

At Home

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With Mass Home Care

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Al Norman, Editor



Brown: Don't Change Medicare As We Know It

On May 17th, Mass Home Care sent a letter to U.S. Senator **Scott Brown**, urging him to reject a budget resolution offered by Congressman **Paul Ryan** (R-WI) that called for dramatic changes in Medicare, Medicaid and Social Security. Mass Home Care urged Brown "to oppose any efforts to enact the Ryan Budget Resolution," which would have converted Medicaid into a capped block grant to states, privatized

Medicare for younger workers, and converted Social Security into a system of private savings accounts.

Here is Senator Brown's response, in which he says Social Security will become insolvent 25 years from now:

"Thank you for contacting me with your thoughts regarding the current and future state of our country's Social Security and Medicare programs. I value your input on these important issues and appreciate hearing from you.

Like you, I support efforts to strengthen and preserve Medicare and Social Security. As a son whose parents are past retirement age, I understand the importance of ensuring that these valuable safety net programs remain strong for current and future beneficiaries. I also recognize that many Medicare beneficiaries depend on Social Security as their primary source of income. Unfortunately, the solvency of these two programs

is in jeopardy. The Congressional Budget Office (CBO) estimates that Social Security, Medicare and other entitlement programs will consume 60% of all federal spending next year. The most recently released Medicare and Social Security Trustees report projects the trust funds will be exhausted in 2024 for Medicare and by 2036 for Social Security. The report concludes that the financial conditions of Social Security and Medicare are a serious challenge and will require legislative corrections to remain solvent.

Several proposals have been presented to Congress in an effort to restrain spending, slow the growth of government, and reduce our historic level of debt. I am encouraged by these discussions and strongly support efforts that keep Medicare and Social Security solvent for today's beneficiaries and future generations. That is one of the reasons why I opposed the federal health care reform law, the Patient Protection and Affordable Care Act, which requires approximately \$500 billion in reductions to the Medicare program.

I do not believe that a new federal entitlement program should be created on the backs of Medicare beneficiaries. To that end, I have taken steps to strengthen the Medicare program by co-sponsoring legislation that would increase needed benefits, such as eliminating the Medicare 190-day lifetime limit for mental health coverage.

In this challenging economic climate, I agree that our country must focus on controlling the cost of health care, while preserving quality care and access for beneficiaries and retirees. With that in mind, I believe we must focus on replacing the worst parts of last year's federal health care law with common-sense policies that protect Massachusetts' ability to innovate and provide access to health care for every Bay Stater.

Specifically, I sponsored legislation to provide states flexibility by allowing them to waive certain requirements of the health care reform law in 2014 rather than 2017.

Please be assured I will continue to evaluate policy proposals with your thoughts in mind and work with my colleagues to find solutions that ensure retirees receive their benefits and have access to affordable health care without compromising the future fiscal health of our nation.”

Brown Tosses Ryan Plan Under The Bus



Congressman Paul Ryan

On May 23, six days after receiving Mass Home Care's letter against Congressman Paul Ryan's budget resolution, Senator Scott Brown published an op-ed in which he states that he "cannot support" the Ryan plan. Here is Brown's op-ed column:

“As part of the 2012 budget discussions, Congress is dealing with Medicare reform. This debate is long overdue, since its increasing cost must be addressed if we are serious about the nation's growing \$14 trillion debt and \$1.6 trillion annual deficit.

President **Barack Obama** unfortunately missed an opportunity to deal with this when he filed his budget. House Budget Committee Chairman Paul Ryan (R-Wis.) offered a plan that at least finally jumpstarted the debate. For those under 55, Ryan proposes transforming Medicare into a premium support plan over the long term. You'd get federal dollars to supplement the purchase of health insurance in a regulated private market.

While I applaud Ryan for getting the conversation started, I cannot support his specific plan — and therefore will vote “no” on his budget.

Why can't I go along with the Ryan Medicare plan? First, I fear that as health inflation rises, the cost of private plans will outgrow the government premium support— and the elderly will be forced to pay ever higher deductibles and co-pays. Protecting those who

have been counting on the current system their entire adult lives should be the key principle of reform.

Second, Medicare has already taken significant cuts to help pay for Obama's health care plan. The president and Congress cut a half trillion dollars to the private side of Medicare — meaning seniors are at risk of losing their Medicare Advantage coverage.

Another key principle is that seniors should not have to bear a disproportionate burden. But that doesn't mean we do nothing. If Medicare is to survive for current beneficiaries and future generations, we must act. The sooner Congress addresses this, the less painful it is likely to be — but more difficult adjustments will be required if we delay.

We should start by making improvements to the traditional Medicare plan. The Government Accountability Office has estimated that nearly 10 percent, or \$47 billion, of annual Medicare spending is nothing but waste, fraud or abuse. Attorney General **Eric Holder** has put the number higher — at \$60 billion. We need Medicare administrators to work to prevent these improper payments — instead of the existing “pay and chase” model that makes the system so susceptible to fraud.

We can also find savings by increasing congressional oversight of how Medicare reimburses providers; as well as improving the quality of medical care to seniors.

I'd also institute tort reform to limit frivolous lawsuits. There are other ideas from members of both parties that can be incorporated into a bipartisan plan — which has a good chance of passing Congress.

What's important is that we get started now and, where appropriate, phase changes in over time. This phase-in should be another principle of reform: give our future seniors enough years to adjust to the ‘new normal.’

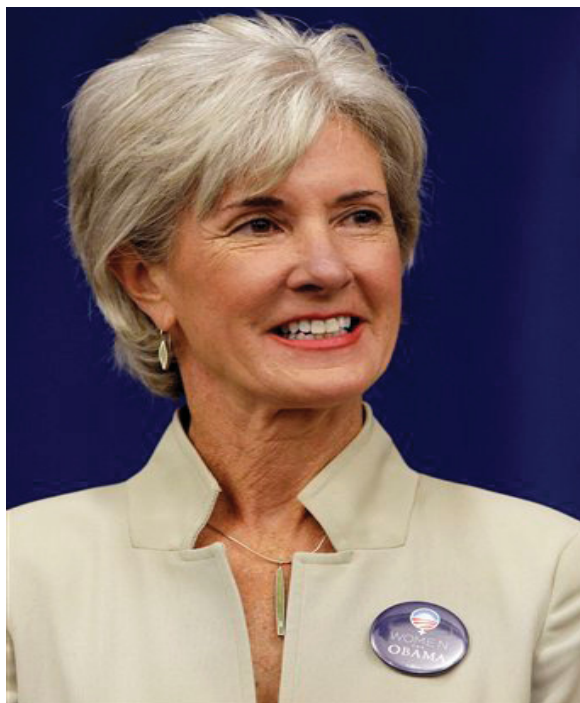
I have made boosting jobs, reducing spending and repairing our economy my top priorities in the Senate. I plan on continuing to work with people of goodwill - in either party - to solve the very real problems we face. Our country is on an unsustainable fiscal path.

But I do not think it requires us to change Medicare as we know it. We can work inside of Medicare to make it more solvent. This is not the time for finger-pointing or the usual blame game. For every reckless decision - on both

sides of the aisle - that led us to this point where we are \$14 trillion in debt, we now will have to make a hard decision to help get the country on the right track.

That track must lead to a sound financial future — where we protect and provide for the elderly while also promoting fiscal responsibility.”

Sebelius: The Right Way to Strengthen Medicare



Secretary Katherine Sebelius

A couple of days after Senator Brown's editorial appeared on the Politico website, Kathleen Sebelius, President Barack Obama's Secretary of Health and Human Services, wrote an op-ed of her own for the Politico website, entitled "Improving the Medicare We Already Have." Here is Sebelius' view of Medicare:

“We got some good news Tuesday about how the Affordable Care Act is helping people with Medicare get the health care they need. Already this year, 271,000 seniors and people with disabilities have saved an average of \$613 with the new 50 percent discount on brand name medications for those in the Medicare prescription drug “donut hole.” In total, Medicare beneficiaries with the highest drug

costs have saved \$166 million — with much of those savings for critical medications like cancer drugs.

Today, it's not uncommon for a Medicare beneficiary to fill dozens of prescriptions a year. Costs can add up to hundreds of dollars a month, or more. Since 2006, Medicare has offered drug coverage through the Part D program. But the law creating the program had a major flaw. Medicare covers most beneficiaries' drug costs, until they hit a certain limit. Once they do, however, Medicare stops paying until out-of-pocket costs hit \$4,550 — when coverage begins again. This gap — the “donut hole” — forced people with Part D coverage to pay up to \$3,600 out of their own pockets or go without medications they needed.

That's a terrible choice — which is why President Barack Obama and Congress made sure last year's health reform legislation closes the “donut hole” in several big steps. First, we sent \$250 checks last year to nearly 4 million beneficiaries, who had reached the donut hole, to help defray their costs. Second, this year we're giving a 50 percent discount on brand name drugs for seniors in the ‘donut hole.’ And we'll keep providing additional relief until 2020 — when the Part D coverage gap will be closed.

People with severe chronic conditions, like cancer and multiple sclerosis, have already seen big savings. In fact, 20 percent, or \$32 million, of the 2011 savings have been for cancer drugs. An additional 10 percent, or \$16 million, helped people with MS get the drugs they need.

That's just the start of the new benefits for those with Medicare. They can now get potentially life-saving preventive care like mammograms and other cancer screenings, with no co-pay or deductible. And they can also get a free annual wellness visit with a doctor of their choice.

Over the past few weeks, much of the Medicare debate has focused on the long-term consequences of the House Republican plan to end Medicare as we know it, and turn future beneficiaries over to private insurance company voucher program. People are right to be concerned — given that the plan would force the average 65-year-old in Medicare to spend an additional \$6,400 out of pocket for health care.

But another consequence of the GOP budget is that Medicare beneficiaries would lose the important

new benefits they're now getting under the Affordable Care Act. Seniors would see new costs for preventive screenings, leading some to put off tests that could save their lives. Disabled and older Americans with high medication costs would again see bills rise, forcing many to go without the medicines they need. Those with the most serious conditions could be harmed the most. New therapies for cancers and a long list of other devastating diseases have given millions of Americans new hope and a new ability to live their lives to the fullest. But these drugs can be incredibly expensive. By eliminating the new Medicare prescription drug discount, the Republican budget would deny savings to the sickest Americans — just as relief has finally arrived.

With health care costs expected to rise rapidly in the coming years, almost everyone agrees that we need to act to protect Medicare for beneficiaries today, and preserve it for our children and grandchildren. But there's a right way to reform Medicare and a wrong way.

The right way is to strengthen it, closing coverage gaps while also bringing down costs by improving care and reducing waste and fraud. Medicare's trustees estimate that the new health care law has already added eight years to the life of the Medicare trust fund by doing just that. The president's fiscal framework would put the program on even more solid ground in the future. Shifting huge costs to seniors and disabled Americans and taking away key benefits is the wrong way to move forward — for Medicare beneficiaries today and tomorrow.”

Senator Brown: “No Areas...Are Immune From Reductions”

In May, Mass Home Care sent a letter to U. S. Senator Scott Brown regarding efforts to protect funding for the federal Older Americans Act. Here is Senator Brown's response, which asserts that because of the national debt today, no areas of the federal budget will be immune from reductions:

“Thank you for contacting me concerning programs designed to help the elderly, specifically the Older Americans Act. As always, I value your input and appreciate hearing from you.

As you know, Older Americans Act (OAA)

programs provide assistance at the local level that help older Americans fulfill the desire we all share to be able to remain as independent and productive as possible in our own homes and communities as we age. The OAA was first passed in 1965 and helps fund home and community-based services to improve the lives of our seniors. Services funded by the OAA include congregate meals and Meals-on-Wheels, transportation, community-based long-term care, legal services, nursing home ombudsman, elder abuse identification and prevention, and senior community service jobs, as well as help for family caregivers.

I understand your support to preserve funding for these programs included in the Older Americans Act for Fiscal Year (FY) 2011. I certainly recognize the critical services provided through OAA programs, which add value to the lives of our older Americans and promote an independent lifestyle. However, because of the trillions of dollars of debt we face, there are virtually no areas of the budget that are completely immune from reductions. Please know that I am committed to working with my Senate colleagues to support ways to get our fiscal house in order for current and future generations while also recognizing the value that key programs provide.

You may be interested to know that the final FY 2011 appropriations legislation included more than \$1.5 billion for the Department of Health and Human Services, Administration on Aging, Aging Services Programs, which directly funds the programs you mention. As the Senate begins to discuss the FY 2012 budget, I will keep your support for OAA programs in mind.”

Federal Housing Programs For Elders Threatened

In early June, the National Association of Area Agencies on Aging (n4a) sent out an alert warning elderly rights groups that Congress was considering budget cuts that would reduce Housing and Urban Development (HUD) funding for the popular “Section 202” program by more than 50%, from \$825 million in 2010, to \$400 million in 2011. This significant funding reduction would leave only \$78 million for new project development. The Obama Administration has request-

ed \$757 million for Section 202 which would bring the program’s funding back up to the pre-FY 2010 level.

According to n4a, the HUD Section 202 program is important to the elderly because:

- 48.5% of renters age 62 and over paid more than half of the income for housing in 2009
- 1.33 million very-low income elderly renters have worst case housing needs (i.e. pay more than 50% of their income in rent and/or live in substandard housing)



- By 2020, there will be 1.3 million low-income elderly who require assistance with activities of daily living and an additional 1/3 millions with cognitive or mental disabilities

In response to budget threats to Section 202 housing, Senator **Herb Kohl** (D-WI) released a letter urging the Senate Appropriations Chair and Ranking Member to support the President’s request for the Section 202 and 811 programs. The “Dear Colleague” letter (see below) asks his Senate colleagues to join him and Senators **Charles Schumer** (D-NY) and **Robert Menendez** (D-NJ) in supporting these critical housing programs for older adults and people with disabilities. The Chairs of the Senate Transportation, HUD (THUD) appropriations subcommittee are Senator **Patty Murray** (WA) and Ranking Member **Susan Collins** (ME). Here is Senator Kohl’s letter:

“Even in this tight budgetary time very-low income seniors and persons with disabilities have critical unmet needs for supportive housing. Affordable housing is essential for all of us, but especially for those living on fixed incomes and managing service needs. There are 3.6 million seniors living below the pover-

ty level. The HUD 2009 Worst Case Housing Needs study includes 1.33 million seniors with worst case housing needs and there is a documented increase in the elderly and near elderly who are homeless.

Seniors and persons with disabilities rely disproportionately on federal housing programs and comprise at least 50% of public housing and Section 8 voucher holders. The average HUD Section 202 resident is a 75 year old woman with an annual income of just over \$11,220 and in need of assistance with a growing list of activities of daily living. It is this type of resident that will be forced into homelessness, institutional care or substandard and unsafe housing if the Section 202 program is not funded. America's elderly and persons with disabilities deserve safe, decent, supportive housing."

Home Care Has \$1.7 M At Stake in Conference Budget

At the end of May, state lawmakers finished work on the FY 2012 state budget, and passed their work on to a Joint Conference Committee to hammer out a final version.

The good news was that elder protective services was increased by \$1 million in both branches of the legislature, But based on final House and Senate language, a difference of \$1.7 million hangs in the balance for home care. The House version as adopted provides \$1 million more for home services, and \$738,000 more for care management services.

On June 3rd, Mass Home Care Executive Director Al Norman sent the following letter to the Chairs of the Ways & Means, Senator Steve Brewer (D-Barre) and Representative Brian Dempsey (D-Haverhill):

"I am hoping that during Conference Committee, you will recede to the House numbers for the home care purchased services account (9110-1630) and care management (9110-1633).

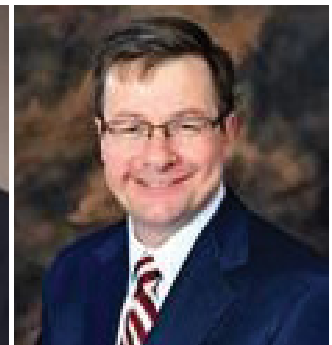
As you know, these two line items fit together to make the home care program work. The Senate numbers for these two accounts leaves us at roughly the same funding level we were at in 2005. The House is \$1.7 million higher, but even with the House numbers we will still have problems in FY 2012 with waiting lists. Let me share the projections:

In the home care account (9110-1630), there will be "managed intake" under both scenarios. The Senate final of \$96.78 million provides a maximum capacity of 363,128 service units in FY 2012, or 30,260 elders per month. The House adds \$1 million to this account, which would raise the yearly unit capacity to 366,880, or 30,573 elders per month. The House allows us to admit an additional 313 elders per month for the entire fiscal year.

Based on caseload utilization trends, the Senate budget will require us to maintain a waitlist average of 1,041 consumers per month in FY 2012, with a waiting list hitting 1,922 elders by June of 2012. The House budget would result in an average wait list of 729 elders per month, reaching 1,346 at its height in June of 2012.



Chairman Brewer



Chairman Dempsey

As for the care management account (9110-1633), this line item pays for the care managers who coordinate the services provided to clients in the home care purchased services program. Many of these workers are now carrying caseloads between 100 and 125 clients each. The assessment process is much more complex than in the past, and care managers are dealing with a more disabled mix of clients. This account also covers the program operations costs for the care managers at the 27 Aging Services Access Points (ASAPs), as well as information and referral operations, and all other ASAP support costs associated with home care. It is important that these accounts stay in balance with the services account.

The recent history of this account illustrates that this line item has faced 9c cuts and FMAP [federal matching funds] cuts over the past several fiscal years that have put severe pressure on our operations. The care management account has fallen -11.5% below its original FY 2009 appropriation level of \$40.368

million. The 1633 account today is funded at \$4.63 million less than in FY 2009. The General Court appropriated \$37.165 million for FY 2011, but on June 30, 2010, the Governor vetoed \$2.853 million for this account to deal with the lack of federal FMAP funds.

When the FMAP funds arrived last fall, only 50% of the Governor's veto was restored, or \$1.426 million, bringing the account up to \$35.738. This account has not fallen so low since FY 2005—seven fiscal years ago—when care management services were funded at \$34.9 million. The Senate level for FY 2012 is \$738,000 below the Governor's recommendation. We are asking that this account be raised to the level of House 1, or \$35.738 million.

The goal of the home care program is to keep elders living in the least restrictive setting possible, at their highest level of functioning possible, for as long as possible. We call that the "Three possibles." At one point in our history, the home care caseloads averaged 44,919 elders per month. That was in 1987. Today we will end up just above 30,000 per month.

We have had great success in 'bending the curve' in nursing facility use. Since the year 2001 a total of 3.78 million MassHealth patient days have been cut compared to ten years ago. That's a 29% drop in patient days paid for by MassHealth, which translates into nearly \$600 million annually not spent on institutional care by taxpayers. One of the ways we shift away from institutions is by having a home care program that is open for business, not handing out waiting list numbers.

We need you to help us retain the \$1.7 million in home care and care management funds found in the House budget. Please help make this happen during Conference Committee."

Final Conference Committee numbers are expected to be released before the end of June for the fiscal year that begins July 1st.

Mass Home Care Backs Special Commission on Elder Abuse

On June 8th, Mass Home Care presented tes-

timony in support of H. 1965, filed by Representative **Paul Brodeur** (D-Melrose), which would create a special commission to study elder protective services.



Rep. Paul Brodeur

Testifying on behalf of Mass Home Care was **Dan O'Leary**, the Executive Director of Mystic Valley Elder Services, based on Malden. Here is O'Leary's statement to the Joint Committee on Elderly Affairs:

"On behalf of Mystic Valley Elder Services and the membership of the Mass Home Care Association, I am speaking to you today in support of House Bill 1965, a petition for an investigation by a special commission (including members of the General Court) to make an investigation and study of elder protective services. Rep. Paul Brodeur and other members have filed this bill as a way to bring to light important issues related to the elder protective services program here in Massachusetts.

The Commission would have the authority to take a broad based look at the elder protective services program including current capacity, best practices and the challenges of financial abuse inflicted upon an increasing number of elders in this state. As an agency that has provided area seniors with protective services for thirty six (36) years, we feel that the program works well but also can be improved.

Recently, the House and Senate responded to our concerns and request for funding to support caseworkers to investigate and respond to reports of

abuse and neglect in communities across the state. Rep. Brodeur and colleagues would like to take the next step in reviewing and supporting the elder protective services program so that we are not only able to appropriately respond in 2011 but also to position the program for an effective response in the future.

House Bill 1965 outlines a sensible framework for the Commission's representatives and a road map for a targeted and useful review to enhance and strengthen the program going forward. We support this initiative and recommend a favorable recommendation for action by the Committee on Elder Affairs.”

Mass Home Care on Accountable Care Organizations



In late May, Mass Home Care submitted formal comments to the federal Centers for Medicare and Medicaid Services (CMS) regarding their 429 page proposed rules for Accountable Care Organizations (ACOs) the new provider-controlled health care delivery system. In its comments, Mass Home Care raised concerns about the role of long term care supports, and its place in a health care driven system. Here are excerpts from that statement:

“Mass Home Care is a non-profit network of 30 agencies in Massachusetts whose mission is to help the elderly and individuals with disabilities to remain liv-

ing in the least restrictive setting possible, at their highest level of functioning possible, for as long as possible.

Our members include all of the state’s designated Area Agencies on Aging, and Aging Services Access Points (AAA). Our network has been helping seniors avoid institutional placement for nearly forty years.

Our major concerns with the proposed rules for Accountable Care Organizations relate to the process for integrating community resources and supports into the array of medical services available from the proposed health systems network.

In a recent survey of more than 400 of our LTSS care managers, nearly 7 out of 10 care managers said they rarely or never had contact with their elder client’s doctors. More than 6 out of 10 care managers said they are informed of a home care patient’s placement in a nursing facility after the decision had been made. The lack of coordination between primary/acute and long term support services leads to readmissions, inappropriate institutional placements, and unnecessary costs to the health care system.

Our comments, as LTSS care coordinators, are targeted towards ways to improve the proposed ACO rules to ensure that LTSS are integrated and coordinated with the rest of the health care delivery system.

In Massachusetts, spending on the elderly, and spending on long term care and supports comprise a very significant portion of MassHealth expenditures. In FY 2009, total MassHealth spending on services for all members---not just duals---was \$12.48 billion---of which long term care was \$3.66 billion. Of this latter amount, spending on elders over the age of 65 was \$2.1 billion---of which \$1.4 billion, or 66%, was spent on institutionally-based care. Savings opportunities in LTSS spending still exists, since Massachusetts’ institutional spending per capita in FY 2009 ranks 9th highest in the nation at \$245---nearly three times the level of spending in states like Oregon (\$89), Washington state (\$87) and Texas (\$86). 42 other states have lower nursing facility spending per capita than Massachusetts.

In the context of all MassHealth spending for dually eligible members (those on Medicare and Medicaid) 60% of expenditures were for long term supports and services, not on primary or acute care. In FY 2007, MassHealth spent a total of

\$7,490 per enrollee. The highest spending per enrollees was on the elderly: \$18,069, compared to \$10,641 for the disabled, and \$4,064 for children.

An integrated care model creates the potential for significant savings in many of the areas that have historically been cost drivers for the target population. Savings can be expected on inpatient hospital (including psychiatric) services, on outpatient hospital (including emergency room) services, and in pharmacy expenditures (due to factors such as duplicative prescriptions and non-optimal brand/generic mix). Other areas with potential for savings include outpatient mental health and substance abuse services and laboratory and radiology services.

The prevalence of chronic diseases and co-morbidities within the target population also tends to promote an inefficient balance in primary care provider/specialty physician utilization. Better coordination and management of these individuals could yield savings as well. Savings in institutional care will continue to result from increases in home and community based services. In Massachusetts, nursing facility patient days have plummeted by -29% since 2001. Nursing facility spending in 2009 at \$1.6 billion was essentially no higher than in 2004. This is a remarkable achievement largely attributable to better substitution of lower-cost community-based settings. Massachusetts nursing facility expenditures per capita are still some of the highest in the nation.

However, overall savings for long-term care and support services are expected to grow in future years as integrated plans have more opportunity to effect the utilization patterns of enrollees. The integration possible from coordinating health and long term supports will achieve better health outcomes for the target population and more effectively use the combined Medicare and Medicaid resources. The integrated care entities will be responsible for using clinical practices that more effectively prevent or reduce unnecessary hospitalizations and readmissions and avoidable emergency department visits, and that allow for investment in areas such as behavioral health services and LTSS.

This approach also will provide more flexible mechanisms and the appropriate incentives to allow individuals to transition more easily from facility-based settings into less restrictive community settings. Pro-

grams like the Options nursing facility pre-admission counseling program (part of the Equal Choice law of 2006), the Comprehensive Services and Support Model (CSSM) of post-admission nursing facility screening, and most recently the new \$110 million Money Follows The Person federal grant--all have a mission to reduce the level of MassHealth patient days in nursing facilities---which have bent the institutional curve by 3.7 million days between 2001 and 2011.

Although primary care providers might seem to be a logical site for care management, stresses on primary care make it difficult to implement effective care management. As one protective services worker explained in a recent National Center on Elder Abuse Forum:

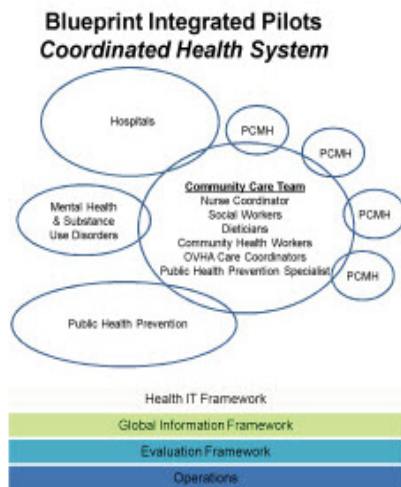


“Not infrequently, the primary care M.D. who may see a client 1-2 times a year, has no way of evaluating how well a person attends to their activities of daily living (ADL's); and they will occasionally challenge our findings because they seem incongruent to how a person presents in a brief, clinical setting. This is where visits to a person's residence can flesh-out one's ability to attend to ADL's. We can assess if there's fresh food in the cupboards and refrigerator; if medications are being taken; if their living space is habitable and safe; or if months worth of bills are piled up, unopened and unpaid.”

Current primary care physician visit lengths are not sufficient to handle the multiple problems of complex patients. Primary care practices need to manage overly large panels of patients with many visits per day. Over half of primary care physicians practice in small or medium-sized offices are without the resources to develop and manage care management programs. A key

to the success of hospital-to-home care management is post-discharge attention paid to members once they are home. Person-to-person encounters, including home visits, are important for effective care management. Co-locating care managers together with physicians may be a key ingredient in physician involvement. Interventions are grounded in a coaching paradigm, in which the care managers teach members and their families the skills needed to address problems themselves.

Several states, including Vermont and North Carolina, have demonstrated that integrated care which combines health and long term supports and services in a holistic manner can reduce costs and improve health outcomes. Both states use models which link community-based entities to health care entities--but do not merge the two under one ownership.



In Vermont's "Blueprint for Health," the state has implemented a "Community Health Team" (CHT) approach in its medical homes project. The Community Health Team provides services free of charge to medical homes patients. According to the Department of Vermont Health Access: "The multidisciplinary CHT partners with primary care offices, the hospital, and existing health and social service organizations. The goal is to provide Vermonters with the support they need for well-coordinated preventive health services, and coordinated linkages to available social and economic support services.

The CHT is flexible in staffing, design, schedul-

ing and site of operation, resulting in a cost effective, core community resource which minimizes barriers and provides the individualized support that patients need in their efforts to live as fully and productively as possible. The CHTs function as extenders of the practices they support, and their services are available to all patients (no eligibility requirements, prior authorizations or copays.)"

In Vermont, the CHT members work closely with hospital staff and other community service providers to implement transitional care strategies that keep patients engaged in preventive health practices, and improved self-management. This creates "seamless coordination" across the broad range of health and human services (medical and non-medical) that are essential to optimize patient experience, engagement, and to improve the long term health status of the population. The CHTs work as partners to the medical providers, but they are not owned or controlled by them.

Under the Community Care of North Carolina (CCNC) program, which has been in place since 1998, the medical home model uses local non-profit "community networks" that are comprised of physicians and hospitals--but also social services agencies and county health departments--to provide and manage care. The CCNC program is centered around these local networks of community providers. Medicaid enrollees receive care through non-profit local community networks. Each network is responsible for managing its enrollee's care. Because the networks are local, they are able to reflect local and regional needs and resources. The networks receive an "enhanced care management fee" of \$3 per member per month, and \$5 per member per month for elderly or disabled enrollees. Networks hire local care managers, and each network also has a physician who serves as a clinical director, and is responsible for working with a statewide board of directors to organize and direct disease and care management initiatives across the networks. As of 2009, there were 14 community networks in North Carolina covering over 913,000 Medicaid enrollees. (By comparison, Massachusetts had 1.4 million MassHealth members as of 2007) Care managers are integral members of each community network, and work in concert with physicians to identify and manage care for high-cost and high-risk patients. Care managers include social work-

ers, RNs, or other local clinicians. These care managers coordinate care and services, provide disease management education, provide transitional support, and collect and report data on process and outcome measures to assist with quality improvement efforts.



Community Care of North Carolina (CCNC)

- Statewide system of 14 regional Medicaid care networks
 - Each has a program director, medical director, steering committee, case managers
- Attention to chronic diseases (mainly diabetes and asthma)
- Guideline dissemination & case management
- Yearly statewide audits and reports with comparison data to local practices

Massachusetts has an advantage over many states in coordinating medical supports with long term supports for elderly individuals, including the dually eligible. The Commonwealth has had since the mid-1970's a statutory community-based network of LTSS care managers organized into services areas covering the entire state. Known today as "Aging Services Access Points," these entities can provide doctors and hospitals with linkage to a care managed long term supports network. In FY 2010, the ASAPs managed care for roughly 62,000 individuals, of whom more than a third were dually eligible.

ASAPs also provide care transition services, nursing home counseling and diversion, disease management, consumer directed care, and other supports that are needed to keep patients living in the least restrictive setting. The ASAP network functions in a manner very similar to the Community Health Teams in Vermont, and the Community Networks in North Carolina.

A key ingredient in any health care payment reform system is the inclusion of "community care teams" as extenders to the traditional role of physicians and hospitals. These community care teams partner with health providers to incorporate social and functional personal care services into the care

planning for people with complex care plan needs. The success in achieving health outcomes are interwoven with the ability to provide coordinated long term supports and services in the community.

Massachusetts also pioneered the integration of health care services with LTSS through the Senior Care Options program (SCO). As in the states cited above, the SCO plans in Massachusetts require the medical networks to forge a contractual link with geriatric service managers—but not to own them. MassHealth members aged 65 and older have the option of enrolling in a coordinated health SCO plan. SCO is a comprehensive health plan that covers all of the services reimbursable under Medicare and MassHealth, through a senior care organization and its network of providers. Enrollment in SCO is voluntary. There are currently 4 SCOs in the Commonwealth serving roughly 18,000 dually eligible seniors.

Members who join SCO have a primary care physician who is affiliated with the senior care organization. The member's primary care team includes a physician and a team of nurses, specialists, plus a geriatric support services coordinator (GSSC) who is employed by a community-based ASAP. This team works with the member to develop a plan of care to address the specific needs of the member. Members enrolled in SCO will have 24-hour access to the team, geriatric support services, and active involvement in decisions about their health care.

Under the SCO law, section 9D of Chapter 118 E, the ASAP geriatric worker is responsible for: (i) arranging, coordinating and authorizing the provision of community long-term care and social support services with the agreement of other primary care team members designated by the SCO; (ii) coordinating non-covered services and providing information regarding other elder services, including, but not limited to, housing, home-delivered meals and transportation services; (iii) monitoring the provision and outcomes of community long-term care and support services, according to the enrollee's service plan, and making periodic adjustments to the enrollee's service plan as deemed appropriate by the primary care team; (iv) tracking enrollee transfer from one setting to another; and (v) scheduling periodic reviews of enrollee care plans and assessment of progress in reaching the goals of an enrollee's care plan."

In addition: “SCOs and ASAPs shall be responsible for developing processes for assessing all enrollees upon enrollment to determine the need for involvement of the ASAPs and to assure appropriate ongoing monitoring of the enrollee's need for medically necessary services. SCOs shall grant geriatric support services coordinators authorizing responsibility over a range and amount of services for specific conditions or circumstances for which agreement of the primary care team would not be required.”

This SCO model is the precedent for the kind of care integration which can be adapted to both the medical homes initiative, and any global capitation plan. The concept of the “community linkage organization” in a global payments context is derived from the years of experience in Massachusetts with the SCO initiative.

As we move forward with any Accountable Care Organizations in Massachusetts, it is important to recognize the role and relationship that LTSS can have to the provision of medical services, and to ensure that health care and functional care are not seen as the same activity—but rather as complementary services which must be carefully coordinated to guarantee the kinds of health and long term support outcomes that consumers want and deserve as part of a cost-effective delivery system.”

Under 65 Managed Care Plan Seen As Precursor for Seniors

Officials in the Patrick Administration are pursuing the creation of a managed care network for people age 64 and under who receive health care services from the Medicare and Medicaid programs---the so-called ‘dual eligibles.’ The state has received a \$1 million planning grant to put together an Integrated Health Entity (ICE) plan. As a first step, the Executive Office of Health and Human Services published a “Request for Information” seeking opinions on a variety of operational challenges facing the program. A total of 41 entities submitted responses to the RFI. The Mass Home Care Association was one of those groups submitting comments on the ICE plan. In its statement, Mass Home Care said that “The ICE should

be required to have a contractual agreement with entities which are responsible for care managing LTSS in accordance with the provisions of section 4B of Chapter 19A. Under the Senior Care Options law, the entities which employ the Geriatric Support Services Coordinators can be subcapitated by the managed care organization: ‘The division may permit a risk-sharing relationship between the SCO and the ASAP, in which the two entities share the financial risk of providing coordinated services to enrollees under a system of capitated or sub-capitated rate payments.’ The LTSS care managers should act as extenders of the medical team, to avoid duplication of existing home and community based infrastructure in the community, and to keep medical personnel operating at the top of their license.



In response to an EOHHS question about what linkages should be established between the Integrated Care Entities and community organizations...such as Aging Services Access Points (ASAPs), Independent Living Centers (ILCs), Recovery Learning Communities (RLCs), and Aging and Disability Resource Consortia (ADRCs) work with Dual Eligible adults, Mass Home Care wrote:

“In a statement before the U.S. Senate Select Committee on Aging, Melanie Bella, now the head of the federal Coordinated Health Care office testified that one of the core elements in each of the existing integrated Medicare/Medicaid programs is as “direct linkage between primary care and other clinical, behavioral, and supportive services. In a November, 2010 report from the Center for Health Care Strategies, researchers con-

cluded that ‘building a program that is designed to meet the varied needs of all eligible beneficiaries may mean establishing clear linkages between the managed long term supports program and other systems in the state that affect it. It is common for managed care entities to use an interdisciplinary team to develop an individualized plan of care. These teams typically include physicians, nurses, social workers, community resource specialists, care managers, pharmacists, and other professionals.

Massachusetts is somewhat unique in that it has developed over the past 37 years a strong community based LTSS built around regional Aging Services Access Points. ASAPs have had a statutory responsibility to manage and coordinate the needs of dually eligible seniors for roughly 16 years. ICEs will have little or no experience managing LTSS for this population, and they can take advantage of the investment and infrastructure the Commonwealth has made in these non-profit, community-controlled organizations that cover every city and town in the state. ICEs should be able to demonstrate a contractual agreement with Chapter 19A, 4B entities as part of their network and referral protocols. The ASAPs should be used in much the same capacity as outlined in the Senior Care Options law under Chapter 118E: to determine upon enrollment the baseline clinical status of all enrollees in an ICE, and begin the community-based lifestyle programs with members who are not yet suffering from major chronic illnesses; to assess and develop a LTSS careplan for those who have complex care needs; to implement the LTSS careplan in coordination with the medical plan of care; to monitor and reassess the LTSS needs of the member as part of the community ICE team. The ICE and the ASAP need to have medical/LTSS records that can be mutually accessed, including full access by the member. IT management data and cost reports also need to be mutually compatible. A web-based medical/LTSS password-protected record would allow all key parties to dialogue on an on-going basis about the member’s changing health and LTSS care plan.

In 2010, the AARP Public Policy Institute studied the SCO plan in Massachusetts. ‘When the state legislature mandated a role for the ASAPs in care management of SCO members,’ the Public Policy Institute wrote, ‘some thought it would produce tensions in the

overall case management process. One of the concerns of the SCOs was that they would be clinically and financially responsible for the member’s care but one component of that care---home care services---would be primarily assigned to another entity (the ASAPs). At our site visits, we did not observe any such tensions.



There appeared to be good collaboration, and mutual respect, between the SCO plans and their associated ASAPs...the nurse care managers and the ASAP GSSCs worked in tandem to provide care oversight for their SCO members. The nurse care managers took the lead on managing the member’s medical needs, while the GSSC took the lead for oversight of the member’s long term support services and general social condition. In some cases, the nurse care manager and the GSSC might work together on solving the same problem. For example, on one of our home visits, a SCO member had lost her primary care physician, who had decided to leave her practice and relocate to another state. The GSSC did a lot of the legwork to relieving the member’s concerns about having to select another primary care physician in the network, and discussing various options with her. The GSSC then worked closely with the nurse care manager to ensure that the member secured a replacement primary care physician of her choice.”

In their conceptual model of care management practices integrated care plans, the AARP Public Policy model has six components that are linked together like pieces in a puzzle:

1. the informal supports of the family
2. the primary care clinician
3. medical management
4. behavioral health
5. member services
6. supportive services

The ASAP/GSSC role in this conceptual model is in supportive services, but also in certain member services, such as language-appropriate supports, transportation to medical appointments, housing-related problem, income maintenance-related problems, arranging back up when gaps in the service plan appear, etc. All of these supportive services and member services can have a major impact on the medical management for a member.”

Echoing many of the comments submitted by Mass Home Care were the comments submitted by the Beverly, Massachusetts-based Northeast Hospital Corporation to the same question about “linkages” with community based organizations. The Northeast Hospital Corporation submitted this comment about the role of ASAPs in an integrated care plan:

“Many community-based organizations such as Aging Services Access Points (ASAPs), Independent Living Centers (ILCs), Recovery Learning Communities (RLCs), and Aging and Disability Resource Consortia (ADRCs) work with Dual Eligible adults.

A core element in each of the existing integrated Medicare/Medicaid programs is a strong connection between primary care and other clinical, behavioral, and supportive services. Integrated Care Entities and community organizations need to build a program that is designed to meet the varied needs of all eligible beneficiaries that establishes clear linkages between the managed long term supports program and other systems in the state that affect it. It is common for managed care entities to use an interdisciplinary team to develop an individualized plan of care. These teams typically include physicians, nurses, social workers, community resource specialists, care managers, pharmacists, and other professionals.

Massachusetts is somewhat unique in that over the past 37 years it has developed a strong

community based long-term services and supports (LTSS) built around regional Aging Services Access Points. ASAPs have had a statutory responsibility to manage and coordinate the needs of dually eligible seniors for roughly 16 years



Northeast Health System has built strong relationships with local ASAPs and can take advantage of the investment and infrastructure the Commonwealth has made in these non-profit, community-controlled organizations that cover city and towns in our catchment area. ICEs should be able to demonstrate a contractual agreement with Chapter 19A, 4B entities as part of their network and referral protocols. The ASAPs should be used in much the same capacity as outlined in the Senior Care Options law under Chapter 118E: to determine upon enrollment the baseline clinical status of all enrollees in an ICE, and begin the community-based lifestyle programs with members who are not yet suffering from major chronic illnesses; to assess and develop a LTSS care plan for those who have complex care needs; to implement the LTSS care plan in coordination with the medical plan of care; to monitor and reassess the LTSS needs of the member as part of the community ICE team. The ICE and the ASAP need to have medical/LTSS records that can be mutually accessed, including full access by the member. IT management data and cost reports also need to be mutually compatible. A web-based medical/LTSS password-protected record would allow all key parties to dialogue on an on-going

basis about the member's changing health and LTSS care plan.”

The Commonwealth Care Alliance (CCA), which is one of four Senior Care Organizations in the state, responded to the “linkages” question from EOHHS as follows:

“CCA would propose utilizing the state’s Senior Care Options (SCO) program-ASAP relationship as a model to follow for the ICE program. The ASAPs provide the SCO primary care team with an expertise in the breadth of community based long term care supports available in the aging network and the Geriatric Support Services Coordinator (GSSC) member of the team (who is employed by the ASAP) is often the team member who arranges for these services. The GSSC is usually involved in components of the assessment (such as ADLs, IADLs, home environment, family support)) and care planning. A parallel approach in the under 65 system would call for relevant organizations related to the specific disabled population, such as ILCs (and/or ADRCs and/or RLCs) to have a formal relationship with the primary care teams for the expertise that they offer for/to the particular disability community. Primary care physicians often have little or no knowledge of what ILCs and ADRCs offer to the disability population; ICEs will, through the broader PCT structure, make it possible to connect in a comprehensive way these systems of care to the benefit of the individual with disability. HIPAA and privacy requirements can be addressed through a signed Business Associate Agreement between the entities.

Senior Whole Health, which is also a Senior Care Organization (SCO), responded to the EOHHS question about ASAPs as follows: “Linkages to these community-based organizations are essential when addressing the Dual Eligible population. These agencies play an important role in advocacy, referrals, knowledge of provider networks, and offer critical support and coordination of services for the under 65 population. Integrated Care Entities should participate on key consortiums/committees for the ADRCs and, at a minimum, educate these organizations about eligibility, services, benefits and referral mechanisms. Procedures for referral should be identified between the ICE and the regional services. The ICE needs to ensure that

the ADRC has accurate and current information about the ICE. The ICE also needs up-to-date knowledge about resources available to serve and support their membership and to identify ways in which to promote collaboration and integration when appropriate.” Mass Home Care President Linda George said her Association wants to see a “hard link” between community-based care coordination entities, like ASAPs, and the Integrated Health Entities. “Anything less than that would be duplicative and wasteful,” George said. “ASAPs

New Financial Protections For Same-Sex Couples



Getty Photo

On June 10th, the federal Centers for Medicare & Medicaid Services (CMS) sent a letter to state Medicaid agencies clarifying that they are able to offer same-sex couples many of the same financial and asset protections available to opposite-sex couples when a partner is entering a nursing home or care facility.

CMS has informed the Medicaid agencies that they can ensure that same-sex partners can remain in shared homes without Medicaid liens being applied. The letter also clarifies that states have the flexibility to protect same-sex partners under estate recovery and transfer of assets rules.

“Low-income same-sex couples are too often denied equal treatment and the protections offered to other families in their greatest times of need,” said Health and Human Services Secretary **Kathleen Sebelius**. “This is

now changing. Today's guidance represents another important step toward ensuring that the rights and dignity of every American are respected by their government."

According to CMS, millions of families each year face difficult decisions associated with placing family members in nursing home care. Medicaid, which is the largest payer of nursing home services in the country, requires individuals in need of care to have exhausted most of their personal income and assets before qualifying for this long-term care benefit. There are protections, however, that ensure that the spouse of a Medicaid nursing home resident may remain in the couple's home. While states may place liens on the property of an individual needing care, if there is a spouse in the home, states must protect that spouse from having a lien attached to their home. For same-sex couples these protections do not always apply.

The CMS announcement clarifies that states can extend these protections when the same-sex spouse or domestic partner of the Medicaid enrollee continues to reside in their home. The letter also outlines how states can apply other protections to same-sex spouses or domestic partners, for example, by allowing individuals needing institutional care to transfer ownership of their homes without financial penalties. States have the choice of extending these protections. "Medicaid gives states remarkable flexibility to set these kinds of policies," said **Cindy Mann**, deputy administrator of the Centers for Medicare & Medicaid Services (CMS) who directs the Medicaid division within the agency. "We want to assure states that they are within the law when they make the choice to extend equal financial rights and protections to all of their citizens receiving Medicaid services, regardless of sexual orientation."

AARP Issues Statement on Social Security

On June 17th, AARP CEO A. Barry Rand offered the following statement in response to what AARP described as "inaccurate media stories" on the association's policy on Social Security:

"Let me be clear – AARP is as commit-

ted as we've ever been to fighting to protect Social Security for today's seniors and strengthening it for future generations. Contrary to the misleading characterization in a recent media story, AARP has not changed its position on Social Security.

"First, we are currently fighting some proposals in Washington to cut Social Security to reduce a deficit it did not cause. Social Security should not be used as a piggy bank to solve the nation's deficit. Any changes to this lifeline program should happen in a separate, broader discussion and make retirement more secure for future generations, not less.



"Our focus has always been on the human impact of changes, not just the budget tables. Which is why, as we have done numerous times over the last several decades, AARP is engaging our volunteer Board to evaluate any proposed changes to Social Security to determine how each might – individually or in different combinations – impact the lives of current and future retirees given the constantly changing economic realities they face.

"Second, we have maintained for years – to our members, the media and elected officials – that long term solvency is key to protecting and strengthening Social Security for all generations, and we have urged elected officials in Washington to address the program's long-term challenges in a way that's fair for all generations.

"It has long been AARP's policy that Social Security should be strengthened to provide adequate benefits and that it is sufficiently financed to ensure solvency with a stable trust fund for the next 75 years. It has also been a long held position that any

changes would be phased in slowly, over time, and would not affect any current or near term beneficiaries.

“AARP strongly opposed a privatization plan in 2005, and continues to oppose this approach, because it would eliminate the guarantee that Social Security provides and reduce benefits, and we are currently fighting proposals to cut Social Security to pay the nation’s bills.

“Social Security is a critically important issue for our members, their families and Americans of all ages, especially at a time when many will have less retirement security than previous generations with fewer pensions, less savings and rising health care costs. And, as we have been for decades, we will continue to protect this bedrock of lifetime financial security for all generations of Americans.”

AARP’s statement was issued in response to a June 17th story that appeared in the *Wall Street Journal* under the headline, “Key Seniors Association Pivots on Benefit Cut.” The *Journal* story began: “AARP, the powerful lobbying group for older Americans, is dropping its longstanding opposition to cutting Social Security benefits, a move that could rock Washington’s debate over how to revamp the nation’s entitlement programs.

“The decision, which AARP hasn’t discussed publicly, came after a wrenching debate inside the organization. In 2005, the last time Social Security was debated, AARP led the effort to kill President **George W. Bush’s** plan for partial privatization. AARP now has concluded that change is inevitable, and it wants to be at the table to try to minimize the pain.”

Bloomberg news carried a story that same afternoon with the headline, “AARP Backs Social Security Cuts to Ensure Solvency.” The story continued: “AARP, a lobbying group for retirees, said today it is willing to support cuts in Social Security over ‘the long term’ to shore up the program’s finances while stressing its opposition to any benefit changes as part of current efforts to slash the federal debt. ‘We are open to talking about different options to strengthen Social Security for the long term’ including ‘changes on the benefit side,’ **David Certner**, the group’s legislative director, said in an interview. He denied a *Wall Street Journal* report that said AARP is changing its policy, and some experts on both sides of the issue agreed.

The *New York Times* ran a story which quoted

AARP’s **John Rother** as saying, “Our goal is to limit any changes in benefits., but we also want to see the system made solvent.” According to the Times, Rother said in a telephone interview that AARP’s stance on possible cuts should be seen less as a major change in position than as a reflection of the political and financial realities facing the Social Security system and the country as a whole. “You have to look at all the tradeoffs,” Rother was quoted as saying, “and what we’re trying to do is engage the American public in that debate.”

Rep. Sullivan Receives Home Care Hero Award



On June 15th, World Elder Abuse Awareness Day, State Representative **David Sullivan** (D-Fall River) was presented with a Mass Home Care “Home Care Hero” award for 2011 for his work in securing a \$1 million budget amendment during House budget debate for the elder abuse/protective services program. Presenting the award was **Nancy Munson** (left) the Executive Director of Bristol Elder Services, based in Fall River, and **Paula Shiner**, the Executive Director of Coastline Elderly Services, based in New Bedford.

This marks the second time that Sullivan has led a successful House effort to add \$1 million to the protective services program. Representative Sullivan was also instrumental in adding “self-neglect” to the definition of elder abuse found in state law.