

At Home

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With Mass Home Care

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Home Care Waits Lists Start Sept. 1st.

The Baker Administration has officially announced that starting September 1st, waiting lists for some elders will begin in the home care program. But according to Mass Home Care, the state has enough Federal dollars to avoid the crisis.

Massachusetts calls itself a “community first” state---but the doors to nursing facilities are wide open, while the entrance to home care will soon be limited. Mass Home Care predicts that the monthly caseload for elders will rise by 150 to 200 new elders each month, for the remaining 10 months of FY 17.

“Due to projected demand exceeding FY17 budgetary limitations,” the Administration said in a memo to Aging Services Access Points (ASAPs), “Elder Affairs will be implementing a managed intake

process. This process will be effective as of September 1, 2016.”

The wait lists were required because the final Conference Committee budget for FY 17 home care items is roughly \$3.5 million below FY 16 appropriations:

| Line Item | FY16 Budget | FY 17 FINAL |
|---------------|----------------------|----------------------|
| ECOP | \$ 70,255,327 | \$ 70,548,399 |
| HOME CARE | \$104,595,483 | \$102,570,589 |
| CARE MGMT | \$ 35,546,961 | \$ 33,795,743 |
| TOTALS | \$210,397,771 | \$206,914,731 |

“This was an entirely predictable—and avoidable—outcome,” said Mass Home Care Executive Director **Al Norman**. “The General Court didn’t give home care enough funding to run a maintenance

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budget, and the Governor filed a supplemental budget that added more federal dollars---but reduced the state share, setting up a wait list situation."

According to the Executive Office of Elders Affairs, elders who have "a critical unmet need for meal preparation" will be put on a waiting list---regardless of where they live in the state. Every elder who applies for home care is assigned a "priority level" based on their need for service. Roughly 150 to 200 elders per month in FY 17 will fall into this wait list category. By June 30, 2017, there will be 1,500 to 2,000 elders on the wait list, representing a loss of 8,250 months to 11,000 over the 10 month period of reduced home care services.

The state is also cutting off funding for the Intensive Care Management program, which helps seniors with behavior health problems to receive care. In addition, a pilot program approved by the General Court to provide up to \$1 million to help seniors with income slightly over the home care eligibility limit has been scrapped.



After the FY 17 budget was completed by the Conference Committee, the Governor filed on July 11th a supplemental budget. In section 4 of that budget the Administration went into the main elder home care services line item, 9110-1630, and added \$4 million in federal "community first" trust fund money---but backed out \$4 million in state funds---leaving the bottom line the same: \$102.57 million. The Governor proposed to change only to the percentage of federal dollars being used for the home care services account--- leaving the bottom line unchanged. The federal share of this line item was boosted from \$1.5 million to \$5.5 million.

"What this proposal demonstrated to us,"

Norman explained, "is that the Governor has at least \$4 million in available 'community first' trust fund money that could be used to avoid the Sept. 1st wait list. The funds that comprise the Community First Trust, are meant to be used to "provide new opportunities to serve more individuals in home and community-based settings," not to offset state spending.

Mass Home Care has asked the General Court to purpose \$3 million of this Community First funding to alleviate the wait list---but the formal session adjourned with no action on our request. "This is a manufactured crisis," Norman concluded. "The state is sitting on federal dollars that were supposed to be used to expand community care. They could end this wait list before it happens."

"We hope they act quickly---on September 1st we start turning some elders away."

Senate Passes Elder Workforce Bill Addressing Elder Abuse

On July 28th, during the final days of the formal legislative session on Beacon Hill, the state Senate passed a critical piece of legislation relative to the workforce caring for older adults in Massachusetts.

S. 2466, An Act relative to the commonwealth's direct-care workforce for elderly and disabled consumers, would begin the important process of reviewing the current status of and future needs for this workforce across the Commonwealth. The bill is comprised of various legislative initiatives filed by Senator **Pat Jehlen** (D-Somerville) over several sessions. Among other things, the legislation requires the Executive Office of Elder Affairs to ensure that training is provided to protective services caseworkers on recognizing the signs and symptoms of cognitive impairments, including Alzheimer's disease, and understanding the effect of cognitive impairment on screening, investigation and service planning.

The bill requires the Baker Administration to "report on the commonwealth's direct care workforce and its preparedness to provide long-term services and supports to the growing population of elderly and disabled consumers. The report would include

an assessment of the current direct care workforce data and recommendations for improvement; and the infrastructure for supporting the efficient provision of long-term services and supports and mechanisms for ensuring quality and recommendations for improvement, such as an assessment of the current training and credentialing infrastructure, strategies for increasing the professionalism of the workforce, an assessment of the quality of support for consumers as employers, supervisors and trainers, an assessment of the adequacy of the existing infrastructure for connecting consumers and workers and recommendations for improvement including the feasibility of expanding the existing personal care attendant referral directory.



Senator Patricia Jehlen

In light of a growing need to review the workforce needs, Senator Jehlen also filed an amendment to S. 2466 that would fix a regulation gap that currently exists in how the state tracks elder abuse complaints. Senator Jehlen sponsored the bill that inspired the amendment after a WCVB Channel 5 investigative team aired a segment citing a number of tragic cases of physical, emotional, and financial elder abuse.

"Though the vast majority of caregivers do their jobs with dedication, competence, and compassion, cases like these bring to light gaps in the ability to prevent vulnerable people from being subject to physical, verbal, and financial abuse," said Senator Jehlen. "This legislation both reaffirms that we cannot ignore workforce needs and reinforces that abuse of vulnerable populations is unacceptable in our Commonwealth."

The adopted amendment ensures that an individual found by the Department of Public Health (DPH) to have abused an older adult would not be allowed to work as a caregiver for any vulnerable people, including children, persons with intellectual or developmental disabilities, and persons with a mental illness. Additionally, any person who has been suspended as a result of abusing an elder cannot advertise themselves for work as a caregiver and if a suspended person does, they will be subject to a fine of not less than \$5,000.

"Senator Jehlen's quick work in getting this issue in front of lawmakers deserves praise," said Al Norman, Executive Director of the Mass Home Care Association.

S. 2466 was referred to the House Ways and Means committee, which is where the bill now resides.

Rate Shock For Group Long Term Care Insurance Policyholders

According to a news story August 8th in the *Boston Globe*, a Chicago-based long term care insurance company, CNA Financial Corp, has hit its policyholders with a whopping rate hike of nearly 100% for a group policy created by a consortium of higher educational groups including Babson College, Brandeis University, Wellesley College, and Wheaton College.

According to the *Globe*, hundreds of Massachusetts residents will see their CNA premiums rise by 95% over two years, CNA has told customers, and as many as 100,000 Massachusetts residents who purchased long-term care insurance through other "group" plans face potentially skyrocketing premiums.

State regulators said there was little they could do to stop the rate hikes. "That's a whopper of a rate hike, without question," a spokesman for the state Division of Insurance told the *Globe*. CNA says it conducted "extensive review" of its expected claims and the life expectancy of its clients, and decided a major rate hike was needed.

Under section 7 of Chapter 176U, the Division of Insurance (DOI) is charged with writing LTC

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insurance regulations that provide “protections for the policyholder or certificate holder in the event of a substantial rate increase and disclosure.” But several years after the LTC insurance law’s passage, such regulations have not been written.

Mass Home Care Executive Director **Al Norman** told the *Globe* that the lack of regulations have left consumers vulnerable to rate shock. Group plans have always been a weak spot in the long-term care insurance market, usually flying under the regulatory radar, Norman said. “This shows how group purchasers who thought they could leverage a better rate by pooling their members, ended up vulnerable to massive rate hikes,” Norman said. “These group plans were one of the major loopholes in the old regs, and now the Division of Insurance is leaving consumers prey.”



The *Globe* noted that John Hancock Financial is raising premiums on federal employees and retirees nationwide who purchased its group long-term care insurance policies by as much as 126% in some cases. Several insurance companies have dropped out of the market entirely. “We have a delicate balance to ensure that carriers can pay their claims down the road while ensuring their rates are justifiable,” a spokesman for DOI told *The Globe*.

ASAPs Awarded Health Policy Commission Innovation Grants

Three Mass Home Care members have received state grants totaling nearly \$1 million as part of the

Health Policy Commission’s “Innovation Investments” awards.

HESSCO, Mystic Valley, and Springwell, were awarded grant funding from the Health Policy Commission, together with their partners, that amounted to \$918,443. The awards are the first phase of the Health Care Innovation Investment awards, totaling \$11million.

According to the Health Policy Commission, the Health Care Innovation Investment Program (HCII) is a “unique opportunity for Massachusetts providers, health plans, and their partners to implement innovative models that deliver better health and better care at a lower cost.” The Innovation program was created as part of Chapter 224 of the Acts of 2012, the state’s landmark cost containment law, established this competitive investment program to support health care innovation and transformation. The first phase of the Innovation Program awarded grants to 20 competitively selected awardees, ranging from \$250,000 to \$1,000,000.

Waltham-based Springwell was a partner in two awards: Brookline Community Mental Health, and Riverside Community Health Telemedicine Pilot. The Riverside Community Health Telemedicine pilot is a partnership between Riverside Community Health, Springwell, HESSCO, and Mystic Valley, as well as Riverside’s Geriatric TeleHealth Vendor/Partner-MedOptions Connect. Beth Israel Deaconess Medical Center is the Teaching Hospital Partner in this award.

Each of the three ASAPs will receive funding for one care manager who will become an integral member of the in-home/telemedicine behavioral health team, coordinating and delivering behavioral health services to hard-to-serve elderly with behavioral health needs.

The Riverside Community Care project, called “OlderAdults Aging in Place,” will target 160 home bound elders, and will provide psychiatry, behavioral health diagnosing, consultation, medication management, and problem-solving therapy (PST) delivered to homebound older adults through remote video consultation. This project was awarded \$499,860.

The Brookline Community Mental Health Center’s “Behavior Health Integration” program will serve 1,142 adults with serious chronic medical

condition and a behavioral health comorbidity. The program will provide “a high-touch care management multidisciplinary team within the BIDCO care management structure integrating behavioral health, primary care, and community services.” The Brookline project was awarded \$418,583.”

Advocates Ask Congress For Spousal Asset Limit Change



Mass Home Care has signed onto a letter to members of the Massachusetts Congressional delegation to remedy a provision in the Affordable Care Act that will harm some married couples in Massachusetts who need home and community based services under the Medicaid program. According to the Massachusetts chapter of the National Association of Elder Law Attorneys (MassNAELA), which drafted the letter, MassHealth is interpreting the Affordable Care Act as establishing the amount of \$119,220 as the ceiling for assets that a spouse of a person in a community waiver can keep. This is a problem for Massachusetts community spouses, as MassHealth had not previously considered community spouses assets so there was no limit for them. The groups warn that changing the spousal asset rules will end an incentive for caring for a loved one at home, and result in people being placed in nursing homes sooner.

Here are excerpts from the letter that was sent to

Congress:

Dear Massachusetts Congressional Delegation:

We represent a group of organizations in Massachusetts who advocate on behalf of seniors and people with disabilities to support policies that make it possible for these vulnerable populations to live with independence and dignity in the community.

We are writing to express very serious concerns about a change in the Affordable Care Act (ACA) that will negatively impact seniors and people with disabilities in Massachusetts. The troubling change is the imposition of an asset limit for married individuals seeking eligibility for the Home and Community Based Services (HCBS) waiver programs. This change in the ACA was intended to protect the spouses of disabled individuals or frail elders by allowing them to keep assets of \$119,220, while qualifying for care at home. These “protections” are having the opposite effect in Massachusetts...by creating an asset limit on the spouse of an applicant where none existed before.

The HCBS waiver is a critically important program. It provides the Commonwealth’s low-income and frail elders with the long-term care services and supports they need to remain living safely in their homes. The program is also a tremendous cost savings to the Commonwealth, since the average cost of in-home care is significantly less than a nursing home.

We hope you will consider supporting our efforts to protect access to these home and community-based services for seniors and individuals with disabilities by (1) communicating our serious concerns to the Centers for Medicaid and Medicare (CMS) and (2) co-sponsoring legislation filed by Senator Al Franken and Representative Betty McCollum, S2836/H.R.5036 “Protecting Families with Disabilities Act of 2016”.

Section 2404 of the Affordable Care Act (“ACA”), titled “Protection For Recipients Of Home And Community-Based Services Against Spousal Impoverishment,” amended Section 1924 of the Social Security Act, effective January 1, 2014. As demonstrated by the title of Section 2404 and the enclosed letter of interpretation from CMS dated May 7, 2015, the intent of this amendment was to make sure spouses of individuals in the community receiving long-term care supports under the HCBS waiver were

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not impoverished. Unfortunately, in Massachusetts, CMS' interpretation of this amendment is likely to cause spousal impoverishment.

In Massachusetts, for more than twenty years, the assets of the spouse of an applicant for services under the HCBS waiver have not been counted pursuant to 130 CMR Section 519.007. Disregarding the assets of the spouse altogether is the best form of spousal protection possible. As a result of the CMS letter, however, our Medicaid agency has been required to impose an asset limit on spouses where none existed before. To implement this federal change, MassHealth recently proposed regulations imposing a maximum asset limit of \$119,220 for the spouse of an HCBS applicant...The proposed regulations are expected to go into effect no sooner than October 7, 2016; they will be applied to new applicants and to existing members of HCBS waiver programs who were deemed eligible after January 1, 2014.



In Massachusetts, spouses of nursing home residents must generally spend their assets down to \$119,220, in order to establish MassHealth eligibility for nursing home care. This change in the ACA now requires spouses of applicants for HCBS waiver services to also spend their assets down to the same limit. Applying the same asset limits to the spouses of those receiving care at home that are currently applied to the spouses of nursing home residents removes the financial incentive to keep an elder at home.

The HCBS waiver programs were designed to encourage elders to receive care at home rather than

seek nursing home placement. The support services provided under the HCBS include home care aides, personal care services, skilled nursing, housekeeping, laundry, companion services, meal delivery, grocery shopping and transportation. Although the services provide significant long-term care services and supports to keep the elder living at home safely, there is still an enormous financial strain on the family. The cost of living in Massachusetts is extremely high and continues to rise rapidly while the couple's income generally remains fixed. Inevitably, the spouse and other family members must still spend substantial assets to pay for housing, living expenses, food, utilities, and care not covered by MassHealth.

If coverage under the HCBS waiver does not begin until a married couple's assets are at \$119,220, the amount of time the applicant will be able to stay at home will be reduced significantly because there will not be enough funds to cover the couple's living expenses and care not covered by MassHealth. This will force individuals into a nursing home sooner.

Once couples have to meet the same spousal asset limit for care at home as they do for MassHealth coverage in a nursing home, they may decide it is simply not worth the added work, stress and financial risk of caring for a spouse at home. The healthy spouse will be better protected by placing his or spouse in a nursing home, and retaining the full community spousal resource allowance of \$119,220 for him or herself. In other words, imposition of an asset limit on married HCBS waiver applicants will remove the current incentive to care for a spouse at home and avoid nursing home placement. In short, more frail elders and individuals with disabilities will seek nursing home placement at greater expense to the Commonwealth...

Senator Al Franken along with the Minnesota delegation in Congress, has filed S2836 and H.R.5036 to amend this particular section of the ACA to ensure that in states where the section will harm frail populations, the rule will not be applied. Since Massachusetts will also be negatively impacted, we wish to wholeheartedly support this legislation.

Massachusetts appears to have been one of the few states in the country to realize that better care could be provided at home than in a nursing home

at lower cost to the State. To encourage families to care for a frail elder or disabled individual at home, Massachusetts' HCBS waiver allowed a frail elder or disabled individual otherwise in need of nursing home care to qualify for care at home without regard to the spouse's assets. Where the majority of states required assets of the spouse to be spent down to qualify for HCBS waivers, Massachusetts did not.

Since the change in the ACA was meant to prevent spousal impoverishment, CMS could have interpreted Section 2404 of the ACA to allow spouses to keep a minimum spousal allowance of \$119,220; instead CMS has interpreted the law to require that the spouse's assets be limited to a maximum of \$119,220. This interpretation will encourage the institutionalization of frail elders and disabled individuals thereby increasing the costs of the Medicaid program. We therefore ask you to communicate directly with CMS to request that it interpret the spousal allowance required in Section 2404 to be a floor rather than a ceiling, to avoid the devastating outcome of enforcing this section in the Commonwealth.

We also urge you to co-sponsor and advocate on behalf of H.R.5036 and S2836, which will allow States to disregard the income and assets of the individual's spouse in determining the initial and ongoing financial eligibility of an individual for services provided under a home and community-based waiver in place of the spousal impoverishment provisions. This bill will allow Massachusetts and Minnesota to continue policies that have worked well for many years.

We look forward to working with you to ensure the continued accessibility of services to enable frail elders and individuals with disabilities to receive care at home and to maintain Massachusetts as a leader in providing health care for all.

Studies Say Obamacare Making People Healthier

An August 9th article in the *New York Times* says that the Affordable Care Act (ACA) has provided health insurance to some 20 million people---and their health is better as well.

The newspaper cites several recent studies that show that because of the ACA, people have become less likely to have medical debt or to postpone care because of cost. They are also more likely to have a regular doctor and to be getting preventive health services, like vaccines and cancer screenings. A new study, published in early August in *JAMA Internal Medicine*, finds that low-income people in Arkansas and Kentucky, which expanded Medicaid insurance to everyone below a certain income threshold, appear to be healthier than their peers in Texas, which did not expand. The survey found people in Arkansas and Kentucky were nearly 5% more likely than their peers in Texas to say they were in excellent health in 2015. And that difference was bigger than it had been the year before.



OBAMACARE

The survey also found that people in the expansion states were more likely to have a doctor and to have a place to go for care. They were more likely to have their chronic disease treated, and more likely to have received screening for high cholesterol or high blood sugar, markers for heart disease and diabetes. Researchers also concluded that people in Kentucky and Arkansas were less likely to postpone care or avoid taking prescribed drugs because of the cost, and that they were less likely to be struggling with a medical bill.

The article on the ACA's impact can be found here: http://www.nytimes.com/2016/08/09/upshot-obamacare-appears-to-be-making-people-healthier.html?rref=collection%2Fsectioncollection%2Fhealth&action=click&contentCollection=health®ion=stream&module=stream_unit&version=latest&contentPlacement=2&pgtype=sectionfront&_r=0

Many Elders' Health Deteriorates While In A Hospital



A new report from *Kaiser Health News* (KHN) finds that many elderly patients deteriorate mentally or physically in the hospital, even if they recover from the original illness or injury that brought them there. About one-third of patients over 70 years old and more than half of patients over 85 leave the hospital more disabled than when they arrived, research shows.

As a result, many seniors are unable to care for themselves after discharge and need assistance with daily activities such as bathing, dressing or even walking.

"The older you are, the worse the hospital is for you," said **Ken Covinsky**, a physician and researcher at the University of California, San Francisco division of geriatrics. "A lot of the stuff we do in medicine does more harm than good. And sometimes with the care of older people, less is more."

Hospital staff often fail to feed older patients properly, get them out of bed enough or control their pain adequately. Providers frequently restrict their movements by tethering them to beds with oxygen tanks and IV poles. Doctors subject them to unnecessary procedures and prescribe redundant or potentially harmful medications. And caregivers deprive them of sleep by placing them in noisy wards or checking vital signs at all hours of the night.

Interrupted sleep, unappetizing food and days in bed may be merely annoying for younger patients, but they can cause lasting damage to older ones. Elderly

patients are far different than their younger counterparts — so much so that some hospitals are treating some of them in separate medical units.

How hospitals handle the old — and very old — is a pressing problem. Elderly patients are a growing clientele for hospitals, a trend that will only accelerate as baby boomers age. Patients over 65 already make up more than one-third of all discharges, according to the federal government, and nearly 13 million seniors are hospitalized each year. And they stay longer than younger patients.

Many seniors are already suspended precariously between independent living and reliance on others. They are weakened by multiple chronic diseases and medications. One bad hospitalization can tip them over the edge, and they may never recover, said **Melissa Mattison**, chief of the hospital medicine unit at Massachusetts General Hospital.

Yet the unique needs of older patients are not a priority for most hospitals, Covinsky said. Doctors and other hospital staff focus so intensely on treating injuries or acute illnesses — like pneumonia or an exacerbation of heart disease — that they can overlook nearly all other aspects of caring for the patients, he noted.

In addition, hospitals face few consequences if elderly patients become more impaired or less functional during their stays. The federal government penalizes hospitals when patients fall, get preventable infections or return to the hospital within 30 days of their discharge. But hospitals aren't held accountable if patients lose their memories or their ability to walk. As a result, most don't measure those things.

Improving care for older patients requires an investment that hospital administrators are not always willing to make, experts said. Some argue, however, that the investment pays off — not just for older people but for hospitals themselves as well as for a country intent on controlling health care spending. Though research on the financial impact of problematic hospital care for the elderly has been limited, a 2010 report by the Department of Health and Human Services' Office of Inspector General found that more than a quarter of hospitalized Medicare beneficiaries had suffered an "adverse event," or harm as a result of

medical care.

Those events, such as bed sores or oxygen deficiency, cost Medicare about \$4.4 billion annually, according to the report. Physicians who reviewed the incidents determined that 44% could have been prevented.

In addition to outright mistakes, poor or inadequate treatment in hospitals leads to needless medical spending on extended hospital visits, readmissions, in-home caregivers and nursing home care. Nursing home stays cost about \$85,000 a year. And the average hospital stay for an elderly person is \$12,000, according to the Agency for Healthcare Research and Quality.

The full story from KHN can be accessed at: <http://khn.org/news/elderly-hospital-patients-arrive-sick-often-leave-disabled/>

Health Policy Commission Examines Dental Care Needs

In a new policy brief released in mid-August, the state's Health Policy Commission is underscoring the importance of oral health.

"The effects of poor oral health include pain, lost work...poorer nutrition, and sleep disruption," the HPC writes. "Numerous studies have also identified chronic oral infections as a risk factor for heart and lung disease, osteoporosis..and diabetes. Regular dental care not only improves overall health, but research has shown that it decreases medical expenses and hospitalizations for some systemic conditions, such as cerebral vascular disease and rheumatoid arthritis." The HPC notes that most oral health disease is preventable, but millions of Americans go without dental care each year—especially low income people who cannot afford the cost of such care. "Forgoing such routine care often leads to more severe, advanced forms of oral health disease later in life." According to the Centers for Medicare and Medicaid Services, 40% of dental spending was paid out of pocket in 2014, versus 11% of medical spending.

The Affordable Care Act did not solve the problem of dental care for the elderly. The ACA requires Medicaid programs to provide dental benefits for children, but coverage for adults is optional. In many

states, coverage for adult/elder dental care is limited to emergency services, such as tooth extractions.

There is also a shortage of practicing dentists in the Commonwealth, and 39% of dentists in the Baystate are 55 years or older. A third of all dentists says they plan to stop practicing within the next decade.

MassHealth has cutback on access to dental care for poor people. In 2010, MassHealth coverage for adults eliminated root canals, periodontics, crowns and denture coverage. Some of these benefits have been restored, including filling in 2014, and dentures, in 2015. Another problem is lack of dentists who accept Medicaid. Only half of Massachusetts cities and towns have a dentist who accepts MassHealth. In 2014, just 35% of dentists in the state treated a MassHealth patient.

Emergency Departments have become the default dental care centers in Massachusetts. In 2014, the HPC estimates that were 36,060 oral health ED visits that could have been prevented. This represents an unnecessary cost to MassHealth of between \$14.8 and \$36 million. More than a third of these ED visits were made by patients who visited the ED with an oral health need more than once that year. Half of all oral health ED visits were by MassHealth enrollees.

One way to increase access to dental care is to encourage additional dental providers to offer basic dental care. Legislation was filed on Beacon Hill this year to increase the supply of dental providers by creating a new mid-level dental provider (MLDP), such as advance dental hygiene practitioners, or dental therapists. MLDPs perform triage and treat simple cases, freeing up dentist's time to focus on complicated cases, and reducing wait times for dental care. Maine authorized dental therapists in 2014, and Vermont in 2016. 14 other states are now considering similar legislation. But the Massachusetts bill did not pass during the formal session.

The HPC concludes that the barriers to dental care include the lack of access to dentists, the willingness of dentists to accept MassHealth, and the affordability of dental care. "Policy initiatives to address these impediments," the HPC says, "when implemented in accordance with appropriate oversight and training guidelines, may not only avert future expensive ED visits, but also improve patient health and wellbeing."

