At Home

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With Mass Home Care

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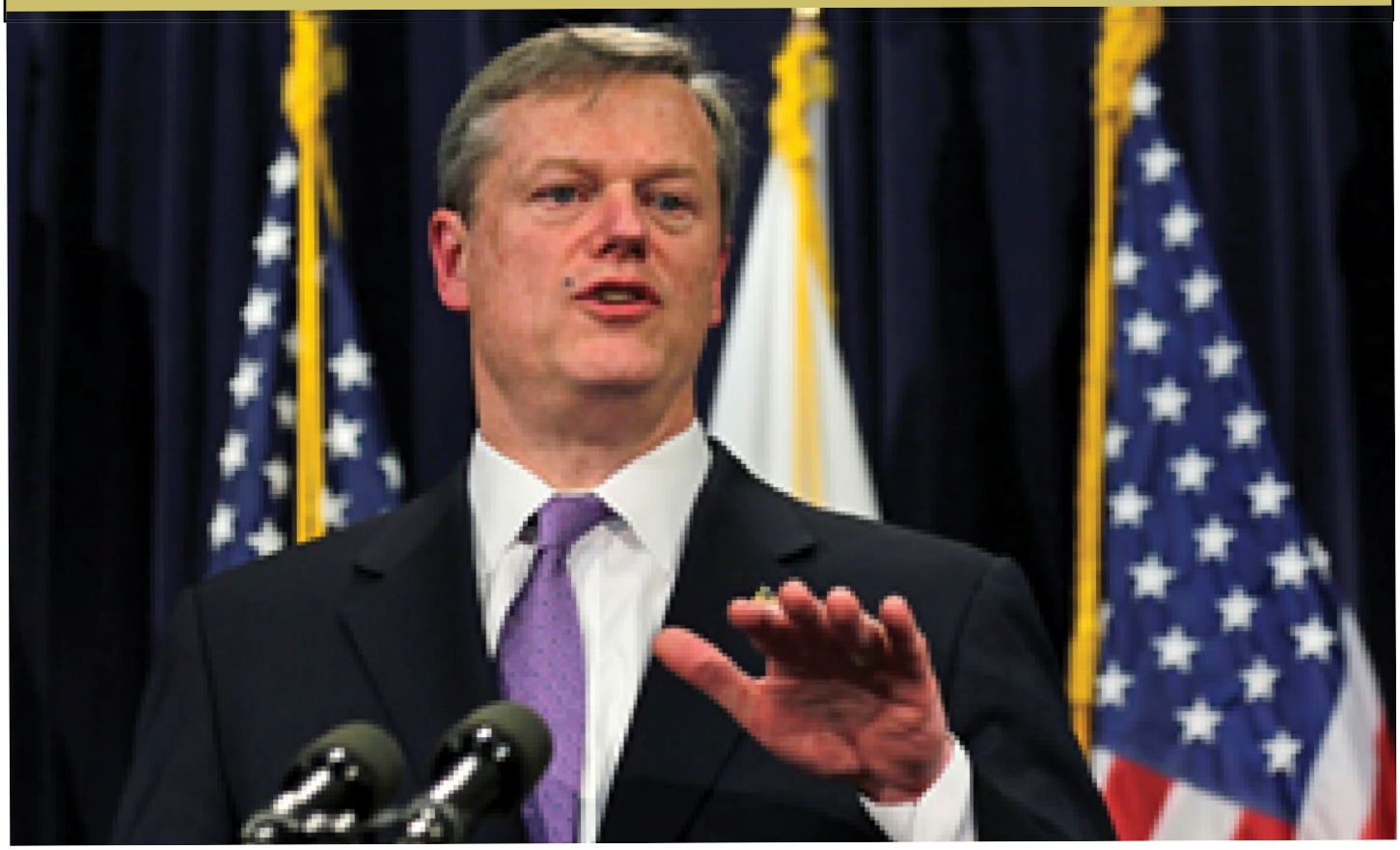
Al Norman, Editor



WBUR photo

112 Elder, Disabled Groups Ask Gov. For "Independent Agent"

In early October, a statewide group of 112 agencies which work with, and advocate for, the elderly and individuals with disabilities in their homes hand-delivered a letter to Governor **Charlie Baker,** Senate President **Stan Rosenberg**, and Speaker **Robert DeLeo** asking that any MassHealth managed care reform contain protections for consumers who need long term support services (LTSS).

The letter was prompted by an effort to create Accountable Care Organizations (ACOs) that place financial and programmatic control over Medicare and Medicaid revenues for all health and LTSS to large networks of health care providers.

According to Mass Home Care President **Dan O'Leary**, the state's home care system has used this "independent agent" model for 40 years to assess the care elders need to remain at home. The independent agent model has proven to be highly successful in helping elders and people with disabilities access the services they need to live as independently as possible.

The LTSS independent agent also is found in state law governing two other large managed care plans: Senior Care Organizations and One Care plans. "If we are going to give large managed care networks control

over long term services," O'Leary said, "we need to ensure that consumers have someone on their care team who is expert in the field of non-medical supports, and who is not owned by the managed care providers. It's a model the federal government proposed in the 2011 Affordable Care Act."

The group letter begins as follows: "MassHealth is currently engaged in an important effort to design a managed care model that will result in a plan that could ultimately integrate health care with behavioral health and long term services and supports (LTSS), controlled by large provider networks called Accountable Care Organizations."

"The LTSS goal of this reform should be to guarantee that all MassHealth members are able to live at their highest level of functioning possible, in the least restrictive setting possible. We believe an integrated, person-centered care plan must balance medical care with non-medical functional supports for the elderly, and individuals with disabilities."

Dan O'Leary, Mass Home Care President

The letter to state leaders is signed by the state's Aging Services Access Points (ASAP), Area Agencies on Aging (AAAs), Councils on Aging, and major elder and disability rights groups like AARP of Massachusetts, Mass Senior Action Council, Mass Association of Older Americans, Disability Advocates Advancing Our Healthcare Rights (DAAHR), Cerebral Palsy of Massachusetts, and many provider groups.

"Massachusetts is currently running two major managed care initiatives for 55,000 individuals on Medicare and Medicaid," the letter continues. "The Senior Care Organizations and the One Care plans both have one feature in common when it comes to LTSS: the statutory inclusion of an independent, conflict-free care coordinator on the member's care team. This "agent" for the member serves several key functions:

• Determine the necessary level of LTSS to be provided
• Prevent the provision of unnecessary or inappropriate care
• Establish a written individualized care plan

"This important consumer protection is defined in the Affordable Care Act, and is part of the regulatory framework that CMS has created for home and community based services. It builds a firewall between the person who helps assess your needs, and the person who provides your care. The Commonwealth has already agreed to accept independent, conflict-free care coordination in return for $135 million in federal Balancing Incentive Payments funding."

"Elder and disabled rights organizations feel very strongly that there need to be checks and balances in managed care to prevent long term supports from being overshadowed by medical care," O'Leary explained. "Whole care depends on many non-medical, functional supports that allow people to live independently at home. We are speaking up now---before the plan is written. This is about much more than what happens in the doctor's office, or in a hospital. We need to focus on care across the community too. Consumer independence, choice and control need to be prominent features of any future managed care model."

The group letter ends with this request: "Whatever plan emerges from the MassHealth reform discussions, we urge you to guarantee that all managed care organizations covering LTSS provide as a standard benefit for their members access to independent conflict-free care coordination."

The MassHealth timetable calls for managed care plans to be vetted this spring, with stakeholder workgroups finishing their work by this January.

One Care Program Gets Financial Boost From Feds

One Care

MassHealth+Medicare

Bringing your care together

On September 22nd, MassHealth announced that it had reached an agreement with the federal government to make important financial enhancements to the state's two year old One Care program for people age 18 to 64 on MassHealth and Medicare. In the first year and a half of the One Care plan, a total of roughly $54 million in losses had been sustained by the 3 managed care plans, prompting one of the three plans to withdraw from the program as of September 30th. Nearly 5,500 plan members had to be moved into other One Care plans, or back to Medicaid fee for service. Without additional financial support from the Centers for Medicare and Medicaid Services (CMS), the financial viability of the One Care demonstration was in jeopardy.

MassHealth hosted a conference call for the One Care Implementation Council, during which they announced a series of CMS/ MassHealth steps to financially stabilize the remaining Plans through to the end of the Demonstration in 2016. These total $29.8M in enhancements from Medicaid and $17.8M from Medicare over 2015 and 2016.

"We are pleased to announce," state officials said, "that MassHealth and CMS have approved a package of capitation rate adjustments that will better reflect the additional services and complex care management required in the demonstration and that more accurately accounts for the acuity and complexity of the population served. Together with additional administrative and operational efficiencies by the plans, we believe these actions will serve to financially stabilize the health plans participating in the One Care demonstration."

EOHHS called these changes "transitional enhancements" to the One Care plan. On the Medicare side they included

- Elimination of the savings factors for 2015 & 2016.
- Reduction in the quality withholds for 2015 & 2016.
- Update the Medicare A & B rates by 5% in 2015 & 2016 (for MA only).

On the Medicaid side, enhancements include updated rates to reflect service and administrative costs that were recognized in fee-for-service but were not included in the One Care rates.

EOHHS reported that both remaining plans (Commonwealth Care Alliance, and Network Health) have accepted these changes, which will be reflected in contract amendments, and have agreed to stay in One Care through the end of the Demonstration in 2016.

EOHHS had previously announced that it had applied to CMS to extend the One Care plan for an additional two years. As of August 1, 2015, the One Care plans had an enrollment of 17,518 members, or 17.5% of the total eligible population of 100,094 eligible MassHealth members. The high point for One Care enrollment came in July of 2014, when 18,816 people were enrolled in the plan. By August 1, 2015, a total of 27,882 people had 'opted out' of the plan, i.e. chose not to enroll, or to leave the program.

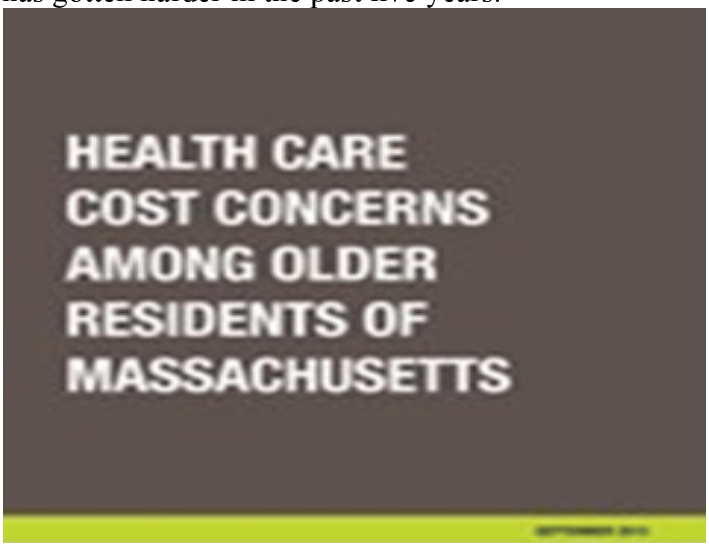
Blue Cross Elder Health Poll

On September 24th, the Blue Cross Blue Shield of Massachusetts Foundation released the results of a July, 2015 poll conducted by a team led by **Robert J. Blendon**, Sc.D. of Harvard T.H. Chan School of Public Health. The poll was conducted to assess the perspectives of Massachusetts adults age 65 and over on the issues of affordability, access, and satisfaction with their health care coverage.

The results show that while a large majority of seniors are satisfied with the health care they receive as patients, over one-quarter of older adults are dissatisfied

with health care costs, and more than one in five report that it has gotten harder to pay for health care services or prescriptions drugs over the past five years. Both concerns are higher among seniors who report poor health or a disability.

The report found that a large majority of Massachusetts adults age 65 and over are satisfied with the health care they receive as patients, but one in four seniors is dissatisfied with health care costs. Many also report that paying for health care has gotten harder for them over the last five years. Dissatisfaction is highest among older adults in the Commonwealth who report they are in fair or poor health or have a medical condition that substantially limits one or more basic physical activities like walking or reaching. One-third of these seniors in poorer health report dissatisfaction with their health care costs and say that paying for care has gotten harder in the past five years.



Financial insecurity due to health care costs is also felt among older adults in households living on $25,000 or less per year, more than one-third of whom report not being confident they will have enough money or insurance to afford the health care they may need in the future. Despite concerns about the high cost of health care services and prescription drugs, older adults in Massachusetts—including those living in lower-income households and those in poorer health—are overwhelmingly satisfied with the care they receive from their doctors and while hospitalized.

The poll also found low levels of interest in long-term-care insurance among Massachusetts adults age 65 and over. Among the three-quarters of seniors who have heard of such policies, only one in five decided to purchase a policy. Most say they did not purchase a policy because they think it is too expensive or they do not need it.

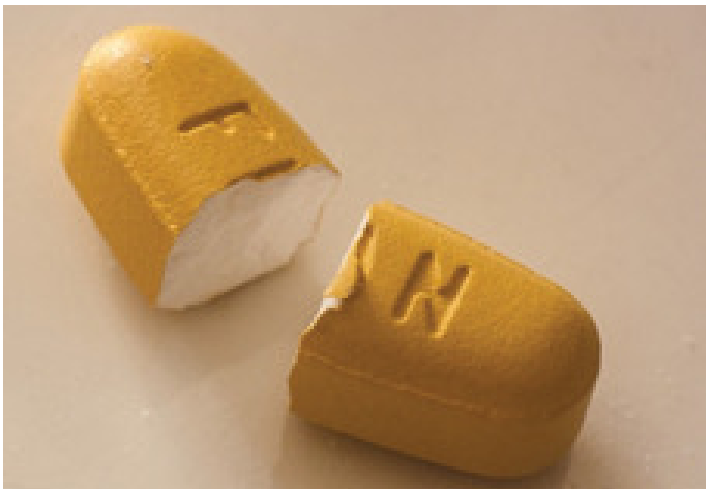
When asked their opinion of the health care system overall, most Massachusetts seniors report being somewhat or very satisfied, although seniors in poorer health are more likely to express dissatisfaction. “Seniors in poorer health” are substantially more likely to report problems with the cost of care than Massachusetts seniors in better health. According to the poll, one-third (33%) of seniors in poorer health report being somewhat or very dissatisfied with their health care costs, and a similar proportion (32%) are not confident they will have enough money or health insurance to pay for the health care they may need in the future. In comparison, about one in five (21%) seniors in better health expresses dissatisfaction with health care costs, and one in six (16%) expresses concern about affording health care in the future.

When asked to reflect on the past five years, more than one in three (34%) seniors in poorer health also report that paying for health care services or prescription drugs has gotten harder for them, as compared with about one in seven (15%) seniors in better health who feels the same. more than one in five (21%) seniors in poorer health report having had problems paying for health care services or prescription drugs. Only 4% of seniors in better health report similar problems. Among those seniors in poorer health who had problems affording health care, the top two reported problems were paying for prescription drugs and the cost of premiums, deductibles, and copays.

Due to these problems paying for health care services and prescription drugs, seniors in poorer health are more likely to report adverse financial events because of large medical bills. About one in ten (11%) seniors in poorer health reports spending all or most of their personal savings or taking on credit card debt that may be difficult to pay off (10%). By comparison, only 1% of seniors in better health report having similar financial circumstances.

Nearly one in five (18%) seniors in poorer health reports having not filled a prescription in the

past year due to cost, whereas less than one in ten (8%) of their peers in better health report having had to do this. Additionally, about one in seven (15%) seniors in poorer health reports cutting pills in half or skipping doses of medicine due to the cost of prescription drugs, as compared with only 2% of seniors in better health. Seniors in poorer health are also more likely to have trouble affording health care services, as nearly one in eight (12%) reports not having gotten a medical test or treatment they needed due to cost. In contrast, only 5% of their peers in better health report having skimped on health care services.



Seniors in poorer health are not the only vulnerable population that has difficulty affording health care in Massachusetts. Seniors in households living on $25,000 or less per year are also more likely to report problems paying for health care services and prescription drugs than are their higher-income peers. When asked about the health care they may need in the future, more than one in three (36%) lower-income seniors report being not too or not at all confident they will have enough money or insurance. In contrast, these worries affected one in ten (10%) higher-income seniors. This population cohort is similar to those elders who are enrolled in the state home care program, where annual gross income limit is $27,000.

About one in four (23%) seniors with a medical condition or a disability reports dissatisfaction with the state's health care system. In comparison, only one in ten (10%) seniors in better health reports being dissatisfied.

The poll also found that more than one in four (26%) Massachusetts seniors have never heard of long term care insurance. Of the 73% of seniors who have heard of it, only one in five (20%) decided to purchase a plan. Among those who have heard of long term care insurance but did not purchase a plan, more than half (57%) cite cost as the main barrier, and about a third (35%) report they do not believe they need such a plan.

In a second report released by the BCBSMA Foundation on September 24th, the vast majority of Medicare beneficiaries in Massachusetts said they have some form of supplemental coverage to help provide financial protection against the significant gaps and cost sharing in Medicare: Medicare beneficiaries in Massachusetts who purchase individual plans to supplement Medicare have a wide range of private coverage options, and many low- and moderate-income beneficiaries can obtain assistance from a number of public programs. About 232,000 people are covered by traditional Medicare supplemental plans, while 218,000 rely on Medicare Advantage HMO and PPO plans. Many other people have retiree health plans through former employers, although the exact number is unknown. Almost one-quarter of Medicare beneficiaries are also enrolled in the state Medicaid program, MassHealth. At least 1 million of the 1.2 million Medicare beneficiaries in the state have prescription drug coverage through private or public plans.

However, some elders in Massachusetts have no health insurance at all: In 2014, a state survey found that approximately 10,000 elders were uninsured at the time of the survey, and 6,000 had been uninsured for the entire year. Forty-six thousand elders (5%) had had a spell without insurance in the prior 12 months. Many, if not most, of these individuals were likely ineligible for Medicare because they did not work, or did not work long enough paying into Medicare, to become eligible.

Some other Medicare beneficiaries lack coverage to supplement Medicare: Although precise data are not available on the number of Medicare beneficiaries in Massachusetts who have no coverage to supplement Medicare, nationally 14 percent of Medicare beneficiaries have no supplemental coverage. Lack of any private or public coverage to supplement Medicare leaves beneficiaries "underinsured" and financially liable for the significant cost sharing and

gaps in the Medicare program if they receive care.

Coverage to supplement Medicare is expensive, particularly when combined with Medicare Part B premiums and when compared with the average Social Security benefit: While low-premium products are available, most Medicare beneficiaries are purchasing more comprehensive, and expensive, coverage. This suggests that individuals are willing to pay higher premiums for more comprehensive financial protection and lower out-of-pocket costs. However, total annual premiums for the most popular plans combined with the Medicare Part B premium exceed $3,800 per year, which is nearly one-quarter of the average Social Security benefit in Massachusetts (the major source of income for most elders). Many beneficiaries may be suffering undue hardship or sacrificing in other areas to pay their monthly premiums, particularly those with chronic health conditions or serious medical problems.

Affordability of coverage to supplement Medicare is a growing concern: Premiums for the most popular supplemental products have risen in recent years, sometimes very rapidly (in the 50-70% range since 2009 for some products, an average annual increase of 9%). In almost every case, premiums have increased much faster than Social Security benefits have. The coverage in some popular lower-premium products has also eroded through increases in deductibles and other forms of cost sharing, which has shifted additional costs to the Medicare beneficiaries with these forms of coverage. Medicare beneficiaries with private coverage, including those with more comprehensive products, still face significant coverage gaps and out-of-pocket expenses, particularly relative to their incomes:

Many of the most popular Medicare Advantage plans have sizable cost sharing for certain services. Most prescription drug coverage has tiered copayments that can be significant for individuals who require brand-name or specialty drugs, and these drug plans generally provide no additional protection in the Medicare Part D coverage gap (often referred to as the “donut hole”). Other issues include the escalating cost of medications, which affects out-of-pocket costs for plans with coinsurance, a form of cost sharing that is becoming more common in Part D plans; the movement of more generics and brand-name drugs into higher tiers with larger cost sharing for consumers; and increasingly narrow formularies, which may limit or exclude coverage for specific medications.

Underinsurance and the lack of private insurance for some Medicare beneficiaries result in expenses for the state’s Health Safety Net: The state’s Health Safety Net (HSN) is a secondary payer for low-income Medicare patients and adults age 65 or older, and a primary payer for certain elders who are uninsured and not eligible for other public coverage. In HSN year 2011 (the most recent for which a report is available), elders accounted for 27% of inpatient discharges paid through the HSN and 14% of outpatient visits. Because the HSN is largely a secondary payer to Medicare, these services accounted for 8 % of total inpatient and outpatient payments, or approximately $22 million. Some HSN expenses at community health centers are likely for medications for Medicare beneficiaries who lack full or partial coverage for prescription drugs, as well as for services that Medicare does not cover at all (e.g., dental care).

Medicare beneficiaries in some counties have limited access to lower-cost Medicare Advantage plans: There are substantial variations in premium rates and plan and product options available by county. In particular, there are significantly fewer choices available to residents in nonurban and less populated parts of the state. The large number of plan types and products, and the lack of standardized benefits and cost sharing, make

it difficult to compare plans and premiums: Even for someone with substantial health insurance knowledge, it is difficult to compare all of the options available for coverage to supplement.

Many Medicare beneficiaries eligible for additional coverage and assistance are not enrolled: Nationally, less than one-third of eligible Medicare beneficiaries enroll in the Medicare Savings Programs (MSPs). Although the exact number of eligible but unenrolled people in Massachusetts is unknown, the percent of eligible but unenrolled beneficiaries here is likely comparable to the national figure. A complicated enrollment process and asset tests are the major barriers to enrollment in these programs.

The income cutoff for MassHealth eligibility is lower for elders than for people under age 65, and even at the same income level, elders may have less access to affordable health coverage than non-elders because of asset tests for public programs that do not apply to younger individuals: Owing to the state's health reform law and the Affordable Care Act, affordable health coverage is available to most people in the state with incomes below 300% of the federal poverty level (FPL), through employers, MassHealth, or ConnectorCare. Eligibility for ConnectorCare and for MassHealth for non-elders is based solely on income; no asset test applies. However, for people age 65 or older, both the MassHealth program and the MSPs have asset tests. Eligibility for public coverage (except for the HSN and Prescription Advantage) ends at 135 % FPL for elders residing in the community, compared with 300 % FPL for people younger than age 65, and Medicare beneficiaries are not eligible for ConnectorCare. Only 16% of elders in the state are covered by MassHealth, compared with 31% of people under age 65 who have either MassHealth or ConnectorCare coverage.

Mass Home Care Director Receives Meals on Wheels Award

On October 8th, the Massachusetts Meals on Wheels Association (MAMOW) presented an award to **Al Norman**, Executive Director of Mass Home Care as the 2015 recipient of the Kit Clark Award, for his work in support of elder nutrition programming.

Catherine "Kit" Clark was a community activist in Boston who dedicated her life to serving others. In the early 1970's, Kit retired and became actively involved in senior issues. In 1974, the doors opened at the Kit Clark Senior House and she became the first Director. The center operated the Title IIIC Nutrition Program providing meals to seniors throughout the City of Boston. Kit died in 1977 leaving behind a rich legacy of community service and involvement. She made a real difference in caring for our seniors and eradicating hunger in Massachusetts.

Al Norman and Jennifer Stiff, Pres. of Mass Meals on Wheels

Since 1986, MAMOW has presented the Kit Clark Award to leaders who have demonstrated dedication and support to senior services across the Commonwealth. "As the long-time Executive Director of Mass Home Care," the group said, "Al Norman has tirelessly sought to articulate and meet the needs of older adults in Massachusetts and the people and agencies who support them. Of particular note to those dedicated to the nutritional wellbeing of elders in the community is his advocacy to support Representative **Paul Donato's** (D-Medford) amendment to restore $871,889 in funding for the elder nutrition programs during the 2016 budget process. His efforts to support elder nutrition have also been manifested in his work

to rectify problems within the Massachusetts DTA and address the drop in Massachusetts SNAP enrollment and consequential loss of important food dollars for elderly households in the Commonwealth. The Kit Clark Award is one small way to thank Mr. Norman for these efforts. MAMOW will make this award at their Annual Meeting on October 8 at The Café Escadrille in Burlington."

The Massachusetts Meals on Wheels Association (MAMOW) is an advocacy organization made up of twenty-six Nutrition Program Directors who are part of the Aging Services Access Point network in MA. The group shares best practices, keeps an eye on current political issues affecting nutrition, and develops plans to support legislative action.

Personal Care Management: 7 Years With No Rate Hike

On October 2nd, Mass Home Care submitted testimony to the Executive Office of Health and Human Services regarding proposed rates for the agencies which manage the Personal Care Attendant Program (PCA), which provides support for roughly 30,000 elderly and individuals with disabilities in the Commonwealth. Here are excerpts of the Mass Home Care statement, which was submitted by **Lisa Prince**, the Assistant Director at Tri Valley, one of the Aging Services Access Points (ASAPs) in Massachusetts:

. "This rate hearing today is a "catch up" hearing. Under Chapter 118E, s. 13D: "The executive office… shall: (i) determine…at least biennially for non-institutional providers, the rates to be paid by each governmental unit to providers of…social service programs." The last time Mass Home Care commented on the PCA/PCM rates was on January 31, 2008. At that time, PCM programs had not received any rate increase for at least two and a half years. PCM rates had remained unchanged from July 3, 2005 to February 29, 2008. The 2005 rates for skills training was a cut below rates prior to 2005. In reality, PCM providers had gone as much as 4 years without any real rate relief. Now we are here today having seen no rate hike since 2008.

Clearly the rate adjustment history for PCMs is not compliant with the biennial requirements of Chapter 118 E, s. 13D. Seven years have gone by without a rate hearing. PCMs have been denied three biennial adjustments to their rates. PCMs should have had rate hearings in 2010, 2012, and 2014. PCM providers have been unfairly denied past rate increases for years---and even a retroactive adjustment today for years without a rate adjustment cannot make these programs financially whole for the rate hikes they should have received.

Here's why this is important: In an EOHHS study dated October, 2007, entitled *The Financial Health Of Providers In the Massachusetts Human Services System*, EOHHS said:

'The Commonwealth has an interest in promoting the financial stability and health of its provider network because organizations with the adequate resources to operate do not need to constantly manage crises and can devote their efforts to innovating, improving and, when appropriate, to expanding services. Stable organizations better attract and retain high quality staff, which enhances continuity of care, service quality and administrative efficiency, and enables them to realize better return on their investment in staff training. A provider system on firm financial footing can achieve quality improvement goals which improve the care clients receive and reduce other costs to the Commonwealth.'

The EOHHS report also noted that 'losing money on Commonwealth activities is a longstanding problem…the consistent loss of money on

Commonwealth operations by more than half of the industry threatens the stability of the system.' The study noted that 'cost-reimbursement, unit rate, class rate… are likely to have differing effects on provider financial health, due to variation in reimbursement policies, frequency of rate adjustments, and inflation factors.'

Another requirement under Section 13D of Chapter 118E is that in establishing rates of payment to providers of services, "the executive office…shall impose such methods and standards as are necessary to ensure reimbursement for those costs which must be incurred by efficiently and economically operated… providers."

Mass Home Care does not feel that the "methods and standards" that EOHHS uses to determine rates are appropriate for determining costs needed for efficiently and economically operated providers. The rate calculations produced in the past have involved a number of separate calculations and adjustments, and at each step, there are many assumptions that go into the crafting of a rate.

We do not know how EOHHS reached a 5.177% cost adjustment factor for calendar year 2016, and an additional .811% factor for calendar 2017, but PCMs have experienced 7 years with no rate hike, and these adjustment factors do not seem reasonable. We agree with the estimate from the Boston Center for Independent Living that were the rates to have increased commensurate with the national rate of inflation, PCM rates would have seen an increase of nearly 11%.

It's hard to describe this entire methodology as a coherent rate setting process…Given the fact that the 2007 rate were in effect for several years, these new rates are simply not adequate for the last half of FY 16. Annual aggregate expenditures under this rate hike during the rest of FY 16 will add only $65,500 per month to the PCMs, or $393,000 by June 30, 2016. The average change for the 28 PCMs in Massachusetts would be only $2,339 per month, or $14,034 for the last six months of this fiscal year. After all the pent up rate demands, this is a form of disinvestment in the future of these programs.

Mass Home Care urges EOHHS to do the following:

1. EOHHS should commit to all PCM providers that it will adhere strictly to the statutory biennial rate setting requirement, and never again leave PCMs hanging for years with no rate hikes.
2. EOHHS should meet with the PAS Coalition and begin a rate making discussion on the standards and methodologies that should go into creating a cost-based rate process for equitable and efficiently run PCMs.
3. EOHHS should work with PCMs on programmatic standards for each cost center, and build a rate that is based on what the program should cost---not as it is constrained by Uniform Financial Report limits.
4. EOHHS should have in place a new rate methodology by September of 2017 that does not depend on UFR expenses, but looks at what programs need per unit to run a quality program.
5. Get on a fiscal year rate schedule that allows PCMs to receive adjusted rates implemented by July 1st of each fiscal year, giving a reasonable and adequate rate increase, including inflation adjustments, for the entire fiscal year.

We close with these words from the EOHHS human services report of 7 years ago: 'A provider system on firm financial footing can achieve quality improvement goals which improve the care clients receive and reduce other costs to the Commonwealth.'"

Mass Home Care indicated it will take weeks or longer before the EOHHS issues it final rate decision to the network of 28 Personal Care Management agencies that oversee the Personal Care Attendant program.

O'Leary Remarks At Mass Home Care Network Conference

Dan O'Leary, EOHHS Assistant Secretary Dan Tsai, and Hebrew Senior Life's Dr. Rob Schreiber, panelists at the Mass Home Care Network Conference.

On September 29th, Mass Home Care President **Dan O'Leary** presented the following comments during a lunchtime panel at the Association's 27th Network Confernce, with close to 400 fronline workers in attendance. On then panel with O'Leary were **Dan Tsai,** Assistant Secretary for MassHealth, and Dr. **Rob Schreiber**, of Hebrew Senior Life and the Healthy Living Center of Excellence.

Here are excerpts from O'Leary's speech on the topic of *Ways to Improve Long Term Supports*:

"Most elders and people with disabilities want to live at home. We all know that from studies, and our own family experience. That's why in 2006 we changed MassHealth law to say that:

'A person determined…to be clinically eligible for long-term care services shall be given the choice of care setting that is the least restrictive and most appropriate to meet his needs…'

That same law in Chapter 118E also says:

'A person seeking admission to a long-term care facility paid for by MassHealth shall receive pre-admission counseling for long-term care services, which shall include an assessment of community-based service options.'

But how many people today go from hospital to nursing home without ever getting counseling on community based care? We know historically that maybe 13% of our home care clients are referred by doctors and hospitals combined. Most of our referrals come from elders themselves, or their families.

The state's Health Policy Commission has said 'Massachusetts has a higher rate of discharge from hospitals to nursing facilities relative to the national average, suggesting an opportunity to manage post-acute care more efficiently.' One image I saw on the internet depicted an ACCOUNTABLE CARE ORGANIZATION as being 3 buildings: a hospital, a clinic, and a Long Term Facility. There was no home in the image at all. Health care was depicted as a shift from building to building.

What we worry about is that health care professionals still see nursing facilities as the default mode. Home care should be the first resort, nursing facilities should be the alternative. But we have 50 years of culture that needs to be turned on its head.

Our State is trying to change the health care system to save money, produce better health outcomes, and increase the consumers' satisfaction with their care. They call that the TRIPLE AIM.

We, in long term services, have our own TRIPLE AIM: INDEPENDENCE, CHOICE AND CONTROL.

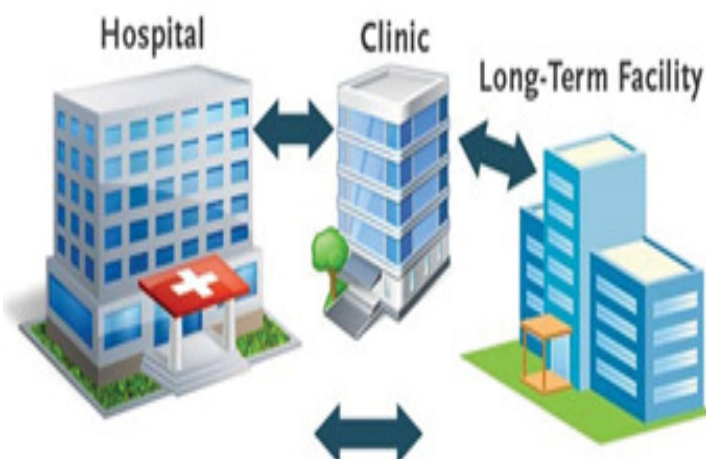
Health care and LTSS come from two very different cultures. The Medical Model emphasizes the doctor as the center of decision-making; services based on what providers offer; and the need for patient safety. In the LTSS culture, the consumer is at the center; services are based on what the consumer wants; the acceptance of some risk is basic to autonomy; and independence and control are more important than safety.

The key to integrating care is for both worlds to accept the cultures of the other—and to stop insisting that the only goals for LTSS are health performance measures.

By the year 2040, 21 million people will be living with multiple chronic conditions in America. In 2013, annual costs for LTSS were $130 billion—with two-thirds of that coming from federal and state tax dollars. We have to design a 'least restrictive' system,

and we need to do it fast!

LTSS is a collection of non-medical services like help with personal care activities (bathing, eating, dressing, toileting, walking) and with household activities (cooking, cleaning, shopping, laundry, etc.) These are supports that do not require a doctor---but they do require a care coordinator to help consumers understand what type of help they can receive.



Accountable Care Organization Graphic On Internet

In addition to personal care supports, research has found that 'social determinants' have a major impact on what determines health. Research says that 60% of health outcomes are influenced by social, environmental or behavioral factors, 20% comes from genetics, and 20% from health. A person's well-being is affected by the quality of their health care—but it is also affected by their income level, adequacy of housing, nutrition, access to transportation, etc. These factors are what one doctor called 'the ambush of social circumstances,' which can marginalize the best intentions of health care providers. Such studies suggest that nonmedical factors play a substantially larger role than do medical factors in health outcomes.

A recent Blue Cross Blue Shield of Massachusetts Foundation study said: 'Massachusetts may wish to accelerate ongoing efforts to link health services and social services…There is strong evidence that increased investment in selected social services as well as various models of partnership between health care and social services can confer substantial health benefits and reduce health care costs for targeted populations.'

When we hear policy makers talking about LTSS, it's usually in the context of how it can be harnessed to improve health goals, like reducing Emergency Room or hospital readmissions. In the health care field, there are scores of quality outcome measures now in use that quantify the impact of medical procedures—yet there are no quality measures commonly accepted for LTSS. A group called the National Quality Forum (NQF) has admitted that there is a wide array of home and community-based services, 'but the quality of those services is not yet measured systematically.'

The NQF report warned that 'over-medicalizing home and community based services must be avoided… .a greater emphasis within home and community based care on health services and health outcomes would eliminate opportunities for individuals to shape and direct their own services.'

MassHealth is now working on a multi-billion plan to put Medicare and Medicaid money under the control of large managed care health networks known as Accountable Care Organizations. We want two consumer protections from this plan:

1) the right for all members to have an 'independent agent' on their care team who is expert in community based care. We want reform that gives people direct access to an independent agent who is not owned by a provider agency, and who---as CMS says---'retains the final responsibility for the evaluation, assessment, and person-centered service plan function for LTSS.

2) a guarantee that if a consumer is unhappy with their managed care plan for any reason, that they have the choice to return to original fee for service Medicaid.

This 'independent' long term agent is actually something the federal government is asking states to do as part of their home and community services Medicaid plan. We have been doing it with home care, Senior Care Organizations and One Care plans for years. These 'independent agents' need to be continually trained, and their agencies accredited for the work they do. We think the Executive Office of Elder Affairs should do that certification for elderly people's agents.

Whole person care means integrating medical care with functional care. It does not mean bringing long term services under the sole control of medical providers. We need some checks and balances that protect the consumer's access to the supports they need

to live independently at home.

These changes are going to have a huge impact on every one in this room. We need 'Accountable Care COMMUNITIES,' where community-based groups that have been on the frontlines for 40 years, are welcomed on the team, not pushed aside.

I believe we can deliver whole care—but the critical start point is with the aspirations of the consumers we serve."

Chet Jakubiak Receives Lifetime Achievement Award from MCOA

David Stevens, MCOA, and Chet Jakubiak, MAOA

On October 7, 2015, the Massachusetts Councils on Aging (MCOA) presented a Lifetime Achievement Award to Chet Jakubiak, who has served as the Executive Director of the Massachusetts Association of Older Americans (MAOA) for the past 6 years.

After college, Jakubiak worked at the Department of Public Welfare. He climbed the ranks, getting into administrative jobs that led him to social policy activism. He decided to pursue a master's degree in social work in the early 1970s.

After graduate school, Jakubiak was recruited to work in a cabinet position with the Massachusetts Executive Office of Elder Affairs under Gov. Michael Dukakis's administration. He worked on legislation to create a protective service mandate and was recruited to implement that policy. Later, he became the deputy assistant secretary for the department that supervised all Council on Aging public sector programs. He helped to introduce the SHINE program (Serving the Health Information Needs of Everyone), and initiated other services such as home care, respite services, adult day health, social day programs and nursing services. He left the post to work on a dissertation but returned to MAOA work 18 years ago and became the agency's executive director in 2009.

Jakubiak has led efforts for over 30 years to obtain economic justice and income security for Massachusetts elders. His work in recent years has focused on economic insecurity among the elderly, in partnership with the group Wider Opportunities for Women. The Elder Economic Security Standard, a measure that benchmarks the basic cost of elder households living in Massachusetts, is the basis for MAOA's current policy advocacy work. MAOA is working to promote the use of the Elder Economic Security Standard in decision-making at all levels of policy and program development. MAOA's policy agenda seeks to improve the economic security of elders in Massachusetts and for future generations. MAOA has supported Mass Home Care's efforts to raise the income guidelines to allow more lower income individuals to receive home care supports, and efforts to raise the wages for home care aides and care managers.

Under Jakubiak's leadership, MAOA has also focused on advocating for community-based mental health services for the elderly and training for frontline workers in behavioral health issues. MAOA's has committed itself to educating practitioners, policy makers, consumers and the general public about the importance of mental health treatment to the overall health and well being of elders. MAOA offers educational conferences across the state each year, which have provided a vehicle for the issues and concerns of elders to be addressed on this often ignored subject. Jakubiak has continued this work to ensure that the foundation for more effective mental health referral and follow up for elders throughout the Commonwealth remains on the agenda of legislators, state agencies, service providers and community elders.

Senate Wants Plan to Raise Home Care Eligibility

Senator Barbara L'Italien

Early in the afternoon of October 8, 2015,, the Massachusetts Senate voted 35-0 to approve language calling for the Baker Administration to study the financial impact of raising the income eligibility limits for the state's elder home care program, and to develop an implementation plan for such expansion.The Senate language also calls for the filing of a Medicaid plan amendment that would allow the state to claim new federal dollars under the Affordable Care Act for elders who are being care for at home.

Here is the language as adopted by the Senate: "SECTION 48A. Item 9110-1630 of said section 2 of chapter 46 is hereby amended by adding the following words:- provided further, that the executive office of elder affairs shall report, not later than December 1, 2016, to the house and senate committees on ways and means on: (i) enrollment data and any other information relevant to caseload forecasting for items 9110-1630 and 9110-1500 at current levels; (ii) projected utilization of services provided by items 9110-1630 and 9110-1500 with eligibility expanded to include the individuals whose income does not exceed 275 per cent of the federal poverty level and with eligibility expanded to include the individuals whose income does not exceed 300 per cent of the federal poverty level; (iii) the projected fiscal impact of expanding eligibility to include the individuals whose income does not exceed 275 per cent of the federal poverty level and the individuals whose income does not exceed 300 per cent of the federal poverty level; (iv) program design considerations regarding the application of cost-sharing revenues to best support individuals in an expansion population of up to 300 per cent of the federal poverty level; (v) an implementation plan for eligibility expanded to include the individuals whose income does not exceed 275 per cent of the federal poverty level and with eligibility expanded to include the individuals whose income does not exceed 300 per cent of the federal poverty level; provided further that the executive office of health and human services shall file a state plan amendment for section 1915(i) of the federal Social Security Act to maximize the opportunity for federal financial participation for any future expansion of eligibility for individuals whose incomes exceed current limits."

This home care implementation plan language, which was offered by State Senator **Barbara L'Italien,** with support from Senate President **Stan Rosenberg** and Senate Ways & Means Chair **Karen Spilka**, was sent to a Joint Conference Committee with the House for final action.

The Senate vote requires the Executive Office of Elder Affairs to prepare a report for the Ways and Means committee of how many new low income individuals would qualify for home care and Enhanced Home Care if the income limits were raised to 275% ($32,081) and 300% ($35,000) of federal poverty level. The report would look at potential client volume and cost, and include an implementation plan for how to increase the income threshold.

EOHHS is also directed to file a 1915i state plan amendment to maximize federal matching funds.

Under a 1915i State plan amendment, states can claim Medicaid payment for home and community-based services for individuals whose income does not exceed 150% of the poverty line without requiring that they need care at a nursing facility level. It has been estimated that a 1915i state plan amendment could bring Massachusetts another $19 million a year in new federal revenues.