At Home

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With Mass Home Care

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Al Norman, Editor

Elder Leap Day At State House Feb 29th

On February 29th, 16 elder advocacy groups will rally at the State House as part of ELDER LEAP DAY. 200 to 300 elder advocates are expected to gather at the Grand Staircase. On this unusual day on the calendar, advocates will be speaking about the unusual challenges facing the Commonwealth as our elder demographics continue to skyrockets.

"Wake up, and smell the Demographics," signs will read. The elderly population in Massachusetts will increase 40% by the year 2035. Our elderly population is rising by 360,000 between 2010 and 2030. 70% of these elders will need some long term services in theier lifetime, and 40% will need long term services for more than two years.

There are several policy issues contained in Governor **Charlie Baker's** FY 2017 House 2 budget that Mass Home Care says have raised some concerns:

1. Senior Care Options "Passive Enrollment" Language: EOHHS has indicated it wants to scale up the Senior Care Options managed care plan, which currently has an enrollment of more than 40,000 seniors age 65 and over. As the name implies, SCO is an "option" for seniors. Under House 2, based on authority requested in Outside Section 39, all seniors on MassHealth would be assigned ("passively enrolled") into a SCO plan, and would have to "opt out" if they preferred not to be in a SCO. Under current state law (Ch. 118E,9D(c), "The division shall ensure that enrollment in the program is voluntary." Passive enrollment has been tried for the past two years in the One Care program with very mixed

results: as of December, 2015, there were less than 13,000 MassHealth members enrolled in One Care, and more than twice that number, 28,747, who have opted out. We believe seniors would prefer a choice of health care plans, rather than auto assignment to a plan they did not pick. When the SCO plan was being created, elder rights groups insisted that enrollment be voluntary. Advocates want to keep the SCO program a voluntary choice for seniors, and maintain voluntary enrollment as currently provided by law. The merits of this plan should be sufficient to attract senior enrollments.

Photo: Gov's Press Office

2. Reducing home care to pay for SCO: House 2 proposes new language in the home care services line item, 9110-1630, that would require EOEA to transfer home care funds to the SCO program whenever a home care client transfers to the SCO program during FY 17. This is a one-way transfer, because SCO clients returning to home care do not bring money with them.

The impact of this transfer would mean that the home care appropriation would drop, and continue to decline all year. Combined with "passive enrollment" for SCO, a transfer could result in a significant loss of home care dollars in the 1630 account. This would reduce funds available for other low income elders who are not on MassHealth, but whose annual income is $27,014 or less. A SCO enrollment transfer would amount to a financial penalty, reducing home care capacity, which would result in reduced appropriation in out years, ratcheting down home care funding for non-MassHealth members. Instead, home care should be open to elders with incomes up to 300% of the federal poverty level, which would give them home care now and delay their enrollment in MassHealth. Advocates want to delete the money transfer language in item 9110-1630, and invest home care funds in serving elders who are not eligible for MassHealth.

3. Community Choices language: House 2 removes language found in the FY 16 budget in item 4000-0600 which says: "provided further, that benefits of the community choices initiative shall not be reduced below the services provided in fiscal year 2015; provided further, that the eligibility requirements for this demonstration project shall not be more restrictive than those established in fiscal year 2015;"

The Community Choices program is 100% targeted to elders on MassHealth who are nursing facility eligible, but are being cared for at home. House 2 removes the language that protects Choices from appropriation and eligibility cutbacks. If the Administration moves forward to mandate that MassHealth elders be passively enrolled in SCOs, there could be forced transfer of elders who are being successfully kept out of institutions by Choices into the SCO program. EOHHS has indicated that people on the "frail elder waiver" will not be passively enrolled---but beyond this fiscal year? This could result in care plan changes, disruptions in medical providers, and other unintended consequences. Advocates want to keep the Choices language in 4000-0600 to protect an elder's right to be in the Choices program, and say that the loss of this language suggests the Administration has plans to cut this critical program.

4. Authority to Restructure MassHealth Benefits: Outside Section 39 of House 2 gives the Administration broad power to restructure MassHealth benefits. This is the same language the Administration asked for in its FY 16 budget---but neither the House nor the Senate included it. The language gives the executive office of health and human services authority to "manage the MassHealth program within the appropriated levels… by restructuring benefits to the extent permitted by federal law. At least 30 days before restructuring any MassHealth benefits under this section, the secretary shall file a report with the executive office for administration and finance and the house and

senate committees." Advocates warn that significant restructuring of MassHealth benefits could have an adverse impact on low-income seniors (see "passive enrollment" issue above). Such restructuring of benefits should be fully vetted by the Executive and the Legislative branch, Mass Home Care said.

5. **MassHealth Estate Recovery:** Elder law attorneys in Massachusetts charged that Outside Section 11 of House 2 makes a series of complex and significant changes to the MassHealth estate recovery statute that will have a significant adverse impact on seniors and their families, and impose a tremendously costly administrative burden on the Commonwealth. Current law limits estate recovery to a decedent's probate estate. The Outside Section 11 would dramatically expand estate recovery to include a vast range of non-probate assets including life estates, joint interests, and trust interests in both real estate and non-real estate assets. Among those who may be harmed by this proposal are (1) surviving spouses who will find newly-expanded estate recovery claims negatively impacting them long after the death of their spouse, (2) families who establish 3rd party special needs trusts for their disabled children, and (3) beneficiaries of a decedent's non-probate assets who are to be held personally liable into perpetuity for estate recovery claims, which they will almost certainly know nothing about due to the woefully inadequate proposed notice provisions. The costs to accurately administer the proposed expanded estate recovery will almost certainly exceed any additional revenue that conceivably may be generated. Advocates seek to maintain the current MassHealth estate recovery provisions in Massachusetts law consistent with and limited to that mandated by Federal Law.

Governor Adds Nearly $5 Million To Elder Protective Services

In related budget news, Governor **Charlie Baker's** $39.6 billion state budget for Fiscal Year 2017 adds $4.97 million increase in elder abuse/protective services funding.

The Administration has also informed home health agencies that there will be a new prior authorization program put into place. This is due to concerns at MassHealth over the rapidly rising level of home health expenditures, which has been attributed in part to an influx of new home health agencies. Massachusetts will also be one of 5 states involved in a new Medicare fraud detection pilot for home health services. (*see article below*)

The Governor's budget also splits the $70 million Enhanced Community Options Program (ECOP) (9110-1500) into two parts: one for care management, which is merged into the home care case management account (9100-1633), and a second part for the ECOP purchased services funds, which are merged into home care purchased services (9110-1630). The consolidated line items in the Governor's budget represents a cut of $770,00 lower than the existing line item funding in the current FY 16 budget. There is also $4.5 M increase in the home care sliding fee limits, allowing Aging Services Access Points (ASAPs) to collect up to $16 million in cost sharing funds from seniors---but this presumes a higher level of home care caseloads---which does not seem likely given other language noted above that siphons dollars away from home care.

In other budget results:

* There is a $174,803 increase (3.18%) in supportive housing, 9110-1604.
* There is a small drop in congregate housing, item 9110-1660 of -$94,828
* There is a negligible increase in elder meals line item 9110-1900 of $3,059.
* There is an insignificant drop in Prescription Advantage, 9110-1455.

* There is a $850,000 cut in the Council on Aging line item, 9110-9002, due to elimination of one-time earmarks in the FY 16 budget. COAs will be level-funded at $9 per elder per year at the FY 17 level.

The House of Representatives is currently in the middle of working up its own FY 17 budget, which will be unveiled by the House Ways and Committee in April.

FY 17 Obama Budget: Lining Bird Cages?

On February 9th, the White House released President **Barack Obama's** $4.23 trillion budget request for FY 2017, and Congressional Republicans did not even set a hearing date for the budget, since the President will serve only 3 months in the budget year covered by his plan. The President's budget, which is politically Dead On Arrival, begins the annual process of determining spending levels for all discretionary federal programs, including for Older Americans Act (OAA) and other aging services. According to the National Association of Area Agencies on Aging (n4a), Republicans have refused to invite the Obama Administration's budget chief to testify on Capitol Hill about the President's plan, as is customary.

In total, the President's budget reflects $4.23 trillion in spending authority, $4.15 trillion in actual anticipated spending and $3.64 trillion in proposed revenue—resulting in an anticipated $503 billion deficit for FY17. The President's budget adheres to the increased budget caps established in the October 2015 Bipartisan Budget Act (BBA), which increased federal spending authority by a total of $80 million for FY16 and 17.

Therefore, says n4a, increases included in the President spending proposal for FY17 are smaller than the FY 2016 increases, when the President's budget outright rejected much lower budget caps and sequester-level spending. As a result, the preliminary OAA funding levels do not reflect the ambitious increases included in last year's budget, but there are still several key increases to core OAA programs, elder justice efforts and other aging programs.

Some of n4a's highlights of the budget include:

• Older Americans Act (OAA) III B Supportive Services: $10 million increase (3 percent)

• OAA III C-1 Congregate Nutrition: $6 million increase (1.3 percent)

• OAA III C-2 Home-Delivered Nutrition: $7 million increase (3 percent)

• The Administration's Elder Justice Initiative appears to be funded at approximately $10 million, which would reflect a $2 million increase (25 percent) from FY 17 funding. Last year, the President requested $20 million and Congress provided $8 million—a 100 percent boost in funding from FY 2015, which was the first time lawmakers funded part of the Elder Justice Act.

• HUD, Section 202 Housing for the Elderly: $72 million increase (nearly 17 percent)

But given the fact that Barack Obama is in his final months in the White House, and handing his numbers off to a Republican-controlled Congress, his budget document probably will end up lining bird cages.

Mass Home Care Asks for Care Management Rate Hikes

The state budget account that funds ASAPs employees and operations costs has been frozen for six straight years.

On February 5, 2016, Mass Home Care submitted testimony to the Executive Office of Health and Human Services (EOHHS) regarding the rate

paid for care management programs in the elderly home care system. These rates are being increased by 3.18% by the Baker Administration retroactive to January 1, 2016. But Mass Home Care says these care management rates have been lagging behind for years, and are overdue for more substantial 'catch up' rates. Mass Home Care's requests seek higher rates for both the Basic care manager account, and for the Enhanced Community Options Program account.

Here are excerpts from the Mass Home Care statement:

"Our testimony today focuses on the rates for ECOP care management, and Basic Home Care case management.

Background: Mass Home Care has testified repeatedly that the use of historical Cost Reports (the Uniform Financial Statements and Independent Auditor's Report (UFR) is an inadequate measure of what an effective and efficient program needs to have in order serve its clients, because UFR costs are based year to year on appropriation levels. If the ASAP budget is cut, its spending is cut, and the UFR reflects this lower spending---not based on client need or cost of service---but based on the need to avoid deficit spending. This spending level is not based on demand for services, or what elders might need to remain living independently---but is a contrived figure backed into based on an annual appropriation.

For this reason, EOHHS' use of a standard cost adjustment---in this case a 3.18% increase above existing rates---begs the question of whether or not past rates are fair and adequate to achieve the mission of the program. The methodology of projecting future rates based on the use of historic spending, which is based on constrained appropriation levels, which are driven by state revenue performance—is inherently arbitrary and capricious. The proposed rate increase of 3.18% is not explained in the filing itself—but this apparent cost of living adjustment is standard across the rates, including Basic CM, ECOP CM and PS services. While we appreciate the fact that EOHHS is providing some level of increase in these rates, we note that these CM rates have not kept up the similar programs operated by the state, or in the private sector.

The ECOP Care Management Rate: The ECOP case management rate currently is set at $209.24 per member per month (pmpm). This is a program for elders who are clinically at a nursing facility level of care (NFLOC), but who are being kept at home at a significantly cheaper cost than institutional care. ECOP is only for elders who are not yet on MassHealth. In most respects, the ECOP program is considered the programmatic equivalent to the "Community Choices" program, which also serves people at a NFLOC. The main difference between ECOP and Choices is that the former is for non-MassHealth members, and the later enrolls only MassHealth members For the purposes of Care Management services required, these two programs are the same. It does not require more skill, training or time for ECOP CMs to manage their clients, than for a Choices CM to manage their clients.

The EOHHS proposed rate for ECOP CM will rise to $215.90, a 3.18% increase over the current rate. Because the ECOP program is described as being the same program as MassHealth's Community Choices program, the rates established by EOHHS should reflect the fact that care management functions are the same.

The rate for Choices CM is currently $275 pmpm. Even though the programs are almost identical, the care management rate for ECOP is 78.5% of the Choices rate. ASAP care managers are routinely assigned to visit both ECOP and Choices clients interchangeably, so the rates for both programs should be the same.

RECOMMENDATION: Mass Home Care asserts that the ECOP and Choices rates need to be stabilized at the same level, and to continue to be adjusted in future years at the same rate. Care managers are working in both programs, visiting clients with the same clinical challenges---the only difference being the fund that pays for the service. Even though the care managers are performing nearly identical home visits and assessments for ECOP and Choices clients, the rate for the former is worth substantially less than the Choices rate. This discrepancy is not something you would discover on any cost report or UFR analysis, because these are separate programs, and subject to different appropriations. If the ECOP rate as of January 1, 2016 was matched to the Choices rate of $275pmpm, the cost to the Commonwealth for the last six months of this fiscal year for the ECOP program would be the difference of $59.10 per unit x 39,157 ECOP units = $2,314,178.

The Basic Home Care Case Management Rate: This line item pays for all ASAP workers--among them care managers and RNs who coordinate services provided to clients in the home care program--and for all program operations costs at the 26 Aging Services Access Points.

According to the Mass Center for Budget and Policy, in adjusted dollars this account has plummeted -42% since FY 2001. In FY 2009 the Governor recommended $40.37 million for this line item, which now stands at $35.54 million—11% lower than it stood 8 fiscal years ago in FY 2009.

There is a significant amount of "catch up" relief needed in this account in order to remain competitive with similar state-operated programs. As we will show below, the rate for 1633 needs to reflect an increase in ASAP personnel and related expenses to manage increasingly complex client needs, and to prevent churning of staff who leave to work at competitive agencies for much higher salaries.

The ASAP care management & operations account (9110-1633) today is under significant financial pressure, because the appropriation has been frozen for the past 6 fiscal years. The personnel paid from this account are not earning wages that are competitive with other comparable workers in the human services field. An independent salary and turnover study released in March of 2015 by the Mass Home Care Association found that care managers and nurses in the non-profit elder home care field are working at salaries considerably lower than at comparable positions in government and private industry. As a result, care manager/RN staff turnover rates are roughly 20% per year---with most workers leaving to pursue higher salaries than the Aging Services Access Points (ASAPs) can pay. The study included 26 ASAPs that cover the entire state of Massachusetts.

The salary study was conducted by LGC+D, a CPA/Business Advisory firm based in Providence, Rhode Island. The study examined salaries of 1,305 ASAP workers, including 261 employees who left their jobs in FY 15. Salaries were compared to several other New England salary reports, and to Massachusetts state job openings for similar CM and RN positions.

Key findings from the salary and turnover study include:

* the average starting salary for an ASAP care manager is $34,255, this is $13,162 below the average starting salary of comparable care manager positions, which are 38.4% higher. An ASAP care manager starts at a lower salary than an EOEA clerical worker, whose entry range begins at a minimum of $40,000. Similarly, the average starting salary of an ASAP nurse is $50,858, this is $11,457 below the average starting salary of comparable positions, which are 22% higher.
* ASAPs are experiencing an annual CM/RN staff turnover rate of 20%.
* Out of 1,305 total employees in the survey 261 workers left their jobs
* The primary reason for staff turnover is better salaries

elsewhere. 47.5% of CMs and 54.2% of RNs said their main reason for leaving the ASAP was higher salaries.
* Based on comparisons with third-party surveys and job postings from the Commonwealth of Massachusetts, ASAPs starting salaries for CMs and RNs are on average the lowest.

The independent salary analysis also noted that the primary destination for care managers and RNs is managed care companies working under state healthcare contracts. The starting salaries for CMs and RNs at these managed care entities are not constrained like ASAPs. ASAPs are only able to pay care managers and RNs based on the appropriation levels received by the Executive Office of Elder Affairs from the General Court.

ASAP salary levels are significantly below comparable positions in the public and private sector. For example, a care manager at DMH whose job is to "conduct client assessments, develop and write individual service plans and care; coordinate, refer and assess the efficacy of services; actively assist in securing treatment and benefit/entitlements, admission and discharge planning from hospitals and institutions; provide advocacy for individual clients on caseload," had a salary range of $46,774 to $63,885. The lowest range of the DMH salary is 43% higher than the ASAP salary—and the state position comes with a pension. In several comparisons of ASAP care manager salaries to comparable positions at state agencies, the ASAP care manager started at a salary $14,000 lower than similar job titles at DMH, DDS, and DSS.

This is the same salary range published by the state's Human Resources Division for similar job postings, such as a DDS Human Services Coordinator. A Social Worker for DSS, which requires a B.A. in human services—similar to an ASAP position—has a salary range of $46,083 to $62,741. Private sector care management salaries, especially in the for-profit sector, are often higher than these state positions.

As noted, one of the major drivers of high turnover is due to staff leaving the home care system for higher wages elsewhere, including similar state positions. As one ASAP wrote: "Pay is certainly an issue when they can leave for a State or hospital position and make $6,000 to $8,000 more. A lack of promotional opportunities is a factor for some. Our supervisory staff does not turn over often, so there are not many opportunities for moving to another level." High turnover hurts the ASAP agencies and its elderly clients, and results in higher advertising and training costs, loss of experienced workers, and less continuity of care for our clients.

One ASAP reported that a care manager at their agency was hired by a Senior Care Organization (SCO) for a salary $10,000 higher than the ASAP was able to pay. A Home Care Supervisor at the same agency was hired away by a managed care company for a $20,000 salary hike. An ASAP in Western Mass reported losing 3 RNs in one month to health care companies offering substantially higher salaries. The ASAPs have to spend money to recruit new hires, then train these new hires.

Other health care agencies see the quality of these workers on shared clients, and then hire them away with significantly higher compensation offer. ASAPs have become the training grounds for other agencies that can offer better salaries. This salary report comes at a time when financial support for ASAP personnel and operations has been falling. For 6 consecutive years, from FY 2011 to FY 2016, this ASAP account has been virtually frozen.

"The ASAPs' below-market starting salaries for care managers and registered nurses in comparison to comparable positions appears to have a direct relationship to the high turnover and reasons for leaving ASAPs positions," said **Michael E. Criscione**, Audit Partner at LGC+D, and author of the Salary and Turnover Analysis. The ASAPs are losing talented employees because the salaries are not competitive.

ASAPs can't run efficient agencies in 2016 on less than they had in 2005.

Mass Home Care is asking for a $5 million increase for FY 2016 in personnel and operations costs. According to recent Uniform Financial Report (UFR) from the 26 ASAP agencies, total personnel compensation and related expenses came to $33,462,047. To provide for a 15% increase for ASAP personnel and related operational expenses for the second six months requires an additional $2,509,653.
An increase in ASAP personnel salaries would make the system more competitive, improve the recruitment of qualified candidates and staff retention, reduce training and advertising costs, improve service to more disabled consumers and generally enhance workforce capacity.

RECOMMENDATION: Mass Home Care urges EOHHS to allow personnel costs in the 1633 account to catch up to competitive costs in similar state and private sector programs. The cost of this increase for the second half of FY 16 is $2,509,653.

BayPath Coaches Get Top Ranking

According to a report from BayPath Elder services, the Aging Services Access Point headquartered in Marlboro, the agency's Care Transitions program—part of a national demonstration project--- recently was ranked fourth out of 36 programs across the country.

The Community Care Transitions Program, launched by the Centers for Medicare and Medicaid Services, allows community-based agencies, working with area hospitals, to seek to reduce unnecessary use of Emergency Rooms and re-hospitalizations.

The current number of CCTP projects is down from a high of approximately 110 programs, as lower-performing programs have been eliminated by CMS. BayPath and its partners in the Central Mass MetroWest Transitions in Care Collaborative have never been in danger of that, as they have consistently been ranked among the top programs in the country, including their fourth-place showing in the most recent rankings released from 2015.

"The coaches have worked incredibly hard to support patients as they transition home from the hospital, and their work clearly shows," said CCTP Supervisor **Gwen Blumberg.** "They're an awesome group of people with a wide range of experience."

The Community Care Transitions Program was introduced as part of the Affordable Care Act and was designed to improve the care of Medicare beneficiaries at high risk for readmission to the hospital. Care transition coaches support patients by providing specific tools and teaching self-management skills to ensure the needs of the patient are met during transitions across settings, such as hospital to home.

(*l-r): Supervisor Gwen Blumberg, Nicole Desimone, Maria Zuniga, Alisa Troncoso, Barbara Fawcett and Sandra De Souza (not pictured: Nancy Dumart*.

Blumberg noted that the average patient at Marlborough Hospital is nearly nine times more likely to be readmitted to the hospital, than a high-risk patient enrolled in CCTP. Marlborough Hospital works exclusively with BayPath's CCTP coaches, while BayPath coaches also work with patients at MetroWest Medical Center's facilities in Framingham and Natick.

BayPath's Care Transitions team consists of Blumberg, who was a CCTP coach herself before being promoted to supervisor last March, CCTP coaches **Barbara Fawcett, Maria Zuniga, Nancy Dumart, Nicole Desimone and Sandra De Souza,** and administrative assistant **Alisa Troncoso**.

Blumberg praised the work of each of her team members. "Alisa regularly works with different departments to ensure communication about discharges as well as set up transportation," said Blumberg.

"Barbara has worked closely with ECC (Elder Community Care) to put mental health services in place for patients struggling to manage both physical and mental health conditions. Maria and the Nutrition department collaborated to provide meals for a home-bound patient discharged home alone with no food.

"This success could not have been achieved without the help and collaboration of every department here at BayPath," said Blumberg. "Nutrition has helped get meals out in less than 24 hours for a patient discharged home without food. Our patients have gotten long-term supports in place with the help and advice of Personal Care Attendants, Adult Foster Care, homecare and Senior Care Options. I&R and our Options Counselors have routinely helped us brainstorm community resources available to patients who otherwise would have fallen through the gaps in care."

Aging Network 'Hanging In The Balance'

The publicly-funded Aging Network has the opportunity to recast its role in the evolving health care system to become a major player—but time is rapidly running out.

That's one conclusion from a January 2016 report from a National Academy of Social Insurance report called *The Aging Network In Transition: Hanging In The Balance*, which examines the future role of agencies like the Massachusetts Aging Services Access Points (ASAPs) and Area Agencies on Aging (AAAs) in light of paid changes taking place in the health care environment.

According to the NASI, the aging network is gradually becoming recognized as an essential component of health care service delivery for a burgeoning number of community-dwelling adults 65 and older. Driven by the large baby boomer cohort, this population will comprise one in five Americans in just 15 years. As they continue to age, the number of old-old Americans (those over the age of 85) will triple by 2050, ushering in a "longevity boom" that will be continued by younger generations– a permanent feature of U.S. society and many others around the world…. many other federal initiatives are designed to foster better integration of services across traditionally "siloed" provider programs and health care settings, while improving beneficiary outcomes and decreasing per-capita cost growth.

Within states, the growth of Medicaid long-term services and supports (MLTSS) programs represents an important trend. While MLTSS offers the Aging Network (AN) potential new opportunities for contracting to provide health-related services, it also brings change and uncertainty, as many states shift from HCBS waiver programs– many of which have been historically administered by the AN – to Medicaid LTSS plans that are being required to assume responsibility for offering HCBS services to their enrolled populations. In light of these and other rapidly-unfolding policy shifts, the AN is working to reposition itself by building out and expanding its business expertise to include contracts with private-sector health care organizations, and by working to capture data that can demonstrate the value of supportive services to health care organizations. Over the next decade, the low-cost, community-anchored AN has an unparalleled opportunity to play a major role in building out a more cost-efficient, accountable, person-centered care system.

The Aging Network's transformation is enormously challenging. At stake is not only the fate and future of AAAs, ADRCs and their community-based partners, but also the capacity of communities across the country to successfully field an adequate supply of "aging in place" services to growing elderly populations and younger individuals with LTSS needs. At this juncture, less than a decade remains for the AN to transform itself into a business-oriented enterprise

that can brand, broker and deliver its services as measurably value-based and delivered in the context of contractual arrangements with health care organization partners and to older adults as direct consumers. Achieving success requires the AN to establish an array of new capabilities. The longstanding pattern of low appropriated funding levels in an era when the number of seniors is increasing by 10,000 each day underscores that the AN cannot rely on OAA dollars alone to finance needed new infrastructure. To date, no public funding has been provided to aid the AN in creating a far more robust, sophisticated technological infrastructure that can support collection and reporting of quality metrics that link to electronic health records, and which can be used to analyze the combined impact of health and social services on beneficiary outcomes. Also needed, but lacking so far, is public and private funding to develop and steward performance metrics that can accurately capture the role of AN services in changing (and hopefully reducing) total care costs.

Yet the AN already has considerable strengths to build on. One is that AAAs and ADRCs are already a trusted point of access and provider of services in communities across the country. **James (Jay) Bulot,** director of the Georgia Division of Aging Services, noted that "access to services that we provide for the public is really crucial, whether it's through a health plan, a health system, or through the AAA. So if we tie this to public awareness of what's out there and how to get there," and then conduct "some sort of consistent outreach, and make sure that folks know it's appropriate to come to that ADRC for assistance, that really is kind of how you get to the 'no wrong door.'"

Another possible area of strength for the AN is that its mission and services can be adapted to fit not only traditional HCBS waivers and managed Medicaid LTSS, but also other types of innovative arrangements and financing models. In this regard, a key trend is the recent rise in interest among states to develop Medicaid ACOs. Although it is early days for Medicaid ACOs, these large integrated systems are designed to explicitly include community-based providers in order to cost-effectively serve large and growing populations of vulnerable beneficiaries, including complex and high-risk patients.

A recently published *ACO Business Planning Toolkit* from the Center for Health Care Strategies (CHCS) argues that "because there are significant inefficiencies in the current health care system including delayed exchange of patient information, lack of preventive care, poor access to care, unaddressed social and behavioral factors, redundant tests and improper financial incentives…well-designed ACOs can improve sharing of patient information, support better management at the point of care and tap community resources to provide much-needed social

No Wrong Door Concept

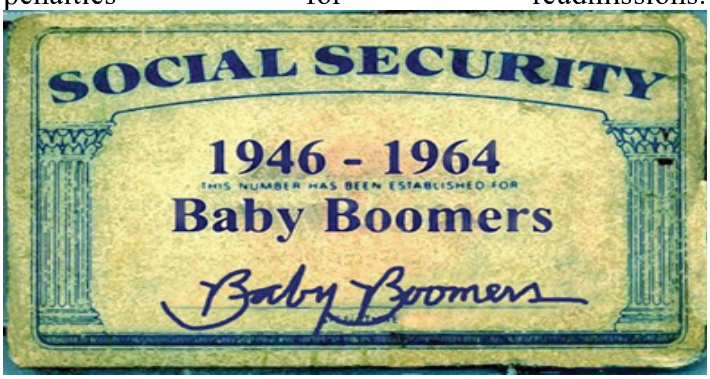
supports such as housing, nutrition, translation and transportation services." The toolkit, which was designed for New Jersey, further notes that "other benefits of an ACO are improved individual and population health, and the potential to reduce overall health care costs by promoting primary and preventative care and lessening the need for expensive services." Some of the specific requirements for establishing a Medicaid ACO in the state include identification of a "designated area;" inclusion of 5,000 or more beneficiaries (either fee-for-service or managed care or both); participation of 75% or more of qualified Medicaid primary care providers and at least four behavioral health care providers in the designated area; a governing board with a mechanism for shared governance, including representation of

health and social services providers and consumer organizations; a "gain-sharing" arrangement "where any cost reductions achieved in the community are shared between participating providers, the state, and potentially managed care organizations and other entities;" a detailed quality plan; and a process for "engaging members of the community."

At the national level, there are hopeful signs that policymakers are beginning to realize that reliable community-based LTSS is essential to keeping Medicare beneficiaries with complex chronic conditions from repeatedly cycling in and out of high-cost health care settings. The Senate Finance Committee's move to charter a bipartisan chronic care working group, chaired by Sens. **Johnny Isakson** (R-GA) and **Mark Warner** (D-VA), requested stakeholder to provide ideas for "transformative policies" in March 2015 and subsequently issued a policy options document in December. The Committee's current recommendations include making IAH permanent, as well as expanding supplemental benefits (such as enhanced disease management) to chronically ill Medicare Advantage enrollees. The document further observes that "a wide range of non-medical or social factors, such as nutrition, are important contributors to the health and costs of chronically-ill individuals."

In conjunction with development, testing and refinement of ACOs and other new and evolving alternative payment models (APMs), slowing spend-down to Medicaid in the population of Medicare beneficiaries who have modest incomes (the "pre-duals") is likely to become a highly salient issue during the next decade. If effective policies are not implemented to slow the rate of spend-down, the resulting Medicaid cost burden for state economies – as well as the federal government, which pays on average 57% percent of Medicaid costs – could become difficult to manage during the boomer-driven peak of the U.S. "age wave." What is certain is that the number of Medicare beneficiaries with both chronic conditions and functional limitations who need a coordinated, seamless combination of medical care and LTSS will increase steadily during the next 15 years and beyond. As such, a primary focus may be how quickly and effectively current programs can be adapted to deliver better-tailored services to many more beneficiaries at significantly lower per-capita costs.

Absent thoughtful, careful reforms in service delivery, both Medicare and Medicaid are at high risk of ballooning costs as tens of millions of boomers move steadily toward "old-old" age (over 85), when needs for care and support are often at their most intense. Older adults who require, but do not receive, reliable community-based social services in order to remain out of crisis will be at high risk of multiple hospital readmissions. This is likely to become increasingly difficult for hospitals to manage due to financial penalties for readmissions.



In addition, Medicaid is already at high financial risk due to its role as the default payer for nursing homes, and the current dearth of affordable private coverage for LTSS. Broader scaling of cost-effective models of service delivery that hold providers accountable for tightly coordinated medical care and the health-related supports that are the hallmark of the AN represents a prudent investment. If successfully implemented, they could also help keep health care expenditures for older adults from crowding out other needed societal investments.

Given these factors, experts at the Claude Pepper Center-NASI symposium agreed that expanding the mission of the AN over the next decade to serve millions of additional vulnerable older adults in need of basic, low-cost community supports is likely to yield broad benefits to society in the form of stabilized overall costs and higher quality of life for millions of long-lived Americans. ACL technical assistance contractor **Tim McNeill** summed up possibilities for

the AN's future in this way: "We're going in one of two directions – either [the Network] grows, strengthens and becomes more cohesive, and works with payers to show the intrinsic value of services through [jointly developed] quality measures…or they're going to shrink" as payers and for-profit entities push prices down. "We will embrace and lead change, and lead development of standards," he said, or "quality [of services] will drop."

Administrator for Community Living (ACL) Administrator **Kathy Greenlee** agreed, predicting that "adequate quality measures across all the domains can really help us, because once we deliver this value base that people want to buy, and we can show this outcome, everybody can kind of move in that direction, and those outcomes can then drive what we should be delivering. It's going to take some time, because we're so far behind in terms of quality measures. But if we can do six or seven things really well and show the outcomes from that – not just output – I think that will shape by itself the nature of where the network will go in the next 10 years, because we will be able to sell that to a whole variety of payers [based on] the value add that we can demonstrate."

Massachusetts Part of Federal Home Health Anti-Fraud Initiativ

In early February the federal Centers for Medicare and Medicaid Services (CMS) announced that it was seeking public comments on a new plan to gather Medicare prior authorization data to reduce fraud and abuse of home health services in 5 states, including Massachusetts. Here are some excerpts from the CMS plan entitled *Medicare Probable Fraud Measurement Pilot:*

*"*The probable fraud measurement pilot would establish a baseline estimate of probable fraud in payments for home health care services in the fee-for-service Medicare program. CMS and its agents will collect information from home health agencies, the referring physicians and Medicare beneficiaries selected in a national random sample of home health claims. The pilot will rely on the information collected along with a summary of the service history of the HHA, the referring provider, and the beneficiary to estimate the percentage of total payments that are associated with probable fraud and the percentage of all claims that are associated with probable fraud for Medicare fee-for-service home health...we seek to develop and implement a Medicare demonstration project, which we believe will help assist in developing improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring among HHAs providing services to Medicare beneficiaries. This demonstration would help assure that payments for home health services are appropriate before the claims are paid, thereby preventing fraud, waste, and abuse. As part of this demonstration, we propose performing prior authorization before processing claims for home health services in: Florida, Texas, Illinois, Michigan, and Massachusetts.

Under the program, home health agencies would be required to perform prior authorization before processing claims for services. The National Association for Home Care & Hospice (NAHC) has stated on its website that they will likely oppose the proposed program "as the antifraud enforcement efforts are already well targeted." NAHC also wrote that prior authorization would likely increase administration costs for home health agencies. One home health care agency told the *Senior Housing News* that "CMS is now proposing that we, home health providers, need to get a reauthorization or an authorization before we see the patients, which is going to kill a lot of the businesses out there, including us. It's going to affect us… Fraud and abuse is killing us. CMS is instituting all these stricter measures to make sure that we are regulated properly and we get rid of fraud and abuse."

The Medicare fraud initiative is only in the proposal phase at the moment. An open public comment period will run until April 5, 2016.