

# At Home

September, 2011

*With Mass Home Care*

**Vol 24 #9**

Al Norman, Editor



## **Elders Ask Kerry For Balanced Approach To Deficit**

On August 11th, shortly after it was announced that Massachusetts senior U.S. Senator **John F. Kerry** had been appointed to the Joint Select Committee on Deficit Reduction, Mass Home Care sent the following letter to Senator Kerry to express our concerns about the deficit cutting task ahead of him:  
Dear Senator Kerry,

We were pleased to learn of your appointment to the Joint Select Committee on Deficit Reduction.

Mass Home Care represents all the Area Agencies on Aging and Aging Services Access Points in the Commonwealth, a total of 30 non-profit agencies.

As you consider the range of options to reduce the federal deficit, we hope you will be guided by the principles that were articulated in a July 29th letter to the President and key Congressional leaders from the Legislative Council of Aging Organizations: "We believe the nation can and should reduce the deficit over time through a balanced approach that includes budget savings from increases in revenue and thoughtful, targeted reductions in spending when and where necessary..."

Among the LCAO principles

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we support for a budget agreement are:

**1. Establish BALANCE:** Any budget agreement must adopt a balanced approach, including revenue raisers, as well as savings from mandatory and discretionary spending.

**2. Protect the most VULNERABLE:** protect Americans in greatest need, both socially and economically, protecting low-income people, taking no actions that increase economic vulnerability or poverty. Programs like the Older Americans Act, which are targeted to low income populations, should be protected as a priority mission of the federal government through the “general welfare” clause in the Constitution. Every \$1 provided to the aging services network is leveraged by nearly \$3 in non-federal support.

**3. Remove Social Security As An Issue:** Social Security has not contributed to the federal deficit---it has alleviated it. The Trust Funds have been used for borrowing in the past to lower the perceived deficit. The system is solvent in the near-term, and any adjustments to accommodate future growth in beneficiaries should take place among the Trustees, not in the context of deficit reduction. The Social Security COLA, which already is biased against the elderly, should not be reduced. Instead, remove the cap on earned income subject to the FICA tax, and consider making unearned income subject to Social Security taxation.

**4. Build a better future:** enhance the economic security for Americans of all ages, strengthening the middle class and promoting job growth.

**5. Address system wide health care inflation:** do not shift higher costs on to consumers, to states or single out Medicare and Medicaid. Address the systemic causes of health care inflation, but do not punish patients for have a chronic condition.

**6. Protect consumers from devastating health costs:** Maintain the federal government’s authority to determine eligibility and consumer protections for federal programs serving older adults and those with disabilities, particularly those living on low, fixed incomes. Medicaid block grants and Medicare privatization in the form of vouchers or premium support, must be averted.

**7. Reject arbitrary caps and triggers:** Avoid resorting to automatic, arbitrary spending caps and sequestration mechanisms which deny leg-

islators the opportunity to set priorities in the allocation of tax dollars, now and in the future.

**8. Ensure flexibility to protect low-income Americans:** Protect income and supports and social insurance programs for low-income Americans. A balanced strategy must include revenue raisers and, where necessary, spending cuts. Raising the tax rate on upper income earners (including unearned income), and on corporate revenues, is a reasonable sharing of the burden of meeting our obligations to the vulnerable in our communities. Closing tax loopholes and exemptions, or means testing deductions and exemptions, is also an approach worth considering.



We believe that reducing the federal budget deficit is important, but spending cuts should not be made at the expense of economically disadvantaged seniors and younger Americans. Due to the recent economic downturn, more seniors than ever need assistance and support to make ends meet.

We in Massachusetts have been working to target tax dollars efficiently. Our efforts have helped reduce institutional long term care use by 29% over the past decade, saving Medicaid hundreds of millions of dollars. At the same time, tax cuts already enacted into law have made it harder for us to get the support we need to keep people living independently at home. As **Thomas Jefferson** once said, “Taxes should be proportioned to what may be annually spared by the individual.” We would like to meet with you to review specific ideas for imprinting the notion of ‘shared sacrifice’ into a deficit reduction package.

We wish you well during these deliberations.

## Deficit Plan: No Agreement on Entitlements

On the evening of July 31st, the White House issued a press restatement on the deficit extension bill endorsed by Congressional leaders. The White House called the plan “a win for the economy and budget discipline.”

In the statement, the White House insists that President **Barack Obama** “did not agree to any entitlement reforms outside of the context of a bipartisan committee process.” A “Bipartisan, Bicameral Congressional Committee” would consider “responsible” cuts to programs like Social Security, Medicare and Medicaid, along with “revenue-raising tax reform,” but no specifics about entitlement or tax reform are spelled out.

The deal includes an automatic “sequester” to ensure that at least \$1.2 trillion in deficit reduction is achieved by 2013. The sequester would exempt Social Security, Medicaid, unemployment insurance, programs for low-income families, and civilian and military retirement. Likewise, any cuts to Medicare would be capped and limited to the provider side.

Here is the White House statement:

“The debt deal announced today is a victory for bipartisan compromise, for the economy and for the American people. The agreement:

- Removes the cloud of uncertainty over our economy at this critical time, by ensuring that no one will be able to use the threat of the nation's first default now, or in only a few months, for political gain;
- Locks in a down payment on significant deficit reduction, with savings from both domestic and Pentagon spending, and is designed to protect crucial investments like aid for college students;
- Establishes a bipartisan process to seek a balanced approach to larger deficit reduction through entitlement and tax reform;
- Deploys an enforcement mechanism that gives all sides an incentive to reach bipartisan compromise on historic deficit reduction, while protecting Social Security, Medicare beneficiaries and low-income programs;
- Stays true to the President's commitment to shared sacrifice by preventing the middle class, seniors

and those who are most vulnerable from shouldering the burden of deficit reduction. The President did not agree to any entitlement reforms outside of the context of a bipartisan committee process where tax reform will be on the table and the President will insist on shared sacrifice from the most well-off and those with the most indefensible tax breaks.

### Mechanics of the Debt Deal

- Immediately enacted 10-year discretionary spending caps generating nearly \$1 trillion in deficit reduction; balanced between defense and non-defense spending.
- President authorized to increase the debt limit by at least \$2.1 trillion, eliminating the need for further increases until 2013.



- Bipartisan committee process tasked with identifying an additional \$1.5 trillion in deficit reduction, including from entitlement and tax reform. Committee is required to report legislation by November 23, 2011, which receives fast-track protections. Congress is required to vote on Committee recommendations by December 23, 2011.
- Enforcement mechanism established to force all parties--Republican and Democrat--to agree to balanced deficit reduction. If Committee fails, enforcement mechanism will trigger spending reductions beginning in 2013 - split 50/50 between domestic and defense spending. Enforcement protects Social Security, Medicare beneficiaries, and low-income programs from any cuts.

### BIPARTISAN DEBT DEAL: A WIN FOR THE ECONOMY AND BUDGET DISCIPLINE

1. REMOVING UNCERTAINTY TO

## SUPPORT THE AMERICAN ECONOMY

\* Deal Removes Cloud of Uncertainty Until 2013, Eliminating Key Headwind on the Economy: Independent analysts, economists, and ratings agencies have all made clear that a short-term debt limit increase would create unacceptable economic uncertainty by risking default again within only a matter of months and as S&P stated, increase the chance of a downgrade. By ensuring a debt limit increase of at least \$2.1 trillion, this deal removes the specter of default, providing important certainty to our economy at a fragile moment.



\* Mechanism to Ensure Further Deficit Reduction is Designed to Phase-In Beginning in 2013 to Avoid Harming the Recovery: The deal includes a mechanism to ensure additional deficit reduction, consistent with the economic recovery. The enforcement mechanism would not be made effective until 2013, avoiding any immediate contraction that could harm the recovery. And savings from the down payment will be enacted over 10 years, consistent with supporting the economic recovery.

## 2. A DOWNPAYMENT ON DEFICIT REDUCTION BY LOCKING IN HISTORIC SPENDING DISCIPLINE - BALANCED BETWEEN DOMESTIC AND PENTAGON SPENDING

\* More than \$900 Billion in Savings over 10 Years By Capping Discretionary Spending: The deal includes caps on discretionary spending that will produce more than \$900 billion in savings over the next 10 years compared

to the CBO March baseline, even as it protects core investments from deep and economically damaging cuts.

\* Includes Savings of \$350 Billion from the Base Defense Budget - the First Defense Cut Since the 1990s: The deal puts us on track to cut \$350 billion from the defense budget over 10 years. These reductions will be implemented based on the outcome of a review of our missions, roles, and capabilities that will reflect the President's commitment to protecting our national security.

\* Reduces Domestic Discretionary Spending to the Lowest Level Since Eisenhower: These discretionary caps will put us on track to reduce non-defense discretionary spending to its lowest level since **Dwight Eisenhower** was President.

\* Includes Funding to Protect the President's Historic Investment in Pell Grants: Since taking office, the President has increased the maximum Pell award by \$819 to a maximum award \$5,550, helping over 9 million students pay for college tuition bills. The deal provides specific protection in the discretionary budget to ensure that there will be sufficient funding for the President's historic investment in Pell Grants without undermining other critical investments.

## 3. ESTABLISHING A BIPARTISAN PROCESS TO ACHIEVE \$1.5 TRILLION IN ADDITIONAL BALANCED DEFICIT REDUCTION BY THE END OF 2011

\* The Deal Locks in a Process to Enact \$1.5 Trillion in Additional Deficit Reduction Through a Bipartisan, Bicameral Congressional Committee: The deal creates a bipartisan, bicameral Congressional Committee that is charged with enacting \$1.5 trillion in additional deficit reduction by the end of the year. This Committee will work without the looming specter of default, ensuring time to carefully consider essential reforms without the disruption and brinksmanship of the past few months.

\* This Committee is Empowered Beyond Previous Bipartisan Attempts at Deficit Reduction: Any recommendation of the Committee would be given fast-track privilege in the House and Senate, assuring it of an up or down vote and preventing some from using procedural gimmicks to block action.

\* To Meet This Target, the Committee Will Consider Responsible Entitlement and Tax Reform. This means putting all the priorities of both parties on the table--including both entitlement reform and revenue-raising tax reform.

#### 4. A STRONG ENFORCEMENT MECHANISM TO MAKE ALL SIDES COME TOGETHER

\* The Deal Includes An Automatic Sequester to Ensure That At Least \$1.2 Trillion in Deficit Reduction Is Achieved By 2013 Beyond the Discretionary Caps:

The deal includes an automatic sequester on certain spending programs to ensure that-between the Committee and the trigger-we at least put in place an additional \$1.2 trillion in deficit reduction by 2013.

\* Consistent With Past Practice, Sequester Would Be Divided Equally Between Defense and Non-Defense Programs and Exempt Social Security, Medicaid, and Low-Income Programs: Consistent with the bipartisan precedents established in the 1980s and 1990s, the sequester would be divided equally between defense and non-defense program, and it would exempt Social Security, Medicaid, unemployment insurance, programs for low-income families, and civilian and military retirement. Likewise, any cuts to Medicare would be capped and limited to the provider side.

\* Sequester Would Provide a Strong Incentive for Both Sides to Come to the Table: If the fiscal committee took no action, the deal would automatically add nearly \$500 billion in defense cuts on top of cuts already made, and, at the same time, it would cut critical programs like infrastructure or education. That outcome would be unacceptable to many Republicans and Democrats alike - creating pressure for a bipartisan agreement without requiring the threat of a default with unthinkable consequences for our economy.

#### 5. A BALANCED DEAL CONSISTENT WITH THE PRESIDENT'S COMMITMENT TO SHARED SACRIFICE

\* The Deal Sets the Stage for Balanced Deficit Reduction, Consistent with the President's Values: The deal is designed to achieve balanced deficit reduction, consistent with the values the President articulated in his April Fiscal Framework. The discretionary savings are spread between both domestic and defense spending. And the President will demand that the Committee pursue a balanced deficit reduction package, where any entitlement reforms are coupled with revenue-raising tax reform that asks for the most fortunate Americans to sacrifice.

\*The Enforcement Mechanism Complements the For-

cing Event Already In Law - the Expiration of the Bush Tax Cuts - To Create Pressure for a Balanced Deal: The Bush tax cuts expire as of 1/1/2013, the same date that the spending sequester would go into effect. These two events together will force balanced deficit reduction. Absent a balanced deal, it would enable the President to use his veto pen to ensure nearly \$1 trillion in additional deficit reduction by not extending the high-income tax cuts.



\* In Securing this Bipartisan Deal, the President Rejected Proposals that Would Have Placed the Sole Burden of Deficit Reduction on Low-Income or Middle-Class Families: The President stood firmly against proposals that would have placed the sole burden of deficit reduction on lower-income and middle-class families. This includes not only proposals in the House Republican Budget that would have undermined the core commitments of Medicare to our seniors and forced tens of millions of low-income Americans to go without health insurance, but also enforcement mechanisms that would have forced automatic cuts to low-income programs. The enforcement mechanism in the deal exempts Social Security, Medicaid, Medicare benefits, unemployment insurance, programs for low-income families, and civilian and military retirement.

## Reaction to the Deficit Extension Plan

It didn't take long for elderly rights groups to assess the extent of damage from Congressio-

nal passage of the deficit extension bill. Below are two responses to the Congressional budget reductions, first from **Sandy Markwood**, CEO of the National Association of Area Agencies on Aging (n4a), and then from the National Council on Aging. Both statements were released on August 2nd, while the final votes were still being taken in the Senate.

## **n4a STATEMENT ON THE DEBT CEILING DEAL**



*Sandy Markwood, n4a photo*

“The debt ceiling legislation passed by Congress and signed by the President, will have far-reaching effects on the future of domestic discretionary programs, such as the Older Americans Act, housing and transportation programs that older Americans depend upon to be able to live safely and independently in their homes and communities.

Although we appreciate the debt ceiling deal spares the entitlement programs from cuts for the time being, it includes provisions that could potentially alter the nature of entitlement programs like Medicare, Medicaid and Social Security for years to come.

While achieving the goal of increasing the debt limit through 2012 and thus allowing the government to pay its bills, the deal takes an unbalanced approach in addressing deficit reduction by not including a single cent of new revenue, putting off the tough decisions, and focusing more than \$900 billion over 10 years

in immediate cuts on discretionary programs. While these cuts would include some shared sacrifice—with \$350 billion coming from defense programs—all non-security domestic programs will be at risk as these funding cuts are determined beginning in FY 2012.

Additionally, the deal charges a joint committee to come up with another \$1.5 trillion in budget reductions by November 23 that would be voted by Congress on a strict up-or-down vote. If these recommendations are not agreed to, a trigger or sequestration mechanism would automatically kick in, making across-the-board cuts to programs. The joint committee is authorized to consider making additional cuts to discretionary programs, cuts to entitlements and tax reform changes.

As this next phase of the debate begins, n4a urges all aging advocates to urge their Members of Congress to support a more balanced approach to deficit reduction based on shared sacrifice which does not place a disproportionate burden on low-income frail older Americans, who can least afford it.”

### **Statement From NCOA**

NCOA is a nonprofit service and advocacy organization headquartered in Washington, DC. The group’s mission is “to improve the lives of millions of older adults, especially those who are vulnerable and disadvantaged.” Here is the statement NCOA released on August 2nd:

“After months of negotiations, Congress and President Obama have agreed on a package of budget cuts along with an increase to the nation’s debt ceiling.

As with any compromise, there’s both good news and bad for seniors and the aging network. On the positive side:

- Debt ceiling: President Obama now has the authority to increase the debt ceiling, which will prevent a default or any disruption in sending out Social Security and veterans’ benefits checks.
- Medicare and Medicaid: Thanks to advocacy by NCOA and other senior groups, funding for Medicare beneficiaries and low-income programs like Medicaid is not cut in the initial package and is exempt from potential automatic cuts later.
- Spending cuts: The first \$10 billion in spending cuts over the first two years of the plan will be split 50/50 between domestic discretionary and defense programs.

On the negative side:

- Medicare, Medicaid, and Social Security: These programs could still be included in a second round of cuts totaling between \$1.2 and \$1.5 trillion to be recommended by a new 12 congressional member bipartisan “super committee” that must act by the end of the year or else trigger automatic cuts. The panel will be called the Joint Select Committee on Deficit Reduction.
- Domestic spending cuts: The full brunt of the initial round of cuts totaling nearly \$1 trillion over 10 years will be on discretionary programs, and the firewalls that evenly divide reductions between domestic and defense programs will only last two years. As a result, domestic discretionary programs such as the Older Americans Act (OAA) could be subject to enormous cuts in later years. In addition, there are no limits to how much OAA and other domestic programs could be cut in the \$1.2 trillion-plus package crafted by the super committee, particularly if revenues do not help offset the price tag, and if a package is not agreed to, the subsequent automatic cuts will largely affect discretionary funding.
- Revenues: Raising revenue is not included in the first phase of the plan, and there are no guarantees that it will be part of the second phase.

What’s ahead?

The initial round of cuts will be enacted through the regular FY12 appropriations process, which could still take several months. Congress will appoint a 12-member, bipartisan Joint Select Committee on Deficit Reduction, which will be tasked with creating another package by Nov. 23 to reduce the deficit by at least \$1.2 trillion over 10 years. If Congress does not approve the second package by Dec. 23, automatic across-the-board cuts will start by Jan. 1, 2013.

In the case of automatic cuts, Social Security, Medicare beneficiaries (but not provider payments), and low-income programs such as Medicaid and Supplemental Security Income (SSI) will be exempt from cuts.

Congress also must vote on a balanced budget amendment to the Constitution, but failure to reach the two-thirds vote threshold for passage will not trigger any additional legislative action.

The bottom line:

It’s clear that the collective advocacy of NCOA, our advocates, and other senior groups made a significant difference in protecting Medicaid and

Medicare beneficiaries from short-term and automatic cuts. However, we have considerable work ahead of us. In the coming weeks, our goals will be to:

1. Ensure that the super committee does not recommend a package of entitlement and discretionary cuts that would adversely affect vulnerable older adults.
2. Continue to educate Congress about the need to invest in domestic discretionary programs such as the OAA, senior housing, and food assistance.
3. Press the super committee to craft a fair, balanced deficit reduction package that includes revenues from those who can most easily afford them.

## Rally for REAL Medicaid Reform



The national disability rights group ADAPT has called for a “Rally for REAL Medicaid Reform” on Capitol Hill in Washington, D.C. on September 21st.

The group warns that Medicaid is on the table for arbitrary and draconian cuts. The disability and aging communities must show Congress that “My Medicaid Matters” by having thousands show up on Capitol Hill on September 21st for a “Rally for Real Medicaid Reform”.

“So far, EVERY plan to address entitlements has included cuts to Medicaid,” ADAPT explains. “NONE has included reform measures proposed by the disability rights community.”

ADAPT has identified the following proposals that contain Medicaid spending while supporting

the right of individuals to live in the most integrated setting and maintaining control over their lives:

\* **Expand the use of community-based services:** Studies have demonstrated that by reducing the over-reliance on institutions and nursing facilities and shifting toward more cost-effective community-based services, states can contain Medicaid spending. Despite the growing body of evidence showing that community-based services are more cost effective, the federal government still allows states to continue their wasteful, institutionally-biased practices.

\* **Demedicalize services:** By reducing the reliance on costly medical personnel to provide assistance by allowing attendants to perform these tasks, states could use the same amount of Medicaid funding to support more seniors and people with disabilities living in their own homes. Changes in state Nurse Practices Acts could save millions of Medicaid dollars. Many of the long term services that are widely perceived as “medical” become a basic part of daily life to a person with disabilities. States continue to require that medical personnel provide such services, unnecessarily increasing Medicaid’s costs.

\* **Expand consumer directed service options:** By empowering people to manage their own services and reducing the need for administrative overhead, states can also reduce Medicaid expenditures. Many seniors and people with disabilities can manage their services and supervise the people providing the direct care, reducing the need for agencies to provide supervisory and administrative supports like training and scheduling.

\* **Reorganize Medicaid services to eliminate wasteful bureaucracy:** The current system wastefully organizes services based on diagnosis and age even though people may have the same functional needs. By organizing services based on functional needs states can eliminate redundant and needlessly expensive bureaucracies and reduce Medicaid expenditures. A system based on functional needs also eliminates gaps in services and makes services easier to access, reducing the need for professional assistance in navigating the system we currently have in place.

On August 11th, ADAPT issued a statement critical of the Obama Administration’s handling of Medicaid cutbacks across the country. The group said it was “outraged” by a letter sent to state Medicaid Direc-

tors by the federal Centers for Medicare and Medicaid Services (CMS) on August 5th. The letter explained how states could cut Medicaid home and community based services and not run afoul of the maintenance of effort requirement in the Affordable Care Act.



*DHHS Secretary Kathleen Sebelius*

ADAPT said it was “particularly upset” because HHS Secretary **Kathleen Sebelius** spoke before national disability rights groups in July, highlighting how the Affordable Care Act benefits people with disabilities, including the potential to improve access to home and community based services. “While the Secretary gave rousing speeches and was applauded by our community, her staff were crafting guidance to states on cutting our services,” said **Rahnee Patrick**, an ADAPT Organizer from Chicago, IL. “This is reprehensible.”

The group charged that the Health and Human Services Office for Civil Rights has done little to address Olmstead concerns identified in the states. “Though talking tough about the need for states to comply with the Olmstead decision, CMS has not developed any accountability criteria to monitor states to assess if states are really complying with the decision” said **Bruce Darling**, an ADAPT organizer.

The letter to Medicaid Directors was developed in response to concerns by states which face increasing costs as Medicaid enrollment increases because more Americans are eligible for the program due to lost income and expansions mandated in the Affordable Care Act. This same federal agency misinterpreted statutory language establishing the Community First Choice Option and developed proposed rules that

would require states to provide more expansive services beyond what the statutory language would require.

“Ultimately,” ADAPT said, “that means fewer states would select the option and fewer Americans will have the opportunity to live in freedom. The fact that the federal agency took this action despite being told directly by the provisions sponsors that this was not Congress’ intent is particularly upsetting to advocates.”

ADAPT said it is seeking to meet with the Secretary to raise their concerns.

## AARP Issues Update on Family Caregivers



In August, AARP released a 2011 national update on *The Growing Contributions and Costs of Family Caregiving*. This study suggests that in 2009 the unpaid work provided by family caregivers was about \$450 billion, or 4 times what Medicaid spent on long term supports directly. Specific numbers for Massachusetts suggest that there are 858,000 caregivers at any given time, providing 821 million hours of care per year, and the value of the care they provide is \$10.9 billion a year.

The study estimates that family caregivers over the age of 50 today who leave the workforce to care for an elderly relative can expect to lose \$115,000 in wages, \$138,000 in Social Security benefits and \$50,000 in pension benefits.

One of the conclusions of this study is that public policy should “Promote expansion of consumer-directed

models in publicly funded HCBS programs that permit payment of family caregivers. Such models allow consumers and their families to choose and direct the types of services and supports that best meet their needs.”

This recommendation on allowing family members to be paid caregivers came on the heels a State House hearing on “spouse as paid caregiver.” Today in Massachusetts disabled people who live with a spouse are penalized, because that spouse is assumed capable of doing the cooking, shopping, transportation and cleaning--unless it can be shown that the spouse is unable to do these tasks. If an elderly or disabled couple gets divorced, the ex-spouse can become a paid caregiver. Mass Home Care has suggested that such policies are anti-family, because they encourage people to get divorced as a long term care services strategy.

According to the AARP study, the “average” U.S. caregiver is a 49-year-old woman who works outside the home and spends nearly 20 hours per week providing unpaid care to her mother for nearly five years. Almost two-thirds of family caregivers are female (65 percent). More than eight in ten are caring for a relative or friend age 50 or older. AARP estimates that the economic value of family caregiving at \$450 billion in 2009 based on 42.1 million caregivers age 18 or older providing an average of 18.4 hours of care per week to care recipients age 18 or older, at an average value of \$11.16 per hour. \$450 billion is—

- More than total Medicaid spending in 2009, including both federal and state contributions for both health care and LTSS (\$361 billion)
- Nearly four times Medicaid LTSS spending in 2009 (\$119 billion)
- More than twice total paid LTSS, regardless of payer source (\$203 billion in 2009)
- As much as the total sales of the world’s largest companies, including Wal-Mart (\$408 billion in 2009, the most of any company) and the three largest publicly held auto companies total \$439 billion)
- Approaching total expenditures for the Medicare program (\$509 billion in 2009)
- Almost \$1,500 for every person in the United States (307 million people as of July 1, 2009)
- About 3.2 percent of the U.S. gross domestic product (\$14.1 trillion in 2009)

These caregiving cost estimates do not include caregivers or care recipients under age 18; nor do they include caregivers who provide assistance to adults who have chronic health conditions or disabilities but do not provide assistance with any activities of daily living (ADLs) (such as bathing or dressing) or instrumental activities of daily living (IADLs) (such as managing medications or finances). The estimate of 42.1 million represents the number of caregivers providing care at any given point in time. Since some episodes of caregiving begin or end during the year, the total number of individuals providing care during the year is significantly higher, estimated at 61.6 million.

AARP notes that “families remain the most important source of support to older adults. Many individuals who provide assistance and support to a loved one with chronic illness or disability do not identify themselves as “caregivers” but rather describe what they do in terms of their relationship with the other person: as a husband, wife, partner, daughter, daughter-in-law, son, grandson, niece, or close friend, for example. An estimated 83 percent of Americans say they would feel very obligated to provide assistance to their parent in a time of need. Those who take on this unpaid role risk the stress, physical strain, competing demands, and financial hardship of caregiving, and thus are vulnerable themselves. Family caregiving is now viewed as an important public health concern.”

Individuals with complex chronic health conditions and functional limitations rely on their families for personal assistance and for coordination of care over extended periods of time. They are more likely to see multiple health professionals, receive services in multiple settings, and experience numerous transitions between care settings, as well as to need supportive services to help with ADLs, transportation needs, and other social supports. In 2006, health care costs for people with both chronic conditions and functional limitations were at least three times higher than for people with only chronic conditions (\$11,284 versus \$3,641).

Individuals and their families generally view chronic illness and disability from the perspective of the “whole person,” not as separate, discrete services or treatments. Consequently, family caregivers frequently experience the enormous fragmentation of both health

care and LTSS systems that are not set up to meet their needs or those of the people for whom they care. However, shortages of direct care workers, such as home health aides, or inability to pay for adequate services can leave many family caregivers with no alternative

## Care Transitions Reduce Hospital Readmissions



Programs designed to help transition care for hospitalized older patients to outside healthcare clinicians and settings are associated with reduced rates of hospital readmissions, according to two reports that were published in the July 25 issue of *Archives of Internal Medicine*, one of the JAMA/Archives journals. "In the United States, 30-day all-cause readmission rates for patients 65 years or older generally range from 20 percent to 25 percent, depending on clinical condition and geographic region, indicating much room for improvement," the authors write as background information in one of the articles. "Interventions addressing patient- and systems-level factors show promise for reducing hospital readmissions." In the first article, **Rachel Voss**, M.P.H., of Quality Partners of Rhode Island, Providence, examined the effects of the Care Transitions Intervention to test its effectiveness in reducing hospital readmissions. The intervention occurred over a period of 30 days and included a coach who completed a hospital visit, a home visit and two follow-up telephone calls with the patient.

Between January 2009 and June 2010, the authors recruited patients at six Rhode Island hospitals for participation in the intervention. Patients were sep-

arated into three groups: intervention group, internal control group (patients were approached but declined the intervention or did not complete the home visit) and external control group (patients not approached but eligible for participation based on study criteria). Of the 1,888 patients approached for the study, 1,042 (55.2 percent) agreed to participate and of those, 257 (24.7 percent; 13.6 percent of the eligible participation group) completed the full intervention with home visit. The odds of hospital readmission within 30 days of discharge were significantly lower for patients participating in the intervention compared with those who were never approached for participation (12.8 percent readmission rate vs. 20 percent readmission rate). Individuals in the internal control group had readmission rates similar to those of the external control group (18.6 percent). The authors concluded that, "the Care Transitions Intervention appears to be effective in this real-world implementation. This finding underscores the opportunity to improve health outcomes beginning at the time of discharge in open health care settings."

In a second article, **Brett D. Stauffer**, M.D., M.H.S., of the Institute for Health Care Research and Improvement, Baylor Health Care System, Dallas, evaluated an advanced practice nurse-led transitional care program for patients 65 years and older with heart failure who were discharged from Baylor Medical Center Garland (BMCG) from August 2009 through April 2010. The program included a pre-discharge intervention by the advanced practice nurse and at least eight post-discharge house calls per patient.

The study examined the association between the transitional program and 30-day (from discharge) all-cause readmission rate, length of stay and 60-day (from admission) direct cost for BMCG with that of other hospitals within the Baylor Health Care System.

During the study period, 140 Medicare patients with heart failure were eligible for the intervention and of these, 56 (40 percent) enrolled in the study. The adjusted 30-day readmission rate was 48 percent lower at BMCG after the intervention than before, however the intervention had little effect on hospital length of stay or total 60-day direct costs for the center compared to other hospitals in the Baylor system.

"Preliminary results suggest that transition-

al care programs reduce 30-day readmission rates for patients with heart failure," the authors conclude. "This underscores the potential of the intervention to be effective in a real-world setting, but payment reform may be required for the intervention to be financially sustainable by hospitals."

## ICE Plan Leaves Some Cold



In January of 2011, the state's Executive Office of Health & Human Services submitted a grant proposal to the federal Center for Medicare and Medicaid Innovation—an office newly created under the federal Affordable Care Act. A total of 15 states received federal design contracts for up to \$1 million. Massachusetts was one of the states receiving an award.

MassHealth submitted the "Integrated Health Entity" (ICE) plan in response to a federal solicitation called the "State Demonstrations to Integrate Care for Dual Eligible Individuals." The purpose of the grant was to test and evaluate a model of care delivery for dual eligible adults ages 21-64 that fully integrates the delivery and financing of all Medicare and Medicaid services for this population—including medical care and long term care services and supports.

Under the proposed model, MassHealth would assume complete operational responsibility for the care of this population—comparable to its responsibility for its MassHealth-only membership—including the administration, management and oversight of all Medicare-funded and Medicaid-funded services.

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“MassHealth believes this unprecedented level of integration is necessary to achieve better health outcomes for this population and to provide higher quality, more cost effective, person-centered care,” EOHHS wrote.

The state said the ICE plan to integrate care and financing for dual eligible adults ages 21-64 was a fundamental component of a broader effort in Massachusetts to transform its health care system by restructuring how care is delivered and how providers are reimbursed. Massachusetts’ reform efforts include initiatives to develop patient-centered medical homes, bundled payments, accountable care organizations, and state legislation to require a transition from fee-for-service provider payments to global payment methodologies.



Through these initiatives, Massachusetts seeks to ensure access to appropriate services, integrate comprehensive services at the person level, improve care coordination, and create payment systems that hold providers accountable for the care they deliver. Massachusetts aims to reward quality care, improve health outcomes, and more effectively spend health care dollars.

According to EOHHS, care for dual eligible adults ages 21-64 is “fragmented, unmanaged and uncoordinated” at the program level, and based on an inefficient fee-for-service (FFS) provider payment system. “Different eligibility and coverage rules in MassHealth and Medicare contribute to these problems. The current system lacks sufficient care coordination for the comprehensive services this population needs, which

inhibits access to critical services, particularly community-based behavioral health services, and encourages cost-shifting between providers and payers. All of these factors adversely impact this population’s quality of care and health outcomes and contributes to MassHealth and Medicare spending problems.”

State officials projects that combined spending on its dual eligible adults ages 21-64 will reach \$3.85 billion in 2011, including \$1.27 billion in Medicare expenditures and \$2.58 billion in MassHealth expenditures. For dual eligible adults ages 21-64 in FFS, few of these expenditures are used for care management. As this group uses a wide array of services, the lack of care management may increase the incidence of duplicative services, contraindicated therapies and drugs, and inefficiencies in care.

Most MassHealth dual eligible adults ages 21-64 have complex care needs (approximately 76% have a chronic medical condition in addition to a disability), but most lack access to integrated care systems that approach care delivery from a holistic, person-centered perspective and promote care management and care coordination. “Dual eligible adults ages 21-64 do not receive managed care under current MassHealth program rules, and are limited to receiving their services in the uncoordinated FFS environment,” EOHHS notes. “Dual eligible adults tend to use a variety of acute and primary care services, behavioral health services, and long term services and supports (LTSS), but these areas of a person’s care often are disconnected in the current delivery system. Individuals may experience limited pockets of case management for certain sets of services (e.g., case management for Home and Community Based Waiver (HCBW) services or Medicare Advantage plan management of acute Medicare services). However, case management focused on only one area of a person’s care is less effective than comprehensive care management that addresses all aspects of care.”

Dual eligible individuals with complex care needs interact frequently with various parts of the health care system; many simultaneously use acute care services, Medicaid or state-funded LTSS, behavioral health services, prescription drugs, and other supports. In a FFS system, many of these individuals, who already struggle with the daily challenges

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of their conditions or disabilities, must arrange their own care. This may entail communicating with multiple providers, coordinating numerous doctor appointments and arranging for transportation needs. These activities may be even more difficult and complex for individuals with cognitive impairments.

MassHealth received \$1 million in planning funds to conduct detailed analyses on the target population particularly to determine the expanded long term services and supports that would be most effective in the model, and to develop strategies to more efficiently care for the subset of the population that drives a large portion of spending. Massachusetts' preliminary analysis on the linked data set shows that 23% of duals in the target population account for 76% of total Medicare and Medicaid combined spending. They further account for 84% of Medicare's acute care spending for the target population. Integrating care has the potential to greatly contribute to quality improvements and potential savings which could be reallocated to better meet the needs of the entire target population.

Massachusetts' integrated care model for dual eligible adults ages 21-64 will be implemented statewide. Through a bidding process, MassHealth will use combined Medicare and Medicaid funding to contract with entities to integrate comprehensive care at the person level, and provide both MassHealth and Medicare services. According to EOHHS, these integrated care entities will deliver care with a person-centered approach that ensures that all of the health needs of individuals in the target population are met and coordinated across the health care and long term support delivery system.

While this model builds off of MassHealth's experience with the Senior Care Options (SCO) program, Massachusetts proposes administering this program at the state level. Massachusetts claims it will significantly improve the alignment of financial incentives and provider accountability by making one global payment for all Medicare and Medicaid services, a broader continuum of behavioral health services, and community support services.

Although EOHHS said the plan would be similar to the SCO plan, the ICE project has made some major changes to the elderly SCO program, which will affect the consumer and the provider community:

Last April, EOHHS issued a Request for Information asking interested parties to comment on the ICE plan. Mass Home Care urged EOHHS to consider the existing Senior Care Options (SCO) plan, which serves people 65 and over, when designing a plan for the age 19 to 64 population. "In the world of elderly long term support services," Mass Home Care wrote, "it is the ASAP care manager that needs to be on the team. The model to emulate is the SCO law under Chapter 118E, in which the SCO 'shall employ geriatric support service coordinators (GSSC), who shall be members of the primary care team.'"



Under the SCO model, the GSSC is responsible for:

- (i) arranging, coordinating and authorizing the provision of community long-term care and social support services
- (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
- (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 are responsible

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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.

Mass Home Care told EOHHS that "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."

Two major issues that EOHHS has to resolve are the issue of voluntary enrollment, and whether or not ICE plans will be required to use the existing LTSS infrastructure for coordinating community-based supports.

Regarding enrollment, EOHHS could "passively" enroll all the Medicare and Medicaid beneficiaries in an ICE plan, and then require the enrollee to disenroll him or herself to get out of the ICE plan. This so-called "passive opt in" concept is not favored by disability rights groups, and breaks with the existing SCO law---which requires enrollment to be voluntary only. Advocates have told EOHHS they want consumers to choose to enroll in an ICE plan---not to be placed in a plan they did not choose.

Regarding a required linkage to community-based LTSS, the state could allow the ICE plans to provide their own LTSS care coordination, and not use entities like ASAPs or Independent Living Centers at all. In responding to this issue, Mass Home Care told EOHHS that the federal Coordinated Health Care office testified before Congress 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 concluded 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."



According to Mass Home Care, Massachusetts has developed over the past 37 years a strong community based LTSS built around regional Aging Services Access Points. ASAPs have a statutory responsibility to manage and coordinate the needs of dually eligible seniors. ICE plans 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. Mass Home Care urged that ICE entities 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," Mass Home Care wrote.

An Integrated Care Entity operating plan will be submitted to the federal government by EOHHS this October, so design issues need to be resolved soon. If the issue of voluntary enrollment and a clear linkage to LTSS coordination are not resolved, the ICE plan could face a chilly reception from some advocates.