The Home Care Alliance of MA welcomes that MassHealth is launching a major initiative to improve health outcomes for MassHealth clients and to make the MassHealth program more sustainable over the long term. We recognize that as part of that initiative, considerable attention will be paid to what, how, to whom and by whom, long term services and supports (LTSS) services are provided in the Commonwealth. We are pleased to offer these comments in the spirit of a shared interest in improving the LTSS “experience” of clients and providers.

Currently, the Commonwealth devotes a significant amount of the state budget to funding LTSS. Progress over the past few years has moved Massachusetts’ spending to a better balance between institutional and community based long term care. The state has taken steps to introduce programs to intervene and prevent a senior’s decline before a nursing home admission becomes all but inevitable. Yet for many, especially those with complex medical and behavioral health needs, programmatic barriers – and information gaps- make it almost impossible for them or their families to choose home based care.

The Patient Protection and Affordable Care Act of 2010 has also provided additional incentives for states to improve their home and community based options and Massachusetts has taken advantage of a number of these, including those who are eligible for both Medicare and Medicaid. Whether the “One Care” demonstration can improve care planning and management for those that have complex care needs and are “dually eligible” or whether the Balancing Incentives Program will have a great impact on access to care - it is simply too soon to tell.

The agencies on whose behalf the HCA presents these comments provide a considerable amount of services to a very high risk population. These agencies believe that it is important to define what LTSS services are and that such a definition must acknowledge that for many clients the needed service package includes both medical and non-medical supports. The question is where and how do such services as maternal child health nursing, psychiatric nursing and therapies fit into the LTSS definition and how can we be assured that the lens through which we look at client need does not skew totally towards non-medical supports?

Home care agencies live in this medical/non-medical world daily. Most of the Medicare-covered medical home care – more than $400 million in services - is provided by our member agencies. These agencies also provide the bulk of Medicaid state plan services – both medical and non-medical, as well as the services included in various state Home and Community Based (HCBS) Services waiver programs,
and the services purchased by ASAPs for those who qualify for the state funded home care program. The agencies that provide these services have come to recognize that their clients require continuity of care, as well as teaching and reinforcement, often over an extended period of time. The care needs can be complex as they are often on long term psychiatric medications, and have or are developing comorbid medical issues such as diabetes, or respiratory and/or cardiac issues. Having a clinical team able to going into the home is a major factor in decreasing their ER use and hospital admissions.

HCA of MA believes that improving the capacity and the experience of LTSS services in MA must begin with major overhaul of our information and referral systems. As referenced in the paragraph above, there are many different federal and state funded LTSS options for citizens of the Commonwealth, each one of which has different income and clinical eligibility criteria. Yet, there is no single site explanation on the MassHealth, Executive Office of Elder Affairs, or AgeInfo websites as to what these programs are, how to qualify for them and what service packages might look like. While less than ideal – this document from Maine at least lists all of the programs, the eligibility criteria, the services and the funding source (state or federal or both) in a single place. http://www.main.gov/dhhs/oads/aging/long-term/documents/comm_opt.pdf

Taking it further and sitting in family member shoes, a search of Age Info is no better. A search for “home Care” within 3 miles of a single Boston zip code (02127) yields about 40 “hits” maybe 5 or 6 of which are actually providers of services – the list includes podiatry offices, at least one hospital (Spaulding), and the state’s Environmental Protection agency. (Searching the site for “Long Term Services and Supports” yields “0” results.) On our own website (www.thinkhomecare.org) the public can search for home based care by geography and type of care need (dementia care, home modification, companion, etc). Surely in this day and age, the state can and must do better than that.

Second, we strongly suggest that care improvement and the provision of community-based services for a growing and more medical complex cohort requires increased attention to funding, to rates and to workforce. MassHealth has failed to provide a rate increase – or even hold a rate hearing on home health rates paid for nursing, therapies and aides services in more than eight years. (ADD >>>>

Despite a lack of rate adequacy, providers of community based LTSS have continued to be subject to multiple costly medical reviews and audits (Third Party Liability/RAC) that add administrative costs and discourage agencies from participating in MassHealth and create an adversarial relationship between MassHealth and home health. In the case of the TPL audits an average of 10-12,000 claims go through three levels of review (36,000 reviews) before a small percentage (less than 10%?) are paid by Medicare’s Administrative Law Judges. This level of review made sense a decade ago, when judges (often erroneously, we believe) were granting a level of coverage in excess of 50%. It makes no sense at present.

Beyond rate adequacy, there is much more that the state can do to support a workforce that will be sufficient to meet the demand for community based LTSS. At the MassHealth level, HCA has been
advocating for coverage for **remote telehealth monitoring** of patients with certain medical conditions. Such monitoring has been proven effective in both avoiding hospital admission and ER visits and has tremendous value as a teaching device to enhance patient self management. We expect that state to soon introduce rules for using such technology for certain chronic conditions and would like to immediately begin working with the state, agencies and vendors on ways to use this technology in other ways, such as to support medication compliance and behavioral health management. HCA would also like to see support from MassHealth and the Baker administration on efforts to modify the Nurse Practice Act to allow home health nurses to operate at the top of their license in terms of delegating in the administration of certain drugs in certain patients. HCA would also request that immediate attention be paid to setting rates that allow for parity across the paraprofessional home care workforce. The rate increase negotiated for PCAs must be introduced into rates for elder services home care program and MassHealth home health aides.

A tremendous amount of care provided by our member home care agencies is managed by the state **Aging Service Access Points**. We support work to advance capacity to handle more complex cases; but see that we need to do more to (WHAT IS THIS COMPLEX CARE TASK FORCE DOING??)

The state’s approach to maximizing access to community based access to LTSS must recognize **private pay or out of pocket spending for in-home support services**. The Alliance of Family Caregivers estimates that somewhere close to 18% of the population identify themselves as family caregivers. Often these families pay out of pocket to supplement their care. Yet, information about the providers of these services or any guidance as to how to access them, what to look for in a provider is virtually absent from EOEA, Age Info, or any ASAP website. In the absence of any licensure standard in MA for these providers, HCA has developed accreditation standards for these providers as well as directories by region. Additionally, HCA of MA has been active in trying to educate families on the risks of using “underground caregivers” instead of agencies – a practice that is also bad for workers (who are uncovered for liability and the state (which fails to collect taxes on those wages).

Finally, the state has asked for feedback on attempts to reorganize MassHealth via more managed care, some sort of **Accountable Care organization models** or the like. The clients who receive long term home health care services pose among the greatest challenge to any ACOs or ACO-like model. They also present a great opportunity for improved care management and cost avoidance. HCA believes that - at a minimum - contracting arrangements will need to ensure that the community-based providers that have history and experience with these populations are part of the ACO arrangement and that savings are not achieved by service and payment rate reductions. The contractors need to be clear about what LTSS providers are in their networks. At present it is almost impossible to find a list of home care or LTSS providers in directories of the insurers contracted for the One Care program. Finally, Masshealth needs to support pilot testing contracting arrangements that allow for care in the home by a broader team. For example: paying per member per month could allow more creativity in services
design. For example: allowing home health agencies to add a community health worker or diabetes educator to the team. (These are services that the current per visit rates do not cover.)

Based on the above, in summary, HCA of MA recommends that MassHealth:

- Develop in a single site and single document consumer friendly explanations of the various state LTSS services
- Overhaul Age Info- most especially the search functions – to be more consumer useful
- Develop a new fee for service rates for MassHealth state plan home health services that are reflective of current costs, that adds enhanced financial incentives for specialty services, such as Psychiatric Nursing and Maternal Child Health and that covers social work
- Implement telehealth, and create a workgroup to evaluate and expand the pilot to include behavioral health, medication prompting and other emerging uses
- Support legislation allowing for nurse delegation of medication in the home
- Support legislation creating a commission to study and make recommendation on state licensure for home care
- Recognize private home care as an important part of the state’s LTSS system by:
  - Including education on private LTSS in all training for Long Term Care Options Counselors and ASAP case managers
  - Putting out a bulletin to ASAP case managers discouraging referrals to “underground: workers
  - Supporting legislative efforts to regulate/license this sector
  - Supporting a family care giver tax credit

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