At Home

April, 2016

With Mass Home Care

Vol 29 #4

Al Norman, Editor

"Passive" Managed Care For Elders

Elder Leap Day photo: Humphries Photography

Although the Administration of Governor **Charles Baker** has proposed no direct budget language to move elders into managed care plans, officials have stated their intention to enroll 90,000 elders who are currently in fee for service Medicare and Medicaid into managed care plans.

The euphemism used to describe mandatory assignment is "passive enrollment." Assistant Secretary for MassHealth, **Dan Tsai,** told advocates recently that the shift away from fee for service will require "capacity scaling as quickly as we can." "We want to encourage members to get into integrated care," Tsai explained. The enrollment transition plan has "no target, no numbers" yet, but will begin with a process to educate enrollees on the benefits of managed care. Passive enrollment has been used with mixed results for the past three years for people under the age of 65 on MassHealth in the so-called "One Care" program, which integrates health with long term supports. The state-level authority to mandate managed care appears to derive from Outside Section 39 of the Governor's budget for FY 17, which gives the Executive Branch the power to 'restructure' $15.4 billion of MassHealth spending without approval of the Legislative Branch. Similar language was stopped cold by the General Court in February of 2015, when the Governor requested a supplemental funding bill.

The federal Centers for Medicare and Medicaid Services (CMS) allows states to request permission to "passively enroll" people into managed care plans. Under a 1915(b)(1) "Freedom of Choice" waiver, a state can restrict Medicaid enrollees to receive services within the managed care network. States must demonstrate that the managed care delivery system is cost-effective, efficient and consistent with the principles of the Medicaid program, and that the approval period for the state's 1915(b) waiver program is limited to 2 years.

A person passively enrolled still has the right to "opt out" of a managed care plan, and cannot be passively enrolled again that year. Massachusetts would have to seek CMS permission for passive enrollment.

Elder Leap Day photo: Humphries Photography

Currently, MassHealth members who are under 65, not permanently residing in an institution, and who don't have other coverage have the choice of enrolling in either the Primary Care Clinician (PCC) Plan or a Medicaid Managed Care Organization (MCO). The Primary Care Clinician (PCC) Plan is a primary care case management program administered by MassHealth.

In the PCC Plan, members enroll with a PCC who provides most primary and preventive care and who is responsible for providing referrals for most specialty services. Members can access specialty services from any MassHealth provider, subject to PCC referral and other utilization management requirements. Members enrolled in the PCC Plan receive mental health and substance abuse services through a behavioral health program contractor.

MassHealth also offers its members under age 65 the choice of joining one of six Managed Care Organizations (MCOs) that provide comprehensive health coverage including physical and behavioral health services and pharmacy services to enrollees. Dental care and any long-term services and supports for which the member is eligible are paid for directly by MassHealth on a fee-for-service basis outside of the MCO.

The Administration now wants to "bring to scale" managed care plans like One Care, the Program of All-Inclusive Care for the Elderly (PACE), and the Senior Care Options (SCO) plan. One way to expand these managed care plans is to require people to join them. But involuntary enrollment has not driven up participant numbers. The One Care program, for example, has had passive enrollment since its creation three years ago. One Care is for people between 21 and 64 years old, but enrollees can remain in the plan after they turn 65. One Care enrollees have access to an interdisciplinary care team that coordinates all of an enrollee's physical, behavioral health, and long-term services and supports. On that team by statute is an Independent Long Term Services Coordinator (ILTSC). One Cares by law cannot have "a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator." But this position was interpreted by MassHealth as being an optional team member. As a result, a 2014 survey of 6,000 One Care members concluded that only 4 in 10 members (42%) were offered the services of an ILTSC care coordinator, and only 18% actually ever met with one. 30% of One Care members were not sure they were offered an ILTSC. Roughly one in four One Care members said they had daily personal care needs, and a quarter of those enrollees said their long term services needs were not being met at all.

Enrollment in One Care as of December, 2015 had fallen to 12,285 members, because Fallon Total Care announced last summer that it was dropping out of One Care, requiring more than 5,000 enrollees to find a new plan, But under passive enrollment, there have been 28,747 One Care opt outs—more than twice the number of current One Care enrollees.

Passive enrollment for seniors has not been tried before. Since its creation 13 years ago, the

SCO program has been voluntary by statute (hence the name "Options.") More than 42,000 elders on both Medicare and Medicaid have chosen to enroll in the SCO program, which makes it almost as large as the basic home care, Enhanced Home Care, and Community Choices programs combined. The SCO program integrates medical with long term supports.

Expenditures in the SCO plan as of SFY 2014 were roughly $1.4 billion---with 60% of that coming from MassHealth, and 40% from Medicaid. Hospitals and nursing facilities accounted for 47% of SCO expenditures, 13% for pharmacy, 12% for community services, 7% for physicians, 6% for care management, 2% for transportation, and 13% other.

Bill Henning, Dennis Heaphy, Charlie Carr at Elder Leap Day event, Feb. 29th. Photo: Humprhies Photography.

Once enrolled in a SCO plan, a member may disenroll any month of the year. Enrollment is open to MassHealth Standard members who are ages 65 or older and meet other qualifying conditions. Every elder with complex care needs must have an independent Geriatric Support Services Care Coordinator (GSSC) who works for an Aging Services Access Point (ASAP), and is not financially owned by the SCO. The GSSC helps develop a care plan for members, and monitors the delivery of that care.

The fate of "passive enrollment" of the elderly into managed care plan now lies in the hands of the State Legislature as part of its FY 17 budget review. The House Ways and Means Committee will unveil its budget proprosal on April 13th. Advocates are working to keep managed care plans a choice, not a mandate.

New Restrictions Placed on Home Health Services

The passive enrollment of elders on Medicare and Medicaid into managed care is just one feature of a larger MassHealth reform plan being implemented by the Baker Administration. The Administration has begun to implement the following changes to MassHealth:

• **Home Health:** MassHealth spending on home health services spiked by $170 million from FY2015 to FY2016, a 41% growth over one year. Home health spending hit $770 million in FY 176, and if unchecked would reach $1 billion by FY 17. The eligible population grew by only 3%---but cost per member skyrocketed. "As a result," says a recent Blue Cross Blue Shield study of the Governor's budget, "EOHHS implemented a moratorium on new health home providers effective February 1, 2016, and referred 12 home health agencies to the Medicaid Fraud Unit within the Attorney General's Office for investigation because these providers were responsible for 85% of the growth in spending over the prior year.

In addition, the Administration announced the imposition of tighter rules to control the approval of home health services. There is now a prior authorization requirement effective March 1, 2016 for all home health services (skilled nursing, physical therapy, occupational therapy, speech-language therapy, and home health aide services.) EOHHS also ended the policy that allowed self-referral by clinicians affiliated with a home health agency. As of March 1, 2016, "the physician providing the certification of medial necessity and submitting the plan of care for home health services must not be a physician on the staff of, or under contract with, the home health agency." The plan of care must also 'document that the physician conducted a face-to-face encounter with the member related to the primary reason the member requires home health services no more than 90 days after the start of home health services." These measures are designed to reduce the opportunity for home health agencies to unilaterally approve services from which they profit.

• **Updated referral procedures to Aging Services**

Access Points: home health agencies are required to complete an ASAP referral form for members 60 and over upon assessment or reassessment for home health services or discharge from home health services. Home Health Agencies are also required to submit a referral form "whenever the home health agency has a reasonable expectation that a MassHealth member will require at least 20 hours of home health aide services per week for an extended period of time (beyond 60 days of starting date of home health services.) Members who need more than 2 continuous hours of nursing care will be referred to other MassHealth care managers who will ensure that there are no duplicative services, and that LTSS care plans are coordinated. MassHealth also says that it will have "clinical managers" working with hospital discharge planners to ensure that the LTSS needed to discharge members to the community are authorized, and to coordinate with other payers.

• **Personal Care Attendant Services:** the governor's budget provides for a 10% increase in personal care attendant (PCA) services spending. This increase of roughly $54 million also assumes the state will save $20 million due to improved PCA program efficiencies, program integrity efforts, and other program management efforts. (see related PCA wage story.)

• **Independent Assessments:** EOHHS says that it will implement independent, conflict-free assessments and care planning for LTSS services. Independent, person-centered assessments will be conducted by a conflict-free party who is independent from the provider of a service. This was a proposal promoted by Mass Home Care, but it is not clear what entities will be considered conflict free by EOHHS, or when these assessments will start.

• **Hospital Assessment:** The governor's budget proposes a new $250 million assessment on acute hospitals. The existing $165 million assessment currently funds expenditures from the Heath Safety Net Trust Fund. The additional $250 million would be deposited into a new "MassHealth Delivery System Reform Trust Fund" to help pay for the state share of a delivery system reform efforts authorized under a new 1115 Waiver being written to replace the existing waiver which runs out the end of June, 2017. The current Safety Net Care Pool agreement is worth $1 billion annually. MassHealth will be submitting a large waiver plan to implement MassHealth delivery system reforms in May of 2016.

Adult Day Care: No Rate Hike

photo: Humphries Photography

On February 28, 2013, MassHealth announced a rate increase for Adult Day Health (ADH) program retroactive to October 1, 2012. ADH is a program that provides "an alternative to 24- hour long-term institutional care through an organized program of health care and supervision, restorative services and socialization." The payment rates from the state apply when (a) a patient's medical condition indicates a need for nursing care, supervision or a need for therapeutic services that alone or in combination would require institutional placement; or (b) a patient's psycho-social condition is such that without program intervention the patient's medical condition would continue to deteriorate or is such that institutional placement is imminent.

ADH providers were granted at that time a temporary one-time enhanced rate for FY 2013. "Due to the delay in implementation of the new rates," MassHealth wrote, "and ensuring all months of FY2013 are included, for the rate increase, Mass Health has determined a temporary rate which will be paid 10/01/12 – 06/30/13 ONLY. This enhanced rate reflects the increased rate AND ensures payout of new rate for the three month delay in implementation from July-September 2012." Starting in October of 2012, ADH programs were paid a day ratge of $58.83 for a

Basic Level of Care, and $74.50 for a Complex Level of Care.

Nearly three and a half years later, the ADH rates effective March, 2016 are the same as they were in October of 2012. ADH programs are not only dealing with frozen rates, but a third rate they had for Health Promotion and Prevention Level of Care has been eliminated. This rate used to pay $30.05 a day.

On March 21st. Mass Home Care submitted the following statement in support of higher rates for Adult Day Health programs:

"Mass Home Care is a network of independent, conflict-free care management agencies whose mission is to help the elderly and individuals with disabilities to live independently in the least restrict setting possible. We do not own Adult Day Health centers, and we do not benefit financially from higher rates for ADH programs. We are here because our clients value this service, and we don't want any more facilities to close due to financial pressures.

In October of 2009, and in February of 2011, Mass Home Care testified in support of adequate Adult Day Health rates—and we are here again because the rates have not been adequate. The Adult Day Health program is a critical component of the Commonwealth's "Community First" strategy. In FY 2010, a total of $53.17 million was spent on 981,116 ADH units. 12.6% of these units were for complex level cases, and 6% for Health Promotion and Prevention. 81% of the ADH program were made up of basic clients. Health Promotion and Prevention is now gone, so all clients now are basic or complex.

In previous years, the state would at least create a rate methodology---even if it made no sense. One year providers were told: "The Division examines whether the provider has met the minimum utilization standard of 85% of capacity…The Division then determines the administrative spending per unit of service per provider, and calculates the median for total industry spending."

The state calculated an "efficiency standard for administrative spending," and providers who spent above this median value had their excess spending reduced to the median level." A " cost adjustment factor" was applied…trending these costs forward through the rate period" to establish the proposed rates.

The major flaw with past rate-setting methodology was that future rates were based on historic costs. But historic costs were based on historic rates, and historic rates were not based on the actual costs of operating an efficient program with quality outcomes. Because of this, the rate calculation was based on the prior years' industry spending---which was constrained by rates that were never determined to be reasonable or adequate for maintaining a quality ADH service. Building future rates on historic industry spending simply built inequities into the rate process year after year.

photo: Julian Ruth House

But what can we say this year about rate methodology? There is no methodology presented, and the rate increase is 0%. Even though this ADH program is not subject to CH. 257, rates of payment for ADH should be "reasonable and adequate to meet the costs which are incurred by efficiently and economically operated social service program." With this rate filing, there is no cost adjustment factor, no mention of quality and safety standards. Nothing. Just an edited version of 101 CMR 310 that freezes the ADH rates at the same level they were at in 2012.

According to Chapter 118E Section 13D of the General Laws, rate hearings are supposed to be held every two years. But the last rate hearing for ADH was in October of 2012. The next time these rates are even dusted off for review will be 2018---so providers are being asked to eat the cost of service increases—such as personnel costs---for 6 years straight!

The current rate for Adult Day Health Programs works out to $9.80 per hour for six hours of care.

According to the Mass Adult Day Services Association, these programs are losing $10 per patient per day. That's a loss of $73,000 a year for a program with 20 clients. The Association charges that 10 Adult Day Health Programs have closed since FY14 and many more are hanging by a thread. This is the same kind of rate starvation that has decimated the rest home industry.

While ADH programs are being restrained, nursing facility rates continue to climb. The Governor's FY 17 budget raises nursing home rates by nearly 10%, from $302.9 million to $332.9 million. Pending federal approval, the increase will be supported by an increase in the current assessment on nursing facilities from $220 million to $235 million. But that means nursing facilities will see a net increase of $15 million---ADH will get nothing! According to the Massachusetts Health Policy Commission, the Commonwealth spent 29% more for Medicaid per capita spending on nursing homes than the national average in 2009.

ADH programs cannot maintain quality services if rates continue to stagnate. In a "community first" state, one would expect the community-based programs to get frontline relief. A 0% rate hike this year appears to be arbitrary and capricious, and certainly does not reflect the costs of operating and ADH, or the state's commitment to keeping people out of institutions.

Mass Home Care urges EOHHS to grant ADH a rate increase that builds in a cost of living adjustment based on actual services cost increases since 2012.

Personal Care Attendant Wage Hikes

On March 16th, the Executive Office of Health and Human Services (EOHHS) announced the new wage rates for Personal Care Attendants effective January 1, 2016, pursuant to a collective bargaining agreement with the PCA Union, 1199 SEIU.

The wage rate for PCAs will be $13.68 per hour. It is estimated that this rate hike for PCAs, will add $13.7 million to the aggregate annual expenditures for this program. For the first time, because of changes in the federal Fair Labor Standards Act (FLSA), PCAs will be paid for overtime at $6.84 per hour on top of their base wage, for a total hourly wage of $20.52 time-and-a-half wage. PCAs will also be paid a normal hourly wage for travel time pay, and pay for 4 named holidays per year. These FLSA provisions will add $44.75 M\ million to the annualized cost of the program, for a total increase of $58.45 million.

photo: 1199 SEIU

"Massachusetts Personal Care Attendants with 1199SEIU are leading the way nationally with the highest PCA starting wage in the nation and a pathway to $15/hour by July 2018," said **Rebecca Gutman**, a spokesperson for the union which represents the PCA workers. "Together, 1199SEIU PCAs with the disability and senior communities, will transform PCA and home care jobs into jobs with dignity and respect and prepare for the growing need for home care services in Massachusetts and the nation."

Rates for Personal Care Management agencies were also included in the rate announcement.

MBTA Hikes Rates

On March 7th the MBTA Fiscal Control Board voted unanimously to raise fares starting July 1st by an average of 9.3% in July. The increases are expected to generate about $42 million for the MBTA. The fare increases were met Monday with protests from activists and riders who said the hikes will hit low-income riders hardest. In 2014, the MBTA increased prices between 5 and 7%. Before that, a 2012 hike raised fares by an

average of about 23% systemwide — an increase so high that it helped push lawmakers to place a cap on fare hikes with a 2013 law. MBTA officials lowered the new cost for senior passes from $32 to $30 per month.

.

Spouse As Caregivers Bill Gets Favorable Report

On March 16th, legislation that would allow spouses of MassHealth recipients to be paid as a caregiver advanced out of the Elder Affairs committee with a favorable report.

Senator **Daniel Wolf's** (D-Harwich) Spouse as Caregiver bill (S. 372) was reported favorably from the Elder Affairs committee and sent to Senate Ways and Means. Wolf's bill would add spouses to the current list of family members who can be paid as caregivers under certain MassHealth programs for the elderly and disabled. Under current regulations, most relatives can be paid as a Personal Care Attendant: sons, daughters, aunts, uncles---everyone but a spouse. Similar legislation was filed by Representative **Jennifer Benson** (D-Lunenberg).

The Veteran's Administration allows vets to hire their spouse to provide their personal care. 17 other states also allow spouses to be paid caregivers. According to Mass Home Care, the spouse bill will have a negligible impact on MassHealth outlays, and will save tax dollars by keeping people out of institutions.

A landmark spouse as caregiver study in California, where spouses have been paid since the 1990s, showed that costs are actually lower with spouses than with non-relative caregivers, because the state can assume certain housekeeping services are the natural work of a spouse, and not billable hours. This makes using spouses more cost-effective.

"This is the consummate family-friendly bill," explained **Al Norman**, Executive Director of Mass Home Care, who has advocated for this bill. "It finally recognizes that spouses can play a key role in keeping a loved one living at home." Norman said many families prefer to get care from a relative, rather than a complete stranger.

On March 8th, the *Boston Globe* printed an editorial supporting elderly caregivers, and endorsing legislation that would allow spouses to be paid caregivers, along with the list of existing family members who are already allowed to be paid as Personal Care Attendants.

"Every day, millions of Americans face a health care crisis at home," the *Globe* wrote. "They're providing around-the-clock care for an ailing parent, spouse, or other relative, often while running a family and holding down an outside job. As the baby boomer generation gets grayer, and pressure to reduce medical spending mounts, more people are joining the ranks of these de facto health care providers. They deserve legal standing."

The *Globe* editorial mentioned "another proposal [which] breaks new ground by recognizing the burden on spouses by offering a modest weekly stipend for those caring for patients covered by MassHealth — the state insurance plan for low-income and disabled residents. Other family members — including children and grandchildren — as well as friends, already are eligible for caregiver payments, but spouses are unfairly excluded. "

In an email to all state lawmakers, Mass Home Care urged them to mark International Women's Day by honoring all the spouses who are caring for a loved one at home, by inserting the following one sentence as an Outside Section into the state budget for FY 17:

"Any program of home and community based services funded pursuant to the provisions of this chapter or pursuant to the provisions of chapter one

hundred and eighteen G, in which family members are permitted to serve as paid caregivers, shall include spouses within the definition of family member."

The *Globe* concluded, "these changes would make a significant difference in the lives of caregivers, and the family members who depend on them. Sooner or later, as a caregiver or patient, it's an issue most of us will take personally."

State Files Plan To Simplify Food Stamp Applications

According to the Mass Law Reform Institute (MLRI), the state Department of Transitional Assistance (DTA) has submitted a request to the U.S. Department of Agriculture Food and Nutrition Service (FNS) to allow Massachusetts to implement a Elderly Simplified Application Pilot (ESAP). "This means a short and data-driven SNAP application for low income seniors," explained **Pat Baker** of MLRI. The Massachusetts waiver request has the following elements to make the process less burdensome on the low-income applicants:

• A short two page SNAP application

• No mandatory interview unless the household a) wants an interview, b) would be denied SNAP based on the information in the application, c) information provided is questionable

• No verifications required (with the exception of medical expenses) because shelter expenses can be self-declared

• Use of electronic verification to verify income, age, SSN residence, etc (via SSA and other easily accessible data bases)

• A three year certification period with a mid way (18 month) interim report

• A dedicated centralized processing unit and a specialized hotline dedicated to elder/disabled households

• Targeted information and outreach to help seniors document medical expenses

• Outreach to seniors and key community organizations that work with seniors to promote the ESAP pilot.

"We think DTA's waiver request is excellent," Baker said, "and includes the critical elements to protect elder households from being incorrectly denied SNAP benefits, and protects DTA from 'quality control' errors by issuing benefits when application information is questionable. On a practical level, we continue to find many low income SNAP applicants denied or terminated from SNAP because they did not have an interview, when DTA had the documents or data it needed to process the benefits. We repeatedly hear from seniors and senior services agencies that their seniors either miss the DTA phone call for the interview or the DTA worker is supposed to call but does not, or the senior is unable to battle their way back into the DTA Assistance Line to talk with a worker and have the interview. Lack of an interview is one of the biggest contributors to 'procedural denials' for otherwise eligible low income households, (lack of verification is the other big factor, but electronic verification resolves a lot of that). Under the federal SNAP regulations,7 CFR 273.2(e), an interview - by phone or in person - is required."

Under the DTA waiver requested of the USDA, the mandatory interview would be waived unless:

1. the SNAP applicant will be denied SNAP based on the information provided (e.g. an applicant appears over income but in fact the Social Security is coming in at a lower rate than SSA reports,
2. the information on the application is "questionable" (e.g. a senior applies in MA when data shows an open SNAP case in NH or VT), or:
3. the information provided appears questionable or the client wants an interview.

"That is how DTA has framed the waiver request and we think it is excellent and fully protects our client's interests," Baker added. Mass Home Care has written a letter to the USDA in support of the SNAP project.

New Report On Sharing Behavioral Health Information

On March 8th, the Blue Cross Blue Shield Foundation of Massachusetts issued a report entitled *Sharing Behavioral Health Information in Massachusetts: Obstacles and Potential Solutions*. Here is the Executive Summary of that report:

Due in part to the stigma that is sometimes associated with behavioral health care, information relating to mental health or substance use disorder treatment is given greater protection under both federal and Massachusetts law than most other types of health records. The benefit of such protection is that it helps keep potentially sensitive information private, and therefore may encour¬age patients to seek treatment. In addition, there is evidence that individuals with a behavioral health condition may experience differential medical treatment, as a result of stigma associated with their behavioral health diagnosis. The greater protection of behavioral health care informa¬tion may help mitigate this issue, but these laws may also limit the ability of providers to share information regarding patients who are jointly under their care, thereby impeding care coordina¬tion and possibly worsening health outcomes. These obstacles to information sharing are at odds with the growing array of behavioral health integration initiatives that are designed to encourage behavioral and physical health providers to work collaboratively to provide better care to patients.

With that as context, this report provides a review of the primary Massachusetts and federal pri¬vacy laws relevant to the exchange of information among physical and behavioral health providers and an assessment of technological and operational challenges faced by providers seeking to integrate care through enhanced data exchange. This analysis yielded the following conclusions:

1. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule does not create substantial barriers to information exchange among physical and behavioral health providers for routine treatment, care management, and quality improvement purposes.
2. The main legal barriers to data exchange arise under the federal regulations governing substance use disorder treatment programs—42 C.F.R. Part 2—and Massachusetts laws governing mental health information.3 The Part 2 rules require patient consent for most disclo¬sures for treatment purposes, and the Massachusetts mental health laws could be interpreted as imposing a similar limitation.
3. In addition to legal barriers, primary obstacles to information sharing include variable adoption of electronic health records across behavioral health providers, the absence of true interoper¬ability between the electronic health record systems maintained by different providers, and the failure of electronic health systems to segregate records subject to heightened privacy restrictions.
4. The impact of the current regulatory obstacles could be mitigated to some degree if (a) Mas-sachusetts provided clarifying guidance on the interpretation of ambiguous mental health reg¬ulations, (b) providers adopted procedures for exchanging data, such as a "consent-to-access" model, that align with existing legal restrictions and (c) the government promoted beneficial technological developments, such as more widespread electronic health record acquisition,

stricter interoperability standards, and enhanced data segmentation capabilities.

5. More effective behavioral health information exchange among all of a patient's treating providers will require changes to current laws and regulations. Key changes could include revisions to the Part 2 regulations to simplify the patient consent process and broader treatment excep¬tions under Massachusetts mental health information laws.

Sanders Urges Funding For Older Americans Act

U.S. Senator **Bernie Sanders** (I-VT) has again this year circulated a letter to his fellow Senators requesting their signatures in support of a request to Senate Appropriations Labor/HHS/Education Subcommittee leaders to increase funding support for Older Americans Act (OAA) programs by at least 12% in FY 2017. The annual appropriations process that determines FY 2017 OAA funding is just beginning. This letter will be one of thousands sent to the Appropriations Committee's leaders asking for particular funding levels for thousands of federal discretionary programs.

This is Senator Sanders' fifth time taking the lead in circulating such a letter and he is requesting funding increases of at least 12% (over FY 2016) for all OAA programs and services. Senator Sanders, who is also the Ranking Minority Member of the HELP Subcommittee with jurisdiction over OAA reauthorization, goes on to note that "a 12% increase, though still insufficient, would be an important step toward meeting existing demand" for OAA programs and service.

Here is the text of the Sanders' letter to U.S. Senators **Roy Blunt** (R-Mo.) and Senator **Patty Murray** (D-WA), the Chaur and Ranking Member of the Subcommittee on Labor, Health and Human Services, Education and Related Agencies Services:

"Dear Chairman Roy Blunt and Ranking Member Patty Murray:

As you consider the Subcommittee's funding priorities for Fiscal Year 2017, we urge you to increase funding by at least 12% above FY 2016 levels for programs authorized under the Older Americans Act (OAA). Your past support for OAA programs has been critical in providing vital assistance for millions of older Americans. With the historic aging of our nation's population, increased funding for OAA programs is particularly important now and in the years to come.

As you know, OAA is the major federal vehicle for the delivery of social and nutrition services for more than 11 million older Americans. These programs include congregate nutrition services, home-delivered nutrition services (i.e., "Meals on Wheels"), supportive services such as transportation services, employment and community service through the Senior Community Service Employment Program, vulnerable elder rights protection including through the Long-Term Care Ombudsman Program, and family caregiver support.

The demand for these programs is great, and in many areas of the country, vulnerable seniors are on waiting lists for services that they desperately need. Meanwhile, the cost of living continues to increase for seniors, particularly for food, medication, and housing. Moreover, the demand is only expected to increase.

Today, there are more than 65 million Americans over the age of 60, with 10,000 baby boomers turning 65 every day. The U.S. Census projects that these trends will continue for the next few decades, and by 2030, the number of Americans age 60 and over will increase to 92 million.

Regretfully, federal funding for OAA programs has failed to keep pace with inflation or the growing

need, despite the cost-effectiveness of these critical programs. There are few better investments than the OAA programs that millions of older adults rely on for a healthy and dignified life. Investing in OAA services saves taxpayer dollars by reducing premature and costly Medicare and Medicaid expenditures resulting from unnecessary nursing home placement or hospitalizations due to poor nutrition and chronic health conditions.

At a minimum, a 12% increase – $230 million – over FY 2016 spending levels would recognize the increased costs of services over the past decade. A 12 % increase, though insufficient to address the significant growth in the senior population, would be an important step toward meeting existing demand.

We realize you face very difficult fiscal constraints. However, we ask that you consider the value and need for OAA services, and fund these programs at the highest possible levels.

We greatly appreciate your consideration, and we look forward to working with you to ensure a sustained investment in OAA services and programs.

Sincerely,

BERNARD SANDERS

Member of the Senate

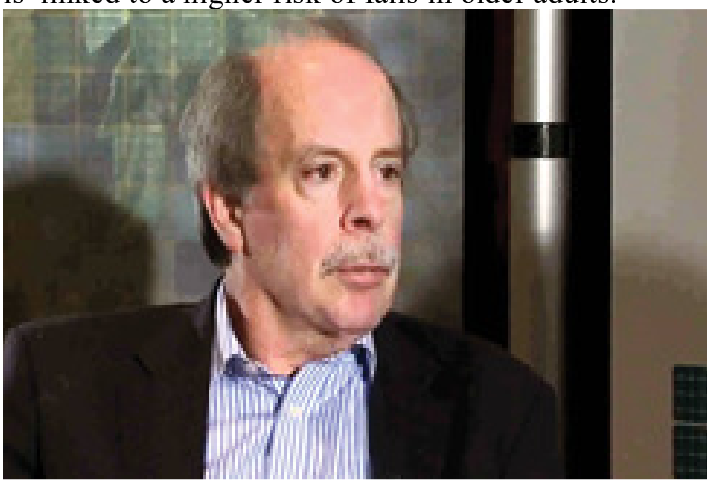
Solving The Elder Malnutrition Challenge

March was National Nutrition Month. In a column released on March 8th, **Bob Blancato** wrote about the challenges facing "those who because of economic, social or health conditions are suffering from malnutrition in America.

Blancato is President of Matz, Blancato, & Associates, a firm integrating strategic consulting, government affairs and advocacy services. He is National Coordinator of the non-partisan 3,000-member Elder Justice Coalition and is Executive Director of the National Association of Nutrition and Aging Services Programs. His column, which appeared in *Next Avenue*, says that many older adults are at risk of developing poor nutrition—which is defined as "a diet that lacks essential nutrients. or can be tied to clinical conditions that impair the body's absorption or use of food."

"Malnutrition is a growing health problem with real consequences to its victims and to our nation," Blancato says. "It is estimated that disease-related malnutrition costs the U.S. $157 billion annually, with older adult malnutrition alone costing $51.3 billion a year. Malnutrition also creates a 300% increase in health care costs."

Blancato notes that 1 in 3 hospital patients admitted to a hospital is malnourished, and 31% of U.S. patients declines in nutritional status while in the hospital. Malnutrition increases the length of hospital stays on average by 4 to 6 days. Also related to malnutrition is sarcopenia (loss of muscle mass), which is linked to a higher risk of falls in older adults.



Bob Blancato

There are some short term solutions, Blancato says. "First, to combat older adult malnutrition, we need to renew and strengthen the federal Older Americans Act," he says. "Its nutrition programs — meals and nutrition education — which already serve 2.6 million seniors per year with the capacity to serve more if there was greater funding, are a highly effective preventive measure against malnutrition. They help older adults gain important daily nutrition. These programs should be funded at higher levels."

These so-called congregate and home-delivered meals programs provide important wellness checks and "social experiences" in addition to nutritional health. But some seniors with chronic disease, may not be able to fully meet their nutrition needs with food alone. For

them, oral nutrition supplements become an important malnutrition therapy. In a recent study of older adults cited by Blancato, use of a specialized nutrition supplement was associated with a 50% lower death rate in patients with heart or lung disease. Such supplements can be provided as part of meals programs.

Hospitals are also targeted as a location where better nutrition screening should take place, Blancato explains. "We must improve and enhance nutrition screening during hospital admissions," he says, "for all patients 65 and over, using a validated tool — particularly ones who are identified as malnourished or potentially malnourished. We must document malnutrition diagnoses for all patients, especially older adults. Finally, we need to establish and implement a malnutrition treatment plan, including intervention, monitoring and discharge and follow-up, for these same patients."

"The same lack of nutritional quality measures are also lacking in community-based settings. "We also need to integrate malnutrition into quality measures at the clinical and community levels," Blancato warns, "since those measures are important to clinicians. Malnutrition-related quality measures would ensure that malnutrition screenings and interventions are occurring and awareness of the problem is raised in general." Malnutrition measures should be incorporated into proposed measures of community chronic disease health care outcomes."

"Over the long term, the Affordable Care Act could help reduce older adult malnutrition. There should be strong components in future care transitions grants on malnutrition screening and intervention, Blancato argues. The law's definition of "essential health benefits" should be broadened to include malnutrition screening and therapy. Malnutrition status should be recorded in all electronic health records. Medicare-covered medical nutrition therapy should include diabetes and other conditions."

"We should set as a national health goal to reduce malnutrition in the U.S. combined with a series of specific actions to address disease-related malnutrition. We should promote the idea that nutrition is a key indicator of older adult health in America."

"We should commit to a national nutrition strategy focused on healthy eating throughout the lifespan," Blancato concludes, "including foods consumed and nutrition education. Yet, for the nutritionally vulnerable of all ages, we must commit to ensuring that our federal safety net is especially extended." The Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) are programs that make a significant difference in the lives of millions of Americans, young and old. "These programs must be protected and it must be ensured that they are serving all who need them."

Independent Conflict Free Agents

Mass Home Care has launched an effort to ensure that future managed care plans for the elderly on Medicare and Medicaid will allow them to have an "independent agent" on their care team to assess and help manage their long term services and supports.

The concept of an 'independent agent' has been in operation in Massachusetts since the mid-1970s, when the state's home care program was established. The home care program is operated by Aging Services Access Points (ASAPs) which are not elderly services providers. These agencies can assess what services an elder needs without having a financial conflict as a direct service provider. In addition to home care, the Senior Care Options Program and One Care, both give seniors an independent agent on their team. Advocates want the new Accountable Care Organization (ACO) plans to have the same consumer protection in place.