



## 3,000 Rally To Stop Cuts To Entitlements

As many as three thousand elderly and disabled individuals converged on the Wang Center in Boston on November 9th to stage a mass protest against proposed cuts to Social Security, Medicare and Medicaid.

Sponsored by Mass Home Care and several dozen elderly rights and labor groups, the rally literally sent a “big message” to one of the members of the Congressional “Super Committee” that is tasked

with developing specific proposals to cut the federal deficit. Seniors took a large envelope stuffed with messages from elders to the Boston office of U.S. Senator **John Kerry**, the only New England lawmaker on the 12-person Deficit Reduction Committee.

The November 9th turnout was described as historic, coming roughly two weeks before the Super Committee was scheduled to submit its findings to the full Congress. The rally began at the Wang Theatre, and was followed by a march and caravan towards the offices of Sen. John Kerry and Sen. **Scott Brown** just off City Hall Plaza in Boston.

**Max Richtman**, head of the National Committee to Preserve Social Security and Medicare told the crowd: “The threat to programs which touch the lives of virtually every American family, has never been as

serious as it is right now. In Washington these days, cutting benefits to middle-class and poor Americans is seen by too many as a sign of courage—rather than what it truly is—misplaced priorities which continue to ask average Americans to pay for fiscal policies which for more than a decade have benefited the wealthy.”

AARP Massachusetts State Director **Deb Banda** noted that “Medicare and Social Security aren’t luxuries. They aren’t fat to be trimmed. They are the backbone of support that allows older Americans to live with a modest level of dignity and peace of mind in retirement.”



*Mass Home Care photos*

At the time of the rally, the Super Committee – a 12 member bipartisan group – is considering potential cuts to Medicaid, Medicare and Social Security that would harm today’s seniors and workers – including: a \$112 billion cut to Social Security by changing how the Social Security cost of living adjustment (COLA) is calculated and reducing benefits; raising the age of Medicare eligibility from 65 to 67; and, increasing out-of-pocket costs for seniors in Medicare.

Rally organizers say these benefits represent an intergenerational commitment – and that cuts of the magnitude being considered by the Super Committee would constitute a betrayal of the seniors, veterans, and workers who have paid into the safety net and retirement systems for years. Today, about one million Massachusetts residents rely on Social Security and Medicare. The average Social Security benefit for middle- and low- income Bay State Seniors is \$13,900, while their average out-of-pocket cost for health care is \$6,800.

Rally organizers noted that Social Security is not part of the federal deficit, and cutting Medicare alone will not address the skyrocketing costs crippling the entire health care system. These proposals will, however, hurt today’s seniors, today’s workers and tomorrow’s retirees. Instead, lawmakers should focus attention on creating jobs, rather than hurting constituents.

**Al Norman**, Executive Director of Mass Home Care, closed down the Wang Rally by asking the crowd: “Do you know who we all are? We are the 99%! The richest 1% in our county do not wait by the mailbox for their Social Security check to arrive. The richest 1% does not worry if they have a Medicare card in their wallet. And the richest 1% are the only people in America who don’t need Medicaid to pay for a nursing home bed. But Social Security matters to the 99%. Medicare matters to the 99%, and Medicaid matters to the 99%.”

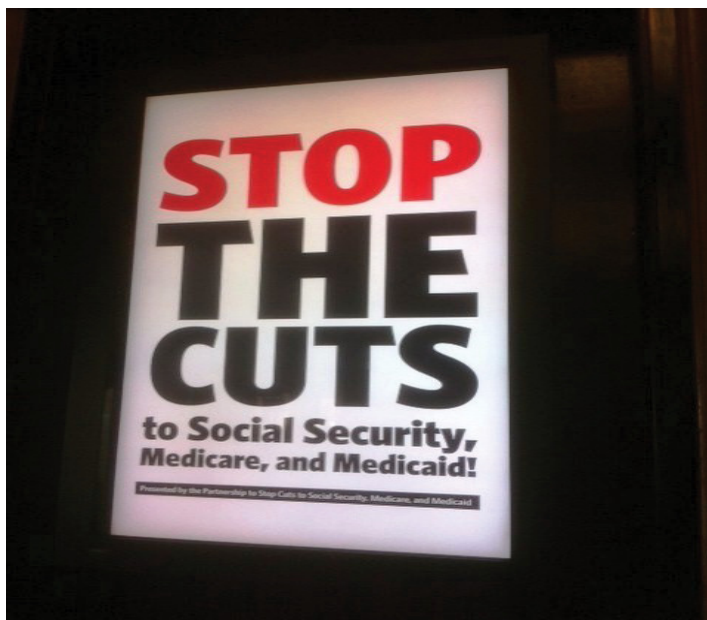
## Super Cuts Coming?

At the end of October, with Halloween approaching, Congressional leaders were leaking out some budget cut ideas that were pretty scary. According to the *Huffington Post*, Democrats on the congressional super committee have proposed a mix of spending cuts and revenue increases to achieve an estimated \$2.5 trillion to \$3 trillion in deficit reduction. Senate Finance Committee Chairman **Max Baucus** (D-Mont.) build a plan that relies on raising revenues and \$200 billion and \$300 billion in new economic stimulus. But the plan also calls for around \$400 billion in Medicare savings, half of which would come from reducing benefits to recipients, the other half from providers. The Baucus plan does not call for raising the Medicare eligibility age. That idea was put on the table during talks between President **Barack Obama** and House Speaker **John Boehner** in the late summer. When the president submitted his own proposal to the super committee, he dropped the idea of raising Medicare's eligibility age.

According to the *Huffington Post*, Democrats were trying to minimize the cuts to entitlement programs. The Democratic plan would produce a roughly 1.5 to 2.5 revenues-to-cuts ratio. The committee must present a plan around Thanksgiving-

ing. A vote is scheduled for the end of December.

The Baucus Plan was described by one aide as not a formal proposal---but many observers believe that steep Medicare cuts will be part of the super committee plan. The committee's co-chair, Texas Republican Rep. **Jeb Hensarling**, said during a hearing on November 1st that President Obama had called Medicare and Medicaid "the single biggest drivers of the federal deficit and the federal debt by a huge margin." Senate Republican. **Rob Portman** (R-Ohio) at one point described Medicare now as an unsustainable program. "A couple retiring today will pay about \$119,000 in lifetime Medicare taxes and receive about \$357,000 in lifetime Medicare benefits. So that's about 3 bucks in benefits for every dollar in taxes. If you multiply this by the 77 million retiring baby boomers, it's not hard to see why we have an unsustainable program."



But this analysis is misleading, because Medicare is not funded just from payroll taxes. There are actually 6 major sources of Medicare revenues. The largest sources are general tax revenues (42%), payroll tax contributions (37%), and beneficiary premiums (13%). Medicare Parts A, B, and D are financed separately, as follows:

- **Part A** hospital care is financed primarily through a 2.9% tax on earnings paid by employers and employees (1.45% each) (accounting for 84% of Part A revenue). Starting in 2013, for taxpayers earning more than

\$200,000/individual and \$250,000/couple, the payroll tax on earnings will increase from 1.45% to 2.35%.

- **Part B** doctor's care is financed through general revenues (74%) and beneficiary premiums (25%). Beneficiaries with annual incomes over \$85,000/individual or \$170,000/couple pay a higher, income-related Part B premium reflecting a larger share of total Part B spending, ranging from 35% to 80%.
- **Part D** drug coverage is financed through general revenues (83%), beneficiary premiums (11%), and state payments for dual eligibles (6%). The health reform law established a new income-related Part D premium similar to the Part B premium, where higher-income beneficiaries pay a larger share of the cost of standard drug coverage.

Given the fact that Medicare's projected revenues come from 6 separate sources (general revenues, beneficiary premiums, payments from states, taxation of Social Security benefits, interest, and payroll taxes) Senator Portman's equation compares Medicare benefits paid out only to Medicare payroll taxes collected, which leaves out 63% of the other revenue Medicare receives. Medicare payroll taxes only account for 37% of the program's revenue--so Portman's comments are misleading at best.

As of November 21st, the Super Committee was telling the media that they could not reach agreement on a deficit reduction package. Senior rights advocates however planned to hold events in front of Senator Kerry's office on November 22nd., suggesting that "No deal is better than a bad deal."

## ICE Plan Fails to Protect Civil Rights

On November 4th, Mass Home Care sent a memo to key officials of the state Executive Office of Health and Human Services (EOHHS) about a new plan designed to integrate health and long term services and supports (LTSS) for people on Medicare and Medicaid between the ages of 19 and 64. The so-called "Integrated Care Entity" (ICE) plan is designed to serve 115,000 of these "duals eligible" people.

Mass Home Care has been critical of certain design elements in the ICE plan, and prepared

a memo pointing out that the plan as written was ignoring the "community first" approach for LTSS that has been adopted by the Administration of Governor **Deval Patrick**. The ICE plan offers seniors guaranteed access to a nursing facility, but not to similar 24/7 housing with supports as a community-based service.

Here is the text of the memo sent by Mass Home Care to EOHHS:

"This memo relates to a disconnect between Medicaid statute, and Medicaid regulations, and the institutional bias of projects like the proposed ICE plan

Under Section 9 of Chapter 118E (the Equal Choice law) it states that:

"long-term care services shall be available to otherwise eligible persons whose income and resources are insufficient to meet the costs of their medical care as determined by the financial eligibility requirements of the program. For the purposes of this section, the division shall establish clinical eligibility for a long-term care services. A person determined by the division 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 as determined by the division."

This law has been on the books since August of 2006. It relates to all MassHealth members, not just the elderly. Although the Division was tasked with establishing "clinical eligibility for long term care services," the regs were never rewritten in this regard since 2006, and the regs still refer to eligibility for a "nursing facility" benefit. Instead, the regs should properly create a "LTSS benefit" that includes community care and institutional care,"and then gives the member "the choice of care setting that is the least restrictive and most appropriate to meet his needs." This choice is not happening. The state plan guarantees SNF care, but not a similar 24/7 housing with supports service that would truly provide members with the "choice" they are promised under Chapter 118E, s. 9.

This carries over into the ICE plan, where the clear benefit available is skilled nursing facility care, but not a similar service in the community. When we raised the issue of 24/7 housing and supports (what the Mass Rehab Commission calls "reshab") we were told it was "too expensive" and would not be included

in the duals plan. The plan as currently written, therefore, denies me the choice of care in the least restrictive setting, and violates Chapter 118E, s. 9. The ICE plan creates an incentive for institutional care by denying me my choice of similar care in a small group home.

The Equal Choice law does not say that the "choice" of care in the most integrated setting shall only be available to certain members who are eligible for waivers. This choice should be available as part of the state plan array of services. Anything less is not a true choice of least restrictive setting.



After the Equal choice law was passed, we asked EOHHS to rewrite MassHealth regs to reflect the new law. This was never done. When the 1115 waiver for seniors was being discussed, we asked again for an equal choice of care in the community, but our request was never implemented, and the 1115 waiver never completed. Most recently, we have asked again for a community based equivalent to skilled nursing facility care in the ICE plan--thus far with no success. The only place a consumer can get a choice of a 24/7 housing with services alternative to a nursing facility is if he or she is enrolled in a Senior Care Options plan, in the future Money Follows the Person waiver, or in an MRC Brain Injury residential waiver.

There are three next steps that we believe should be taken:

First, Community based options should be written into the state plan on a level playing field with SNF care, so that members can freely choose between the two without having limited access to one or the other.

Second, demonstration projects like ICE should be consistent with the equal choice law,

and provide a true choice of most integrated care.

Third, we hope MassHealth will begin in earnest to rewrite its regs to meet the Equal Choice law, and ensure that all waivers, demonstrations, and other benefit programs provide members with a LTSS benefit that gives an equal choice between community care and institutional care.

Choice of care in the most integrated setting is a civil right as stated in the U.S. Supreme Court *Olmstead* decision of 1999, interpreting the federal Americans with Disabilities Act. The ICE plan, as proposed, violates the *Olmstead* decision and the Equal Choice law. To deny members an equal choice of care in the community is a form of "unjustified segregation," and should be corrected before the ICE plan is submitted for public comment, or for submission to CMS. Furthermore, the community based settings are less expensive than institutional care, thus denying the state the opportunity to assert that it 'cannot afford' to give people their civil rights.

## Fuel Assistance: Not Enough In the Pipeline

Critically needed home fuel assistance for low-income households has gotten off to a slow start across the nation, and at least a quarter of a million low-income households in Massachusetts may run out of fuel this winter without additional fuel aid.

The Commonwealth submitted its plans for the federal Low Income Home Energy Assistance Program (LIHEAP) in August of 2011. At that time, based on President **Barack Obama's** budget nationally of \$1.98 billion, Massachusetts was planning on receiving \$81.75 million for fuel assistance for the poor. The program year was to begin November 1, 2011, and run through the end of April, 2012. A maximum benefit level was set at \$400. But as the proposal noted, "the benefit levels are subject to change based on final availability of federal funds." Last year the maximum fuel benefit was \$1,050. November 1st rolled around, but there was no fuel assistance program in sight.

According to one agency which disburses the funds in Massachusetts, "Some LIHEAP funding was authorized but the U.S. Department of Health and Hu-

man Services decided not to release the funds to the States. As of late October, some funds were released. Approximately \$77million will be distributed in Massachusetts once the state Dept. of Housing and Community Development has set the benefit levels. Just to stay even with last year Massachusetts needs nearly \$200 million. We are truly worried that benefit levels will not be high enough for those who heat with oil for a 100 gallon delivery. Most dealers won't deliver for less. Most qualified households should get 100 gallons delivered. Which will last them until---we're guessing maybe until December 1st. So without Congress acting soon there will be a real crisis for low income residents whether they are seniors, families or individuals. The Continuing Resolution ends November 18th, so we hope that at that point LIHEAP will be funded at about \$4.7 billion nationally. That is about where we were last year. But with all the deficit talks going on, we can't be sure if the funding will be approved---or subject to another incremental increase -- a true killer for a program that is front loaded for the winter months."



Fuel programs in Massachusetts note that for the first time in three decades, the aid program did not start on November 1. On November 4th, the federal government gave the green light so that fuel deliveries could be made. The funding released to Massachusetts was based on President Barack Obama's budget, which had \$1.85 billion for fuel assistance. The President's budget was lower than the U.S. House (\$3.4 billion) and the U.S. Senate (\$3.6 billion), so the feds used the lowest number to be conservative.

But advocates fear that the first round of federal funding could be the state's last, given the uncertainty surround deficit reduction talks. The state now has in hand authorization to release \$77.6 million in fuel aid--but this is only 42% of the \$185 million that the Commonwealth had last winter to distribute. At the state level, the state Senate passed an amendment to "advance" \$10 million for fuel assistance from the Rainy Day Fund, with the understanding that when the federal fuel aid funding arrived, the money would be paid back to the state. That amendment was dropped during conference committee discussions, because it appeared the federal government was going to release the first round of funding. But now that the first pipeline of funding is out, the problem of the shortfall in fuel funding may require more supplemental funding at the state level.

In early October, U.S Senator **John Kerry** wrote to the Obama Administration, asking them to release the \$5.1 billion for LIHEAP nationally. Kerry noted "Those who need assistance from LIHEAP the most are often our 'Greatest Generation seniors' who have contributed to our country all their lives and now live on fixed incomes, in addition to low-income working families struggling to pay rent and keep their heads above water in a difficult economy."

With the heating season now begun, the uncertainty over future federal fuel aid is making prospects for a difficult winter even more difficult.

## Support for Adult Day Health

On November 8th, Mass Home Care submitted a statement at a "Stakeholder Feedback Forum" about the Adult Day Health (ADH) program in Massachusetts. **Daniel O'Leary**, Executive Director of Mystic Valley Elder Services (MVES), made the following statement on behalf of Mass Home Care:

"I am here to support the importance of adult day health as a high value, high impact service among the array of programs and services that ASAPs are able to select from to meet consumer needs and preferences.

ADH offers consumers and the Commonwealth excellent value when considering the amount, type and hours of service provided to eligible consumers in the

course of a day even at the complex care rate of \$68/day. This daily rate includes nursing oversight, personal care, structured failure-free activities, socialization, physical and mental stimulation, companionship and nutrition. In terms of overall value, ADH is one of the services that we highly recommend to elders and families. ADH is a cost effective venue to provide high quality services to those that need that level of care and supervision.

MVES is one of the agencies that contracts with a number of approved ADH programs and performs eligibility determinations under the Comprehensive Assessment and Eligibility (CAE) program for Mass Health. As such, we see the value of ADH. In fact, MVES would like to see more clients with health care needs select ADH as a primary service as ADH will not only contribute towards their overall health and well-being, but also serve as a way to limit premature institutionalization and re-hospitalization for conditions such as congestive heart failure and chronic obstructive pulmonary disease.



We might want to consider an independent review of clients on a regular basis that would not be an obstacle for appropriate care either for the consumer or provider. We also want to highlight the need for quality ADH that focuses on the needs of people with cognitive impairments and behavioral health issues as this is an area where there is a short supply.

We hope that the outcome of this program review will find that ADH should be expanded and supported as a preferred service in the Commonwealth's Community First initiative."

Mass Home Care added that while its mem-

bers do face-to-face screens of all individuals referred to the ADH program, there could be more independent oversight of people when they are changing levels at an ADH to complex care, which pays the ADH center a higher level of reimbursement, and that annual reassessments should be treated as if a consumer was a new referral and in need of a face-to-face assessment to assess continued need for the service at the appropriate level.

## U.S. HealthCare Scorecard: Costs Up, Access Down

On October 18th, the Commonwealth Fund issued a report called *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011*. This study updates a series of comprehensive assessments of U.S. population health and health care quality, access, efficiency, and equity. It finds that the U.S. health system performance continues to fall far short of what is attainable, especially given the enormity of public and private resources devoted nationally to health. Across 42 performance indicators, the U.S. achieves a total score of 64 out of a possible 100, when comparing national rates with domestic and international benchmarks. Overall, the U.S. failed to improve relative to these benchmarks, which in many cases rose. Costs were up sharply, access to care deteriorated, health system efficiency remained low, disparities persisted, and health outcomes failed to keep pace with benchmarks. The health system as a whole scored 36 percent below the benchmarks of best performance.

The overall score for U.S. health system performance failed to improve over the five years since the first National Scorecard in 2006. Access to care declined substantially, owing to the continuing erosion in health insurance coverage and affordability. Across the 42 core indicators, performance more often declined than improved, primarily because of worsening national rates. Indicators showing notable deterioration included:

- affordability of insurance premiums and medical bill problems;
- coverage and insurance adequacy among adults; and
- hospital readmissions among patients discharged to

nursing homes.

Indicators showing notable improvement included:

- adoption of electronic medical records by primary care physicians;
- control of high blood pressure—adherence to evidence-based treatment standards in the hospital;
- declines in rates of some preventable hospitalizations;
- reduction in pressure sores among nursing home residents; and
- improved mobility among home health patients.

The report says that “despite encouraging pockets of improvement, the U.S. still has a long way to go to make its health system the best it can be. The country as a whole is often failing to keep pace with levels of performance attained by leading nations, states, and health care delivery systems, and consistently ranks poorly in comparison with other countries on measures of healthy lives, care experiences, and efficiency.



Here are some examples from the Commonwealth Fund Scorecard:

- *Healthy life expectancy.* Life expectancy in the U.S. has not kept pace with gains made in other advanced countries, even as the U.S. rate reached a new high of 78-plus years in 2009. The nation also ranks low on “healthy life expectancy,” a measure of population health that combines length and quality of life into a single measure, taking into consideration time spent in poor health as a result of disease and/or injury. In a 2007 comparison of 23 countries, the U.S. was among the bottom five on healthy life expectancy at age 60. On average, U.S. men at age 60 enjoy two fewer healthy years, and U.S. women three fewer

healthy years, than their counterparts in the benchmark countries. This finding is perhaps not surprising, given that older adults in the U.S. face a greater burden of chronic health problems and are more likely to experience gaps in insurance coverage and other access problems, leading to adverse health consequences.

• *Activity limitations.* More than one of six (18%) working-age adults reported being unable to work or carry out everyday activities because of health problems—physical, mental, or emotional—in 2010, compared with 15 percent reporting limitations in 2004. Activity limitations increase with age, affecting one-quarter of adults ages 50 to 64. Reducing health-related activity limitations will depend not only on prevention and management of chronic diseases but also on reducing obesity, which has been a major contributing factor in rising rates of disability among working-age adults.



• *Mental health care.* Treatment of mental health problems remains inadequate in the U.S. Among adults who had major depressive episodes during 2009, more than one-third did not receive treatment. Rates were substantially lower among minority Americans (e.g., 49% for Hispanics vs. 69% for whites) and those without health insurance (e.g., 48% for the uninsured vs. 79% for Medicaid beneficiaries). Collaborative care interventions show promise for improving the detection and treatment of depression by primary care providers. But poor care coordination and the lack of reimbursement for deploying multidisciplinary care teams and for training primary care providers in mental health, among other enhanced services, impedes uptake of such interventions.

• *Chronic disease management.* Control of two common chronic conditions—diabetes and hypertension—improved from 1999–2000 to 2003–04, based on the results of physical exams conducted on nationally representative samples of community-dwelling adults. From 2003–04 to 2007–08, there was continued improvement in hypertension control, but not diabetes control. Again, rates varied significantly by insurance coverage and income. Achieving the rate of control in the best-performing health plans could annually prevent up to 89,000 deaths and save up to \$3.1 billion in medical costs. Control of high blood pressure increased from 31 percent of adults with hypertension in 1999–2000 to 41 percent in 2003–04 and 50 percent in 2007–08. This improvement corresponded to increased awareness and treatment of hypertension during this time. 71 percent of uninsured adults with hypertension did not have their blood pressure under control during this time, compared with 45 percent of adults with public insurance.

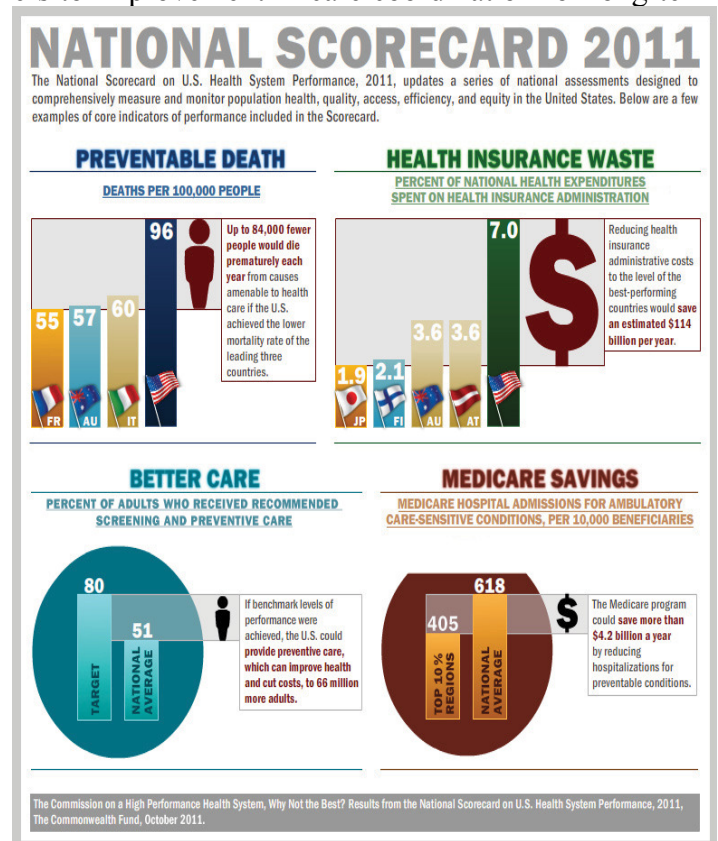
• *Coordinated Care:* Poor coordination of care continued to characterize the U.S. health system during the 2007–09 period covered by this National Scorecard, owing to a fragmented delivery system, a lack of incentives for integrating care across providers, weak attachments to primary care, and communication gaps across sites of care. Symptomatic of our fragmented care delivery system are hospital readmission rates that remain high and variable, especially for frail, disabled, or older patients. Coordination scores were, on average, 28 percent below achievable benchmarks, and the majority of rates worsened or failed to improve substantially. Better coordination of services throughout the course of treatment and across sites of care help ensure that patients receive appropriate treatment and follow-up care, minimize the risk of error, and prevent complications that can lead to costly emergency department visits and hospitalizations. Good coordination also reduces patients' stress and confusion and saves them time navigating a complex health system.

• *Coordination of care for hospital patients.* Proper hospital discharge planning ensures that patients understand what to do when they get home and whom to call if they have questions or concerns, and it facilitates arrangements for follow-up care. In 2009, 90 percent of patients hospitalized with heart failure received written

instructions at discharge, based on hospital records—a major increase from 2004, when the rate was just 53 percent. Still, one-third of heart failure patients discharged from those hospitals among the bottom 10 percent of performers did not receive such instructions, although the variation among hospitals narrowed. Persistently high hospital readmission rates—particularly for heart failure patients—further indicate there is substantial room to improve teamwork among providers and coordination across sites of care. Proper follow-up care is also essential for patients who have been hospitalized with mental illness. Such care is needed to ease patients’ transition back into the community, and to head off further acute crises. But in about one of every four cases in private health plans, and about two of five cases in Medicare and Medicaid health plans, follow-up care was not provided. Rates varied by as much as threefold between the top and bottom-performing health plans, with two-thirds failing to receive follow-up care in the worst-performing plans.

• *Hospitalization of nursing home residents and home health patients.* Potentially avoidable hospitalizations put frail elders at risk for poor outcomes or complications that can lead to deterioration in their health. Trends in this area are moving in the wrong direction. One of five (20%) long-term nursing home residents was hospitalized in 2008, up from 18 percent in 2000. Moreover, 21 percent of hospitalized patients who were discharged to a skilled nursing facility in 2008 were readmitted to the hospital within 30 days, up from 18 percent in 2000. Geographical performance on these two indicators varied widely, with a 10-to-16-percent-age-point spread between hospital referral regions with the lowest and highest hospital admission or readmission rates from nursing homes. Among home health care agencies, 29 percent of patients on average were hospitalized during an episode of care during 2009, virtually unchanged from 2004 (28%). Rates for the top and bottom quartiles of home health agency performance ranged from 19 percent to 45 percent. The greater-than-twofold difference in performance between the lowest- and highest-performing groups of nursing homes and home health agencies on these hospital admission measures indicates there is substantial room to improve care coordination for frail and dis-

abled elderly patients. Toward this end, the voluntary, federally funded Home Health Quality Improvement Project is disseminating resources on best practices and collaboration to help home health agencies reduce hospitalizations. Rates of potentially avoidable hospital readmissions serve as a system-level indicator of quality across the care continuum, including the adequacy of hospital discharge planning and timing, the availability of high-quality postacute care services, and the coordination of care transitions. Medicare and Medicaid payment policies currently in place are often barriers to improvement in care coordination for long-term



care residents— particularly in the case of “dual eligibles” who qualify for both Medicare and Medicaid. Moreover, neither hospitals nor nursing homes have financial incentives to work together to improve care outcomes and avoid acute-care episodes that result in hospitalization. Leading hospitals are collaborating with post acute care and community-based providers and agencies to reduce readmissions in their communities. The Affordable Care Act’s Community Based Care Transitions program creates a payment mechanism to promote such cross-continuum partnerships.

# At Home

## December, 2011

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• *Potentially Avoidable Hospital Use:* When patients have timely access to primary care and are fully informed about how to manage their health condition, they are much less likely to require expensive visits to the emergency department (ED) or to be admitted to the hospital, and their risk of medical complications is greatly diminished as well. In a 2008 cross-national survey, more than one of five (21%) U.S. adults with health problems reported that they received treatment in an ED for a condition they thought could have been treated by a regular doctor if one had been available. In contrast, only 7 percent of adult patients in Germany, the benchmark country, reported using an ED for routine care. Hospitalizations for ambulatory care-sensitive (ACS) conditions is a key indicator of efficiency, since such hospitalizations can often be avoided with high-quality, well-coordinated care. Between 2004 and 2007, hospitalization rates for heart failure fell 13 percent. There has been little change, however, in admission rates for uncontrolled diabetes and related complications. Reducing Medicare ACS admissions to benchmark levels would save \$4.2 billion annually.



Hospital readmission rates are in effect a “whole” system indicator, providing a marker for potentially poor-quality hospital care, poor discharge planning and care transitions, weak primary care, or fragmented postacute care provided in the community. Nationally there has been a failure to improve readmission rates, which are costly, put vulnerable patients’ health at risk, and put patients and their families at financial risk. In 2009, 20 percent of Medicare beneficiaries hospitalized with one of 45 conditions or procedures were readmitted with-

in 30 days of discharge. On average, there was little change in readmission frequency between 2003 and 2009. An analysis completed by the Medicare Payment Advisory Commission found that up to three-quarters of readmissions may be preventable through better primary care and transitional care and through reducing complications from care received while hospitalized, which cost Medicare \$12 billion a year. Reducing the national average to benchmark levels alone would save the Medicare program \$4.0 billion annually.

The National Scorecard on U.S. Health System Performance, 2011, finds that the United States is losing ground in ensuring access to affordable health care. The Scorecard also finds broad evidence of inefficiency and inequity in the delivery of care. Other advanced countries are outpacing the U.S. in terms of providing timely access to primary care, reducing premature mortality, and extending healthy life expectancy, all the while spending considerably less than the U.S. on health care and administration.

Achieving benchmark levels of performance, even among a subset of indicators, would yield considerable gains. Improving national rates of hypertension and diabetes control to those achieved by the top group of health plans could save up to 89,000 lives each year. Achieving benchmark levels for control of diabetes and blood pressure would prevent disease development and reduce complications, saving \$1.6 billion to \$3.1 billion per year in medical costs. Reducing Medicare hospitalizations for preventable conditions to benchmark levels would save \$4.2 billion. The Medicare program could potentially save up to \$12 billion by reducing preventable hospital readmissions, based on a cost estimate by the Medicare Payment Advisory Commission. And over \$1 billion could be saved annually by improving care and preventing unnecessary transfers of frail nursing home residents to the hospital.

A recent study by The Commonwealth Fund and the Center for American Progress estimated that a combination of provisions in President Obama’s health reform legislation will reduce health care spending by \$590 billion over 10 years and lower premiums by nearly \$2,000 per family, by slowing the annual growth rate in national health expenditures from 6.3 percent to 5.7 percent. The health reform law seeks to

improve primary care by: 1) enhancing Medicaid and Medicare payments for primary care services, which are undervalued relative to specialty care; 2) providing new payment arrangements to support team-based care delivery; and 3) building on existing private sector efforts to encourage and support physician practices to serve as patient-centered medical homes.

Better primary care, along with better care coordination, is also essential for lowering the total costs of treating the chronically ill and for reducing the nation's continuing high rates of hospital readmissions and admissions for conditions treatable in ambulatory care settings. Studies indicate that it is possible to prevent



hospitalizations or rehospitalizations with better primary care, discharge planning, and transitional and follow-up care<sup>88</sup>—all elements of an integrated, systems approach to care. The Affordable Care Act creates incentives for hospitals to reduce readmissions and to collaborate with postacute care providers and physicians to improve care transitions and coordination. Demonstration and pilot programs, meanwhile, will develop and test innovative payment and care delivery approaches to improve outcomes for patients and use health resources more efficiently. For example, a shared-savings program to support the development of accountable care organizations is intended to promote innovative, integrated care models designed to achieve better health, better care experiences, and slower cost growth.

Promoting healthy behaviors will be a key strategy for preventing unnecessary deaths and chronic conditions among both children and adults. Provisions in the Affordable Care Act that support prevention, such as expanded preventive benefits under Medicare, and

the creation of community care teams, such as those operating in Vermont, can help health care providers and local communities take up this challenge.

As mandated by the Affordable Care Act, the federal government released the National Strategy for Quality Improvement in Health Care, which sets three targets for public- and private-sector improvement efforts. These are:

1. Better Care: Improve the overall quality of health care by making care more patient-centered, reliable, accessible, and safe.
2. Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address the behavioral, social, and environmental determinants of health, in addition to delivering higher-quality care.
3. Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.

Access to affordable care is foundational to achieving this “triple aim” for health system improvement. As rising costs put family, business, and public budgets under stress, access to care and financial protection are eroding for middle-income and low-income families alike. Successful implementation of reforms will require stakeholders at all levels to adopt a coherent, whole-system approach in which goals and policies are coordinated to achieve the best results for the entire population. By integrating all components of the health system to ensure better access, higher quality, and greater value, we would be far more able to safeguard the health and economic security of current and future generations.

## Senescent Cells: Forestalling Aging?

A story in the *New York Times* on November 2nd indicates that researchers have opened up a new approach to combating the effects of aging with the discovery of a special category of cells, known as “senescent cells.” According to researchers, these senescent cells are “bad actors” that promote the aging of tissues. Ridding the body of these cells could postpone many of the diseases of aging. But the research

did not prove that such actions would prolong life. The findings raise the hope that any therapy that eliminating senescent cells would protect the body from the ravages of aging. Senescent cells accumulate in aging tissues, like arthritic knees, cataracts and the plaque that may line elderly arteries. These cells secrete agents that stimulate the immune system and cause low-level inflammation. These cells hasten aging in the tissues in which they accumulate. Researchers at the Mayo Clinic in Minnesota generated a strain of mouse in which all the senescent cells were purged by giving the mice a drug that forces the cells to self-destruct. The mice's tissues showed a major improvement: they did not develop cataracts, avoided the usual wasting of muscle with age, and could exercise much longer on a mouse treadmill. They kept

more, to see if its life span is extended as expected.

The Mayo Clinic team told the *New York Times* that the purpose of research on aging was not to let people live a thousand years, but to increase health span, the proportion of people's natural lives that they live in good health. "People used to see aging as a rusting nail -- there's nothing you can do about it," one researcher said. "But we now know that there are processes that are driving aging, and that those processes can be meddled with."

## Going Like 90

The Census Bureau reported in November that there has been a dramatic increase in the number of "old-old" in the population.

America's 90+ population has tripled over the past 30 years, and will more than quadruple over the next 40 years, the U.S. Census Bureau said.

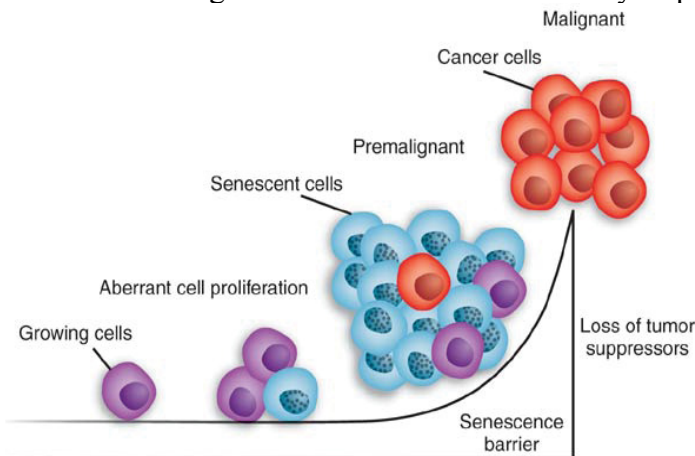
The 90+ segment of the population reached 1.9 million in 2010, roughly 4.7 percent of the nation's residents in the 65 and older population. Back in 1980 the 90+ age group was 2.8 percent of the population. By the middle of this century, the share of "old-old" will reach 10 percent.

There are 3 90+ women for every 1 man, and they have higher widowhood, poverty and disability rates than people just under the age cutoff.

Most people 90 and older either live alone or in a nursing facility.

## DPH Issues New Safe Driver Rules

At the end of September of 2010, a new state law (Chapter 155 of the Acts of 2010) took effect that allows certain health care providers and law enforcement officers to file a confidential report with the Registry of Motor Vehicles on any driver who they have reasonable cause to believe "is not physically or medically capable of safely operating a vehicle." The law was prompted by several high profile fatal accidents involving drivers who appeared to lack the capacity to drive safely. The statute also says



the fat layers in the skin that often thin out with age and, in people, cause wrinkling. The discovery that senescent cells seem to be the cause of tissue degeneration opens out a new direction for researchers on aging to explore. Killing the cells should therefore have large benefits with little downside. The gene-altering approach used on the mice cannot be tried in people, but now that senescent cells appear to be harmful, researchers can devise ways of targeting them.

If aging of the tissues is delayed by eliminating senescent cells, the mice should, in principle, have lived longer. But researchers chose a fast-aging strain of mice in order to save time. These particular mice succumb to heart attacks at an early age, regardless of the state of their tissues. The Mayo Clinic team plans to repeat its experiment with an ordinary strain of mouse that normally lives three years or

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drivers who have “a cognitive or functional impairment” that will affect their ability to drive safely may also be reported to the RMV. The key word is “may.” During the debate on this bill last year, some health care providers argued that they should not be required to make these reports to the RMV, with the result that reports “may” be submitted---but are not mandated. But if a doctor or a police officer, for example, report that a driver is impaired, and not able to safely drive a car---as long as that report was made “in good faith”---the reporter is protected from civil lawsuits. The same protection is provided, however, if they do not file a report.

Elder rights groups fought to ensure that the reporting law would not just be used on older drivers. The new law clearly states that reports of impaired drivers “shall not be made solely on the basis of age” or because of a diagnosis or condition. A report of an impaired driver must be based on observation and evidence.



Once a report is filed, the RMV, in consultation with medical experts, is required within 30 days to conduct a review to determine if the driver has the capacity to continue driving. The RMV is empowered to suspend a driver’s license if he or she is determined to be unable to safely drive. After the bill was signed into law by Governor Deval Patrick, the RMV had to come up with a set of regulations that define what “cognitive or functional impairments that are likely to affect a person’s ability to safely operate a motor vehicle” meant. On November 9th, the Department of Public Health issued proposed new regulations for Chapter 155, to give health and law enforcement officials their first

look at standard definitions. “Cognitive impairment” is defined as “any condition that impairs...attention, alertness, perception, comprehension, judgment, memory, or reasoning that may influence the physical action, reaction time, or other responses to understand and interact with the environment.” A “functional impairment” is “any symptom of a disease or medical condition that results in full or partial decrease in any or several sensory or motor functions,” which includes “peripheral sensation of the extremities, strength, flexibility, motor planning and coordination.”

Any cognitive or functional impairment that limits a person’s attention, or the ability to understand “the immediate driver context,” or to make appropriate decisions while driving, or “visuospatial processing,” or impairs their “strength, flexibility, reflexes, sensory perception and physical coordination,” is considered a “driving relevant” impairment.”

Finally, a driving impairment “is one not based solely on age or diagnosis of a medical condition or functional/cognitive impairments,” but is based on observation and evidence of the “actual effect of that condition” on a person’s ability to drive safely. The impairment must also be one that cannot be “sufficiently corrected or controlled” by medication, therapy, surgery or by some adaptive equipment or driving device

These proposed regulations may be subject to further refinement, but elders should understand that they cannot lose their license simply because they have celebrated another birthday.

## **CMS Awards Care Transitions Grant To Merrimack Valley**

On November 18th, the federal Centers for Medicare and Medicaid Services announced the list of first grants awarded for “care transitions” funding under the “Partnership for Patients” Project. Only seven grants were awarded nationwide. One of the awards went to Elder Services of the Merrimack Valley, in partnership with Anna Jacques Hospital, Saints Medical Center, Holy Family Hospital, Lawrence General Hospital, and Merrimack Valley Hospital. The funding will be used to help reduce avoidable hospital readmissions.

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