non-medical-care spending In short, even Social Security does not fully insulate older households from the erosive impact of inflation, and this concern is serious given that other sources of retirement income offer virtually no inflation protection.

The flap centers on the premiums for Medicare Part B. Typically, the Medicare Part B premium is increased each year in line with Part B per capita expenditures. In the absence of any complicating factors, the premium would increase from $104.90 in 2015 to $120.70 for 2016. The problem is that the law contains a hold-harmless provision that limits the dollar increase in the premium to the dollar increase in an individual's Social Security benefit. This provision applies to roughly 70 percent of Part B enrollees. The 30 percent not eligible for the hold-harmless provision include new enrollees during the year; enrollees who do not receive a Social Security benefit check; enrollees with high incomes, who are subject to the income-related premium adjustment; and dual Medicare-Medicaid beneficiaries, whose full premiums are paid by state Medicaid programs. Because the COLA for Social Security benefits is expected to be zero for 2016, premiums would not increase for the 70 percent protected by the hold harmless provision.

Under current law, Part B premiums for other beneficiaries must be raised enough to offset premiums foregone due to the hold-harmless provision. Under the intermediate economic assumptions, the estimated monthly premium in 2016 for these other beneficiaries is $159.30. That means that, unless the Administration figures out some work-around, the base Part B premium would rise from $104.90 to $159.30 – a 52-percent increase. Higher income participants would then pay multiples of $159.30 depending on their income level.

For example, each member of a married couple with household income between $170,000-$214,000 would pay a Part B premium in 2016 of $223.00. Premiums would top out at $509.80 per person for couples with income of more than $428,000. Clearly political pressure will build for some kind of work-around.

For more on this story, go to: http://crr.bc.edu/wp-content/uploads/2015/08/IB_15-14.pdf

CHIA Releases Hospital Report

The Massachusetts Center for Health Information Analysis (CHIA) released a report on the financial status of hospitals in the Commonwealth as of FY 14. The report examines hospital profitability, liquidity, and solvency in order to monitor and compare the financial status of acute care hospitals. Taken as a whole, the metrics in this report provide insight into each hospital's financial health.

Here are some highlights from the CHIA report:

• Eighty-seven percent, or 54 acute hospitals reported positive total margins in FY 2014. Total Margin reflects the excess of total revenues over total expenses, including operating and non-operating activities such as investment income, as a percentage of total revenue.

• Seventy-nine percent, or 49 acute hospitals reported positive operating margins in FY 2014. Operating Margin is the ratio of operating income/loss to total revenue. It reflects revenues and expenses associated with patient care activities, but does not include investments, research, and other non-operating

revenues or expenses.

• Most hospitals continued to be profitable from non-operating activities, with the statewide median non-operating margin remaining relatively stable over the past three years. Non-Operating Margin is the ratio of non-operating income to total revenue. It includes items that are not related to operations such as investment income, contributions, gains or losses from the sale of assets, and other unrelated business activities.

In examining statewide performance, CHIA says that hospital profitability improved for acute hospitals statewide in FY 2014 relative to FY 2013. Eighty-seven percent, or 54 acute hospitals reported positive total margins in FY 2014, with the statewide median increasing slightly from 4.1% in FY 2013 to 4.2% in FY 2014. Similarly, operating margin improved overall; fewer hospitals reported a negative operating margin in FY14, and the statewide median operating margin rose from 2.3% in FY 2013 to 2.6% in FY 2014. Overall, liquidity remained consistent with FY 2013 across for all three measures.

In terms of solvency, the statewide cash flow to total debt, debt service coverage, and equity financing medians improved relative to FY 2013.

Examining financial performance trends within the context of utilization trends, CHIA finds that overall, inpatient discharges decreased 2.6% at Massachusetts acute hospitals between FY 2013 and FY 2014. Median outpatient visits decreased by 1.0%, and Emergency Department visits decreased by 0.9%.

Some of the most profitable hospitals included Mass General, $200 million profits; Brigham Women's, $151.7 million; Baystate Medical Center, $96 million; Lahey Hospital/Medical Center, $67 million; Beth-Israel Deaconess, $63 million.

Hospitals showing the biggest losses included Quincy Medical Center, $39.1 million in losses; North Shore Medical Center, $22.2 million in losses; Cambridge Health Alliance, $19.3 million in losses; Steward Carney Hospital, $9 million in losses.

Advocates Call for End Of "Observation Status"

On July 1, 2015, the federal Center for Medicare and Medicaid Services (CMS) released proposed updates to a policy known as the "Two-Midnight" rule regarding when inpatient admissions are appropriate for payment under Medicare Part A. "These changes would continue CMS' long-standing emphasis on the importance of a physician's medical judgment in meeting the needs of Medicare beneficiaries," the federal agency said.

Because of the way the Medicare statute is structured, the Medicare payment rates for inpatient and outpatient hospital stays differ. CMS pays acute-care hospitals for inpatient stays under the Hospital Inpatient Prospective Payment System (IPPS) in the Medicare Part A program. CMS sets payment rates prospectively for inpatient stays based on the patient's diagnoses, procedures, and severity of illness. In contrast, the Hospital Outpatient Prospective Payment System (OPPS) is paid under the Medicare Part B program and is a hybrid of a prospective payment system and a fee schedule, with some payments representing costs packaged into a primary service and other payments representing the cost of a particular item, service, or procedure.

"Not all care provided in a hospital setting is appropriate for inpatient, Part A payment," CMS explained. "Therefore, when a Medicare beneficiary arrives at a hospital in need of medical or surgical care, the physician or other qualified practitioner must decide whether it is appropriate to admit the beneficiary as an inpatient or treat him or her as an outpatient. These

decisions also have significant implications for provider reimbursement and beneficiary cost sharing."

To provide greater clarity to hospital and physician stakeholders, and address the higher frequency of beneficiaries being treated as hospital outpatients, CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the criteria that should be used when determining whether inpatient admission is reasonable and payable under Medicare Part A.

In general, the Two-Midnight rule stated that:

• Inpatient admissions will generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.

• Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.

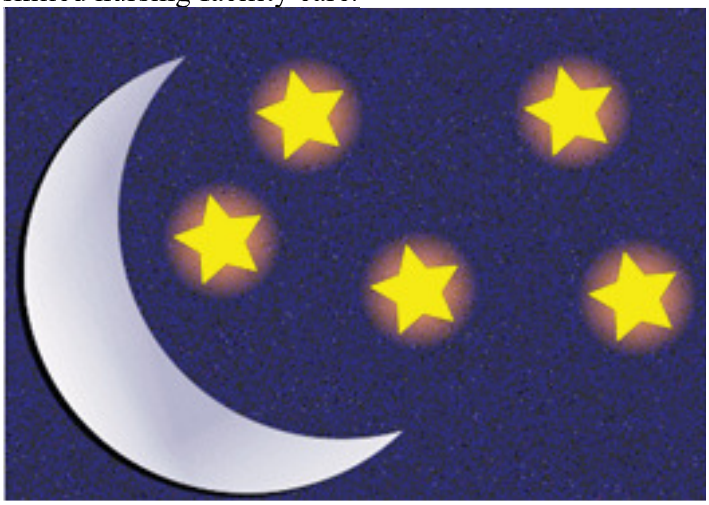
The Two-Midnight rule also specified that all treatment decisions for beneficiaries were based on the medical judgment of physicians and other qualified practitioners.

In late August, the Medicare Advocacy Project (MAP), which ensures that Massachusetts Medicare beneficiaries receive the Medicare and Medicare-related health insurance coverage to which they are entitled, sent a letter to the federal Centers for Medicare and Medicaid services regarding continuing problems with elders being put on "observation status" when entering a hospital, In our September issue of AT HOME, we reported on a new law that will help clarify for seniors when they are being placed on "observation" status, but it does not resolve the issue for consumers.

Here are excerpts from the MAP letter:

"On behalf of our clients, most of whom have low incomes, [and] on behalf of the many beneficiaries we have tried to help who were unwittingly hospitalized in outpatient/observation status for at least three consecutive overnights and then learned that their subsequent skilled nursing facility care could not be covered by Medicare because they had not been hospital inpatients, we wish to voice our concurrence with the comments submitted by the Center for Medicare Advocacy on your proposed changes to the 2-midnight rule under your short inpatient hospital stay policy .

Our response to these solicitations is to urge you to eliminate the 2-midnight rule, as you state was recently recommended by MedPAC, and to put forth a proposal instead to count any nights spent in a hospital towards the three-day hospital requirement for Medicare Part A skilled nursing facility coverage. As you acknowledge in the proposed rules, observation status is a billing, not a health care, issue and hospital care for beneficiaries in observation status and other outpatients is indistinguishable from the care received by formally admitted beneficiaries. The financial consequences, however, for beneficiaries whose indisputably medically necessary hospital care is categorized as outpatient/observation, rather than inpatient, is frequently enormous due to the necessity of their having to pay privately for their post-hospital skilled nursing facility care.



As advocates for many Massachusetts Medicare beneficiaries who have sought our assistance due to the adverse impact they have experienced from their time spent in hospitals receiving observation, rather than inpatient, services, we wish to reiterate our concerns with this practice…From the standpoint of our clients, attention to this problem has been long awaited and is long overdue. By precluding meeting the three day hospital admission prerequisite for Medicare Part A skilled nursing facility coverage, observation status costs many beneficiaries the full costs of skilled nursing facility care which frequently amounts to thousands of dollars. In addition, the loss of Part A coverage for their medically necessary hospital stay subjects beneficiaries

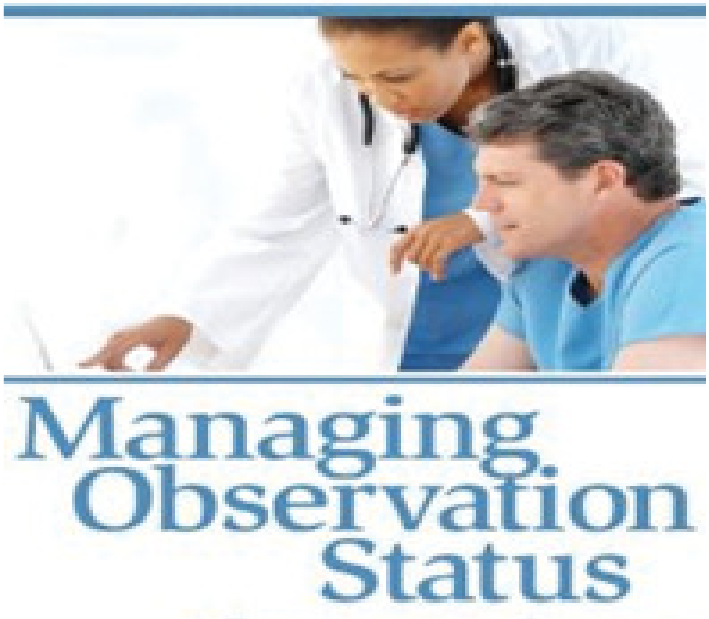
to out-of-pocket costs for services covered by Part B.

We tried to assist a 90 year old woman from Lynn, MA, who fell in her home, called 911, and was transported by ambulance to North Shore Hospital. She arrived at the hospital on April 15, 2012, and was discharged to a Medicare-certified skilled nursing facility on April 19, 2012. The woman lives at home with her elderly husband, she ambulates with a walker; and her past medical history includes diabetes, myocardial infarction, breast cancer, chronic acquired lymphedema, hyperlipidemia, hypertension, stasis dermatitis, AFib on Coumadin, diabetic retinopathy, cellulitis, osteoarthritis, GI hemorrhage, pneumonia, diastolic CHF, cystitis, hypoglycemia, edema and dehydration. While in the hospital, she was treated for what x-rays revealed to be a fractured right shoulder, received several tests and was placed in a bed in a room on a hospital floor. The hospital emergency room disposition summary includes an order to admit and a hospital April 15, 2012, notes states "Patient will be admitted to the Medical service. Will place an orthopedic consult and physical therapy evaluation. Will check some lab stats and continue home medication and treat her pain which may be the triggering factor for her showed blood pressure is still elevated….Will place her on omeprazole for gastrointestinal prophylaxis."

On April 18, 2012, the hospital issued a "Preadmission Hospital-Issued Notice of Noncoverage" and on April 19, 2012, the beneficiary left the hospital for rehabilitation at a skilled nursing facility. Although the hospital discharge summary states that the patient was admitted to the hospital and two physicians and a hospital caseworker recommended the patient for inpatient status, they were allegedly overruled by the caseworker's supervisor and the entire stay was classified as observation.

The woman remained at the skilled nursing facility until July 11, 2012, where she required and received daily skilled care which, but for the fact that her hospital stay was classified as observation, rather than inpatient, would have been covered by Medicare. Instead she has had to pay more than $40,000, at $395/ day, for nursing home room and board. She also had to pay therapy copayment amounts and prescription drug charges. This is an intolerable result if CMS's goals include the best interests of the beneficiary.

Another beneficiary, whose case is still in process, is a 90 year old woman from Weymouth, MA, who, on March 28, 2013, due to severe right low back spasms and right hip pain such that she was unable to walk or sit, called 911 and was transported by ambulance to South Shore Hospital. She had been taking oxycodone at home without relief, and was given IV morphine in the emergency room. Prior to arriving at the hospital, she had been living at home independently.



The beneficiary was admitted to the hospital due to intractable pain and remained in the hospital until March 31, 2013, when she was discharged for short term rehabilitation to a skilled nursing facility/ rehabilitation center. She remained in the skilled nursing facility/rehabilitation center until April 6, 2013. While in the hospital, in addition to morphine, she required MRI of the pelvis and lumbar spine, which showed an insufficiency fracture to the pelvis as well as compression fracture of thoracic spine and a blood clot in her leg, and a renal ultrasound to address right kidney abnormalities observed on one of the MRIs. Despite all this medically necessary care, the hospitalization was deemed to be observation/ outpatient, rather than inpatient, and she was obligated to pay $3,000 on admission for her short term rehabilitation.

Responding to the beneficiary problems as

presented to us, our first suggestion is to eliminate the classification of hospital stays into observation or inpatient days. All medically necessary hospital stays on a hospital floor should be inpatient stays. The disparate classification is very difficult to fathom, as hospitalized beneficiaries, regardless of classification, are on the same floor, in similar rooms and receive the same services. Our experience has been that most beneficiaries who have experienced an observation stay did not know that such a classification existed and were unaware of their status during their hospitalization. They usually only learned of the distinction after the fact when informed of their ineligibility for Medicare-covered skilled nursing facility care, for which they would otherwise be eligible or when presented with a bill for services that they believed were covered by Medicare. While in the hospital, they had no idea that their status was any different from that of others on their floor.

In response to these crises, recently enacted federal legislation mandates that beginning in August, 2016, hospitals will be required to provide written notice to Medicare beneficiaries about their status and its potential ramifications when they are receiving observation care and have not been admitted. This will at least put beneficiaries on notice, but provides no formal recourse to changing their status. A better solution would be to provide not only immediate written notice, but also the opportunity for an expedited appeal. It is outrageous that, as things currently exist, there is no such requirement and beneficiaries are effectively left with no means of appealing the classification.

Your proposed changes to the 2-midnight rule do nothing meaningful about addressing this problem and continue to allow Medicare beneficiaries to be penalized due to a hospital's arbitrary categorization. Rather, if observation days are not eliminated, then pending bipartisan legislation in the House, HR 1179, and Senate, S 569, which would allow hospital observation days to count toward the three-day hospital inpatient prerequisite for Medicare coverage of skilled nursing facility care, should be strongly supported. Even without this legislation, however, CMS can and should revise its definition of inpatient care, for the purpose of qualifying for Part A skilled nursing facility coverage, to count all medically necessary time spent by a beneficiary in hospital. An even better solution would be to eliminate the three day prior inpatient hospitalization prerequisite for Medicare Part A skilled nursing facility coverage, as is currently done by many Medicare Advantage plans and in several demonstration projects. Repealing that requirement would, however, require congressional action. Meanwhile, counting the medically necessary observation days towards the Medicare Part A skilled nursing facility prior hospitalization requirement would at least help those beneficiaries who but for their observation status classification would be eligible for Medicare Part A covered skilled nursing facility care.

State Seeks Two More Years For One Care Plan

One Care

MassHealth+Medicare

Bringing your care together

On August 18, 2015, the Executive Office of Health and Human Services (EOHHS), sent a letter to the Director of the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services, asking for a two year extension of the One Care program for "dually eligible" individuals age 18 to 64. The One Care plan was launched in October of 2013. According to recent press reports, the plan has sustained major financial losses, which advocates blame on inadequate federal payment rates. In July, one of the three plans in the state, Fallon Total Care, dropped out of the program effective September 30th, citing financial losses. Roughly 5,400 clients in the Fallon program are now being placed in other One Care plans, or back to the Medicaid fee for service program. In August the largest One Care Plan, Commonwealth

Care Alliance, announced that is was not accepting new clients on a temporary basis. CCA had a total of 10,683 clients as of August 1st.

The extension request was sent by **Daniel Tsai**, Assistant Secretary for MassHealth, and it read in part:

"The Commonwealth of Massachusetts Executive Office of Health and Human Services is pleased to submit this Letter of Intent pursuant to your July 16, 2015 Financial Alignment Extension Opportunity Memorandum. Massachusetts intends to pursue a two year extension of its capitated Financial Alignment Model and Demonstration to Integrate Care for Dual Eligible Beneficiaries (known as One Care), currently authorized through December 31, 2016. We look forward to addressing sustainability issues for the Demonstration together with CMS."

State officials and advocates have travelled to Washington, D.C. to talk with state officials about how to provide better rates for the One Care demonstration.

The One Care program had 17,518 members as of August, 2015. In July of 2014, there were 18,816 people enrolled in One Care. EOHHS estimates that the program today is serving roughly 17.5% of the total population of 100,094 eligible people in the state.

LGBT Aging Report Released

On September 17, 2015, the state's Special Legislative Commission on LGBT Aging released its final report. The Commission was established two years ago by the General Court.

Dale Mitchell, the Executive Director of Ethos, and Mass Home Care's representative on the Special Commission, said the Commission's report reflects over a year of discussions, deliberations and community consultations. "This report may indeed be the most comprehensive set of public policy recommendations ever compiled to improve the quality of life for LGBT older adults," Mitchell said. "Areas around which recommendations have been made include long-term support services, housing, public health, senior centers/ community engagement and legal concerns/ legislation."

Here is the Executive Summary from the Special Commission report:

For more than a quarter century Massachusetts has been a leader in promoting legal equality for lesbian, gay, bisexual and transgender (LGBT) people and same-sex couples. Ten years after it became the first state to legalize marriage for same-sex couples and 21 years after Governor **William Weld** launched the first Governor's Commission on Gay and Lesbian Youth, Massachusetts continued in this proud tradition in 2013, when the state legislature and Governor **Deval Patrick** joined together to create the first-ever statewide LGBT Aging Commission to address the unique concerns and needs of LGBT older adults.

From April 2014 through June 2015 the Massachusetts LGBT Aging Commission held listening sessions around the Commonwealth, consulted with elder service providers and experts on LGBT aging, and developed comprehensive recommendations in a number of issue and service areas. For a number of reasons including lower rates of parenting and estrangement from families of origin, LGBT elders may be more in need of formal elder services. But because LGBT elders fear that they will experience discriminatory treatment in elder services, and often experience discriminatory or culturally incompetent care, they may be less likely to access those very services.

In this report the Massachusetts LGBT Aging Commission makes recommendations in five major areas: long term support services, housing, public health, senior centers and community engagement, and legal considerations. It also makes recommendations regarding data collection, needs assessment, cultural competency training and evaluation, outreach and access, service delivery, complaint resolution, and legislation. Overall themes include:

• the need for training of elder service staff in the unique experiences and needs of LGBT elders;
• the importance of collecting data on sexual orientation and gender identity to quantify, understand, and address any disparities that LGBT elders experience compared with the majority of elders who are heterosexual and not transgender;
• the need for nondiscrimination protections, especially protections for transgender people against discrimination

in public accommodations, which include nursing homes, health centers, public transportation and retail establishments;

• the need for outreach and access to ensure that LGBT elders are accessing services they need and are entitled to, such as veterans services;

• the importance of emulating big cities across the U.S. that have created elder housing communities for LGBT elders and their friends and allies;

• the need for an LGBT ombudsperson within the Executive Office of Health and Human Services to ensure the integration of LGBT concerns into the Commonwealth's aging and human services networks, and to advocate for LGBT elders who experience barriers to accessing and utilizing services as whole human beings;

• and the need to assist LGBT elders in advance planning for decision-making during periods of incapacity or end of life.

The LGBT report includes a section on Long Term Services and Supports. Here are excerpts from that section of the report:

"There is significant evidence that LGBT older adults are in greater need of long-term services and supports at earlier stages of life than are non-LGBT older adults. This is largely because of two significant demographic differences between LGBT and non-LGBT older adults: 1) LGBT people are less likely to be partnered or married than non-LGBT people; and 2) LGBT people are more likely to be childless than non-LGBT people. Additionally, LGBT older adults are more likely to be estranged from both immediate and extended family, who often provide supportive services to their non LGBT counterparts. Since spouses, partners and children are the principal caregivers for older adults with functional impairments, the lack of familial resources increases the need of LGBT older adults to rely on publicly-funded LTSS."

• EOHHS should establish a "cross secretariat" LGBT ombudsperson to address harassment, bullying and discrimination in delivery of aging services and activities.

• EOEA should maintain designation of LGBT older adults as a population of "greatest social need" under the Older Americans Act…EOEA should also designate older adults living with HIV/AIDS as a population of "greatest social need" under the Older Americans Act for state and local Area Agency on Aging planning and program development.

• EOEA should require protective service agencies to conduct outreach and education to local LGBT communities and individuals.

• EOHHS & EOEA should develop and apply best practices in promoting and assessing the participation of and development of registries for LGBT-inclusive Adult Foster Care (AFC) hosts, Personal Care Attendants (PCAs) and state-funded guardians/conservators.

• EOHHS should ensure that every program area relevant to the needs of LGBT older adults, including substance abuse, behavioral health, suicide prevention, domestic violence, emergency shelter, and veterans services, has at least one LGBT-inclusive and culturally competent component.

• EOHHS should make spouses eligible caregivers for the Personal Care Attendant (PCA) program and for other consumer-directed long-term support services.

• EOHHS and EOEA should requests federal waivers to allow for small "group homes" for nursing home eligible elders and, if approved, create at least one LGBT- inclusive and culturally competent home as an alternative to nursing homes.

• EOHHS, EOEA and DHCD support the development of social networks of LGBT older adults at high risk of isolation, including: veterans, persons of color, immigrants, non-English speakers, people living with HIV/AIDS, ex-prisoners and the disabled.

"We have long known that LGBT older adults face unique challenges as they age," Senator **Patricia Jehlen (**D-Somerville**)**, the Senate Chair of the Special Commission told *The Rainbow Times*. "Few of them have the family connections such as partners or spouses; children; and extended family who can provide the care that much of the general population relies on from their families as they age. This first-in-the-nation state commission will provide a roadmap for giving our state's LGBT older adults the care that they deserve, and it is one that other states can follow."

The House Chair of the Commission was State Representative **James O'Day** (D-West Boylston), the former Chair of the House Committee on Elder Affairs.

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