At Home

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Al Norman, Editor

Senate Health Reform Adds Long Term Support Coordinator

On May 17, 2012, the State Senate adopted an amendment to give the elderly and disabled enrolled in managed care plans access to an independent long term supports and services (LTSS) coordinator. The Senate version is slightly different from the House version of the same concept, but it means that both branches have endorsed the idea that consumers should have someone on their care team who is not owned by the managed care company, who can act as an "agent" for the member.

This provision was made part of the health reform legislation, and would be part of a federal initiative known as the 'Integrated Care Organization' plan that will affect as many as 115,000 low-income consumers between ages 21 and 64. The ICO plan represents $2.5 billion worth of Medicare and Medicaid services.

The Senate LTSS amendment was sponsored by Senate Health Care Finance committee Vice Chairman, Senator **Brian Joyce** (D-Milton), with help from Senate President **Therese Murray** (D-Plymouth), Senate Minority Leader **Bruce Tarr** (R-Gloucester), and Senate Minority Whip **Richard Ross** (R-Wrentham).

According to the Senate language, here is the role of the LTSS Coordinator:

The community care coordinator shall assist

in the development of a long term support and services care plan. The community care coordinator shall: (1) participate in initial and ongoing assessments of the health and functional status of the member, including determining appropriateness for long term care support and services, either in the form of institutional or community-based care plans and related service packages necessary to improve or maintain enrollee health and functional status; (2) arrange and, with the agreement of the member and the care team, coordinate the provision of appropriate institutional and community long term supports and services, including assistance with the activities of daily living and instrumental activities of daily living, housing, home-delivered meals, transportation, and under specific conditions or circumstances established by the ICO or successor organization, authorize a range and amount of community-based services; and

Senator Joyce at the Sharon Council on Aging

(3) monitor the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the member and the care team; and track member satisfaction and the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the member and the care team."

The LTSS Coordinating agency is to be financially independent from the managed care company, to avoid conflicts of interest. The amendment spells out the relationship of the LTSS Coordinator as follows:

"The ICO or successor organization shall not have a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator. Providers of institutional or community based long term services and supports on a compensated basis shall not function as an independent care coordinator, provided however that the secretary may grant a waiver of this restriction upon a finding that public necessity and convenience require such a waiver. An individual who becomes dually eligible after the age of 60 shall receive independent care coordination services pursuant to section 4B of chapter 19 A. For the purposes of this section, an organization compensated to provide only evaluation, assessment, coordination and fiscal intermediary services shall not be considered a provider of long term services and supports.

A few days after this Senate amendment was adopted, an identical amendment was offered into the FY 2013 Senate budget as well, creating a back up vehicle in case the health reform bill did not pass. However, the same amendment in the Senate budget died, because disability groups objected to some parts of the language. The Senate, wanting to steer clear of any controversy, rejected the whole amendment.

At this point, the House will debate its version of the health reform bill, and then the two health reform bills have to be reconciled in Conference Committee.

Health Reform Bill Takes First Step

On May 9, 2012, the Massachusetts Senate released S. 2260, "An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation." Five days earlier, the House released similar legislation, H.4070, the "Health Care Quality Improvement and Cost Reduction Act of 2012." The Chief architect of the Senate bill was Senator **Richard T. Moore** (D-Uxbridge)

In a summary of the Senate bill, lawmakers said the legislation would address "one of

the greatest challenges of our generation: Reducing the growth in health care costs while improving health care quality and patient care."

Here is the health reform bill summary produced by the Senate:

" From 2009 to 2020, health spending is projected to double, outpacing both inflation and growth in the overall economy. The rapid rate of growth squeezes out other spending, for individual households, for businesses, for communities and in the state budget. That is why this effort is essential for our long-term economic competitiveness and for the health of our residents. This comprehensive bill will build on past reforms led by the Senate by:
•Establishing a statewide health care cost growth goal for the health care industry pegged to the growth in the economy. This will result in over $150 billion in savings over the next 15 years.
•Supporting health care professionals in developing innovative payment and care delivery models to reduce cost growth will improving patient care.
•Establishing tools to help health care providers meet these targets through market-based solutions- not through punitive government-imposed restrictions, regulations, or price caps.
•Requiring the state's Medicaid program, the state's employee health care program, and all other state-funded health care programs to transition to new health care payment methodologies by 2014. These payment models incentivize the delivery of high- quality, coordinated, efficient and effective health care.
•Establishing a certification process for "Beacon ACOs" – health care provider systems dedicated to cost growth reduction, quality improvement and patient protection. These Beacon ACOs would receive a contracting preference in state-funded health care programs.
•By not imposing a "one-size fits all" mandate on the private health care marketplace.

The Senate bill also invests in a Healthy Future for the Commonwealth. Current trends indicate that the total financial impact on the state economy from preventable forms of chronic disease will reach $62 billion by the year 2023. This must be addressed in order to meet the long-term health care cost growth goals. This bill:
•Dedicates $100 million over the next 5 years in a historic investment in community-based prevention, public health, and wellness efforts to reduce the rates of costly preventable chronic diseases, such as obesity, diabetes, and asthma.
•Expands an existing wellness incentive program for small businesses offered by the Commonwealth Connector to provide a subsidy of up to 15% of premium costs.
•Requires the Department of Public Health to develop a "model guide" for wellness programs for businesses and to provide stipends to help businesses establish programs that improve health, reduce recidivism, and help control the growth in business health care premium costs.

Senator Richard T. Moore

The Senate bill establishes a Health Care Workforce Transformation Fund to invest in the training, education, and skill development programs necessary to help workers succeed and flourish in the health care system of the future. The legislation increases access to health care services by expanding the role of physician assistants and nurse practitioners to act as primary care providers in order to expand access to cost-effective care. The bill also expands an existing workforce loan forgiveness program to include behavioral and mental health providers.

The Senate bill also requires the development of standard prior authorization forms, which would be available electronically, so that providers would use only one form for all payers, and streamlines data reporting requirements by designating a single agency as the secure data repository for all health care information reported to and collected by the state.

Under the Senate bill, the Attorney General

will monitor trends in the health care market including consolidation in the provider market in order to protect patient access and quality. A process will be created to track price variation among different health care providers over time and establishes a Special Commission to determine and quantify the acceptable and unacceptable factors contributing to price variation among providers.

The Senate bill also reforms medical malpractice laws by reducing unnecessary litigation and malpractice claims costs by creating a 180-day cooling off period while both sides try to negotiate a settlement, and allows providers to offer an apology to a patient.

The new, quasi-public Health Care Quality and Finance Authority will be governed by an 11-person board consisting of state officials, health policy experts, business, consumer, and labor representatives. The Governor, the Auditor, and the Attorney General are all appointing officials and must jointly agree on the appointment of the chair of the board. The powers of the Authority are limited to 2 specific duties: (1)The Authority will establish the annual health care cost growth benchmark. (2) The Authority will support the development, experimentation, and evaluation of market-based "best practices" for care delivery and payment reform models, by: Developing a certification process for "Beacon Accountable Care Organizations." This will be a voluntary certification. The standards for "Beacon ACO" certification will be based on the best practices in the market and shall reflect a high-commitment by the provider organization to reduce cost growth, improve quality, and coordinate care. Provider organizations so certified will be given a preference in the contracting of any state-funded health care programs.

A few days before the Senate health reform bill was unveiled, the House released its own version of the plan. The House health care reform bill, H. 4070, crafted by State Representative **Steve Walsh** (D-Lynn) contains the following provisions regarding the MassHealth program: * the Governor's 2015 Medicaid budget will include a plan for more stable Medicaid rates, and a reserve fund for establish Medicaid rates a year in advance. * On July 1, 2013, Medicaid rates for hospitals and primary care will increase by 2%, only for hospitals making a significant transition to the use of alternative payment methodologies. * Medicaid will develop an accountable care organization and patient-centered medical home innovation project, with bundled and global payments and other innovative payment methods, starting FY 2013.

Rep. Steve Walsh with Paul Crowley, GLSS

* Medicaid will use ACOs and medical homes as much as possible - at least 25% by the beginning of calendar 2013, 50% by the start of 2014, and 80% by the beginning of 2014.. * Remaining Medicaid fee for service will use a shared savings approach, where providers keep some savings for under benchmarks, and are at risk if costs increase above benchmark. * Every Medicaid member will be given a primary care provider.

In addition, the House version contains a section that deals with the role of long term supports and services coordinators as part of the 'Integrated Care Organization" demonstration project (see lead story).

Linda George, President of Mass Home Care, said that codification of the role of an independent "agent" on behalf of the consumer is one of the key provisions of health care reform that is supported by Mass Home Care. "We want consumers to have someone on their team who is independent from the health plan, and who can help push for the long term supports and services that the enrollees want."

The House health reform bill will now be taken up in June, and passage of a final version reconcil-

ing the two reform bills is expected to be completed by the end of the legislative session at the end of July.

Senate Approves Protective Funding

Mass Home Care continued its spring push for additional state funding for two key elderly services line items in the budget known as the 'Enhanced Community Options Program (ECOP) and Protective Services. On May 24th, the ECOP amendment failed, and the protective amendment passed.

Senator **Pat Jehlen** (D-Somerville) filed an amendment to add $1.32 million to the ECOP program. Senator **Katherine Clark** (D-Melrose) filed an amendment to add $621,825 to the protective services program.

Senator Jehlen's ECOP amendment would have added a $1,327,853 increase above the SWMs recommended appropriation for the Enhanced Community Options Program (ECOP) to match the FY 2013 House appropriation for this item. The average ECOP elder costs $10,489 per year, so this funding creates roughly 127 new openings in the ECOP program. That will reduce the current wait list by only 13.6%---but its 127 more people receiving the care they need to stay out of a nursing facility.

In final floor action in the House, the Enhanced Community Options Program (ECOP) was funded at $47.789 million. This is an increase of roughly $2 million (+4.3%) over the FY 2012 appropriation of $45.789 million.

As of May 15th, there were 935 elders on the ECOP wait list. The annual cost of adding these people to the ECOP caseload beginning July 1st for the rest of FY 2013 would be $9.8 million above the FY 2012 funding level of $45.789 million, or a total of $55.6 million. Even with this amendment, the ECOP program based on the recent waiting list would be $7.8 million short.

Jehlen's amendment also would have reduced the basic home care wait list by 127 units, and freed up $406,176. By moving ECOP people out of the home care program, it allows basic home care to avoid putting 127 per month on a waiting list. With no additional appropriation in home care, another 127 elders per month do not have to be wait listed, so some financial pressure on the home care program is relieved. All of these elders on ECOP are eligible for nursing facility care, so this is the right population to target for savings.

Senator Pat Jehlen

Each elder who remains in the ECOP program for a year saves MassHealth $47,976 annually ($58,765 NF cost - $10,789 ECOP cost). Keeping 127 nursing facility eligibles out of nursing homes would save $6 million. Assuming only one-third of these individuals would actually enter a nursing facility and spend down to Medicaid eligibility, this amendment would still produce a net savings of $2 million after home service costs.

The ECOP program, which was combined from two separate accounts in 2003, is targeted exclusively to seniors who are 1) not on MassHealth and 2) are eligible to be in a nursing facility. This is a program that some basic home care program clients will transfer into as their functional capacity declines. As a result, this program is the only alternative to a nursing facility for people who are not yet on MassHealth. The ECOP program is 100% targeted to disabled seniors.

According to the Mass Budget and Policy Center, this program increased in nominal dollars by 18% since 2003, when the appropriation stood at $37.488 million. In inflation adjusted dollars, however, which is a better measure of what this program can buy for seniors, this account has fallen -11%.

In 2009, the ECOP appropriation stood at $48.199 million. Three years later, in FY 2012, the account had fallen -5% (- $2.41 million) because of 9c impoundments that were never restored. In FY 2010, FY 2011, and FY 2012, the ECOP account was frozen. For FY 2013, the House has raised ECOP funding by $2 million over FY 2012 levels---far short of what is needed to avoid significant waiting lists in ECOP for FY 2012.

Based on the FY 2012 appropriation level of $45.789 million (level funded to FY 2011), the ASAPs have a target figure of serving 4,365 elders per month in the ECOP program, or 52,383 units on an annual basis. The unit rate in FY 2012 is $874.12 per month.

As of May 15th, there were 935 seniors on the ECOP wait list, and 689 seniors waiting to get into the basic home care program. Many of these ECOP clients are people who are in the basic home care program---but their increasing disability and impairment have made it necessary to move them into a program with a higher level of care. (The basic home care program only provides around 3 hours of homemaker a week, and is not sufficient for people who are nursing facility level of care.) On average, more than 5 ECOP clients can be kept at home for the cost of one person in a nursing facility. It is clearly a great savings to the Commonwealth to keep these individuals living at home.

Senator **Katherine Clark** was successful in winning her protective services amendment, which added $621,825 to the elder abuse/protective services line item to match the House appropriation for FY 2013.

Protective Services is a line item that is chronically underfunded, because the program incurs expenses which are not covered by the state, and even though abuse reporting is mandatory---funding for those investigations is 'subject to appropriation.'

In FY 2011, the General Court appropriated $16.734 million for protective services--but later that year, the Governor vetoed $1.5 million because federal FMAP funds had not arrived. When the FMAP funds arrived in the fall, the vetoed funds were never restored---even though most elderly line items that lost FMAP funding were made whole. Protective never recovered the vetoed funds.

In FY 2012 the House budget added $1 million to the protective account, and the Senate matched that number. Every day across Massachusetts another 54 reports of elder abuse and neglect are filed. Yet these are only the reports we know about. One recent study from Cornell University's Weill Medical College estimates that for every one report filed—another 24 go unreported.

Because of funding shortfalls in this account, between October of 2010 and March of 2012, the elder protective services programs statewide have been forced to "triage" 3,962 abuse reports without investigating them. This is a form of "report roulette," because any one of these cases could become front page news story.

Senator Katherine Clark

Elder abuse can mean physical violence against our seniors---but it also means financial exploitation by scam artists, mental abuse at the hands of family and caregivers, and cases of self-neglect---such as extreme hoarding. Many of these cases are appalling to investigate---and some are even dangerous.

Elder abuse is far more rampant than previously known. Just since 2008, reports of elder abuse in the Commonwealth have risen 31%. But funding for abuse investigations has risen only 1.6%. In FY 2011, funding for elderly protective services actually fell by -9%.

The protective services program investigates and resolves elder abuse and neglect, and deals with very complex and volatile family situations. The protective services programs, which are housed in designated

Aging Services Access Points (ASAPs) have had to use other funds to cover the structural deficits in line item 9110-1636, because cer-

tain services implicit in this program are not funded by the state, including legal services to handle cases which end up requiring court-involvement..

In 2004, the General Court amended the elder abuse law to include 'self-neglect' cases. By 2009, confirmed cases of self-neglect had risen slightly higher than confirmed cases of abuse by caregivers. Self-neglect cases have become a major driver of increased pressures on the limited protective services funding.

As a direct result of declining funds, reports of elder abuse are now being 'triaged' using a standard 'risk matrix,' which means that some reports are not being investigated.

This is one program where the state can't turn to the federal government for relief---because the problem is just as bad there. Older persons, and younger adults with disabilities, who are victimized by violence, neglect and exploitation, are the only category of crime and abuse victims who receive no dedicated help from the federal government. The National Adult Protective Services Association (NAPSA) has urged Congress to rectify this gross injustice by fully funding the federal Elder Justice Act. But it is not enough for the state to wait for Congress to respond—we must take action ourselves.

Chapter 19A in state law created an elder protective services program as the Commonwealth's only reporting and investigation program for elder abuse and neglect in the community. The protective services statute is "subject to appropriation," and over the years, appropriations have simply not kept up with the dramatic rise in reports of elder abuse and neglect.

When protective services were first created in FY 1984, a total of 1,529 reports were investigated. This year, abuse reports are projected to reach 19,554. Every hour of every day, another 2 reports of abuse are filed in Massachusetts. Because of the 'risk matrix' now in effect, as many as one in five elder abuse reports are not being investigated.

Senator Clark's amendment was critical to the future of this effort to combat violence against elders, and to help reduce the "triaging" of reports that never get fully investigated because of inadequate funding for investigators.

In related Senate budget action, Senator Jehlen also filed an amendment to increase home care purchased services, and Senator Brian Joyce filed an amendment to add roughly $2 million to the home care case management account. Both were rejected.

During floor debate on May 24th, the Senate also pproved a $20 million salary reserve for human services workers, and added $900,000 to the Council on Aging account.

Now budget action will shift to the Joint Conference Committee, which will reconcile differences in the two budget versions. Senate Ways and Means Chairman **Steve Brewer** (D-Barre) told Mass Home Care that "sometimes things work out for the best in the end."

Money Management 's 20th Anniversary

State Treasurer Steve Grossman at MMMP Event

State leaders celebrated the 20th anniversary of the Massachusetts Money Management Program on May 8th, and the dedicated volunteers who help older people keep their household finances together.

More than 200 people from across Massachusetts attended the State House event, including several individuals who have volunteered for the program since its beginning.

The Money Management volunteers meet

on a regular basis with low-income elderly clients who need help managing their finances, whether it's balancing the checkbook, setting a budget or simply making sure the electric bill gets paid on time.

"The Massachusetts Money Management Program's clients are often homebound, disabled, visually impaired or forgetful. Many have no family, relatives or friends to help them manage their finances," said **Cheryl Cannon**, statewide coordinator of the Money Management Program. "Providing help with routine finances could mean the lights stay on, the threat of eviction disappears, and the need to make hard choices between food and medicine is eliminated."

Jointly sponsored by Mass Home Care, the Massachusetts chapter of AARP, and the Executive Office of Elder Affairs, the Massachusetts Money Management Program has provided free services to more than 9,500 Massachusetts residents since it was established 20 years ago.

As keynote speaker at the event, State Treasurer **Steven Grossman** praised the program's trusted volunteers who enable the elderly to remain independent by providing regular help with their finances. "Initiatives such as the Money Management Program make Massachusetts one of the best places for financial literacy to thrive," said Grossman. The Treasurer's office has been working to set up a Financial Literacy Trust Fund, which will help finance efforts like the Money Management Program.

State Senator **Katherine Clark**, a key supporter of Money Management and protective services funding, thanked volunteers for their efforts to keep older people living in their homes. Clark won budget language to increase state funding for the account which pays for Money Management services.

Safe Driver Rules Move Forward

On May 9, 2012, the state's Public Health Council voted unanimously to approve new safe driver regulations that were written six months ago.

The history of these new driver rules goes back to the end of September, 2010, when a new state law (Chapter 155 of the Acts of 2010) took effect that allows certain health care providers and law enforcement officers to file a confidential report with the Registry of Motor Vehicles on any driver who they have reasonable cause to believe "is not physically or medically capable of safely operating a vehicle." The law was prompted by several high profile fatal accidents involving drivers who appeared to lack the capacity to drive safely. The statute also says drivers who have "a cognitive or functional impairment" that will affect their ability to drive safely may also be reported to the RMV. The key word is "may."

During the debate on this bill, some health care providers argued that they should not be required to make these reports to the RMV, with the result that reports "may" be submitted---but are not mandated. But if a doctor or a police officer, for example, report that a driver is impaired, and not able to safely drive a car---as long as that report was made "in good faith"---the reporter is protected from civil lawsuits. The same protection is provided, however, if they do not file a report.

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

Once a report is filed, the RMV, in consultation with medical experts, is required within 30 days to conduct a review to determine if the driver has the capacity to continue driving. The

RMV is empowered to suspend a driver's license if he or she is determined to be unable to safely drive.

After the bill was signed into law by Governor **Deval Patrick**, the RMV had to come up with a set of regulations that define what "cognitive or functional impairments that are likely to affect a person's ability to safely operate a motor vehicle" meant.

On November 9, 2011, the Department of Public Health issued proposed new regulations for Chapter 155, to give health and law enforcement officials their first look at standard definitions. "Cognitive impairment" is defined as "any condition that impairs…attention, alertness, perception, comprehension, judgment, memory, or reasoning that may influence the physical action, reaction time, or other responses to understand and interact with the environment." A "functional impairment" is "any symptom of a disease or medical condition that results in full or partial decrease in any or several sensory or motor functions," which includes "peripheral sensation of the extremities, strength, flexibility, motor planning and coordination." Any cognitive or functional impairment that limits a person's attention, or the ability to understand "the immediate driver context," or to make appropriate decisions while driving, or "visuospatial processing," or impairs their "strength, flexibility, reflexes, sensory perception and physical coordination," is considered a "driving relevant" impairment."

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

On May 3, 2012, the Department of Public Health notified the Public Health Council that the safe driver regulations issued in November of 2011 were essentially unchanged after receiving no public comments on the rules. Three public hearings were held, and no testimony was received from the public. DPH said the proposed regulations will create "a standardized framework for voluntary reporting by health care providers to the RMV of applicants/licensees with driving relevant cognitive or functional impairments." DPH concluded, "Because no testimony was received during the public comment period," the regulations remain the same as they were when first written in November of 2011. Now that the Public Health Council has approved the regulations, they will be filed with the Secretary of State for publication.

Congressional Budget: On "Two Separate Paths"

The U.S. House of Representatives voted on May 10, on budget legislation that would severely cut or repeal several critical programs serving older adults. It would:

• Cut $36 billion from the Supplemental Nutrition Assistance Program (SNAP), or Food Stamps program, severely limiting low-income older adults' access to benefits that help them afford nutritious food.

• Repeal the Social Services Block Grant (SSBG), removing the only consistent source of funding for state Adult Protective Services to help victims of elder abuse or neglect and cutting key resources that expand the availability of Meals on Wheels and congregate meals.

• Repeal the Prevention and Public Health Fund, eliminating funding for evidence-based health promotion and disease prevention programs that help older adults, such as the Chronic Disease Self-Management Program (CDSMP).

This vote is one of many as the budget battle

heats up this year, and these proposals are expected to resurface throughout the debate. The House passed a sweeping measure to replace deep, across-the-board cuts mandated by last year's debt ceiling agreement with targeted reductions to entitlement programs for the poor. Over passionate objections from many Democrats, the bill passed on a 218-199 mostly party-line vote. No Democrats voted for the bill; 16 Republicans voted "no" and one voted "present."

Although the budget proposal lays out the Republican-preferred method of rolling back the sequester, in reality it will become not much more than a campaign talking point. Senate Majority Leader **Harry Reid** (D-Nev.) said he would not take up the measure.

Nonetheless, House Budget Chairman **Paul Ryan** (R-Wis) heralded the measure as a win for fiscal prudence."When we hear the other side talk about no spending cuts but more tax increases, that's just going to slow down job creation," Ryan said on the House floor. "We need to come out of this debt crisis."

The reconciliation process, laid out in Ryan's House-passed budget, instructed six committees to come up with alternate cuts to the sequestration ordered by the debt ceiling deal. Those committees approved largely partisan cuts, which come from mandatory spending accounts. They would cut funding for things such as food stamps, the health care reform law and the Dodd-Frank financial regulation law.

House Minority Leader **Nancy Pelosi** (D-Cal) decried the plan, saying she wished Republicans had worked across the aisle."I wish this was a statement on what we could [work] together on," Pelosi told reporters."Except instead of finding common ground, we find two separate paths."

Disabled Activists Surround HHS Headquarters

In late April, after months of pressure on the U.S.Department of Health and Human Services' (HHS) Medicaid division to release federal regulations for a program known as "Community First Choice (CFC) Option," the national grassroots disability rights group ADAPT stormed the HHS headquarters once again by surrounding its doors.

This time, the protests yielded the long-awaited result—albeit seven months late: **Cindy Mann** Director of the Center for Medicaid and State Operations regulations brings the possibility of much-needed Federal assistance to states struggling with massive Medicaid cuts.

"After almost two years of working to get the CFC Option in the Affordable Care Act and then waiting for the regulations, ADAPT truly is celebrating this moment," said **Bruce Darling** of Rochester ADAPT. "We thank Ms. Mann and **Henry Claypool**, Principal Deputy Administrator of the Administration on Community Living, for working with us to see the regulations come out."

The Community First Choice Option is a provision of the Affordable Care Act that would provide Federal matching dollars, plus an extra six percent, to states that amend their Medicaid state plans to provide home and community based services for people with disabilities who meet a certain level of need, determined by each state.

The completion of the regulations marks a high point in a saga of front line battles between advocates in the states and their respective Medicaid administrators. Most states, faced with the prospect of budget cuts in a time of austerity, have not committed to taking advantage of the CFC Option. Some, like Massachusetts, Illinois and Montana, have held off on final decisions pending release of the CFC regulations. Others, like New York and California, have moved forward with planning for

the CFC Option implementation. In states that have not made such a commitment, Medicaid administrators have met with ferocious grassroots pressure from ADAPT.

HHS itself became the main focus of ADAPT efforts once it was clear that the agency was working on the regulations. The Affordable Care Act provided the deadline of October 1, 2011 for the publication of the CFC rules. Once that date passed, tensions in the disability community ratcheted up as anxiety grew about whether the Administration would hold firm to its commitment to community living and the U.S. Supreme Court's Olmstead decision implementation for people with disabilities. The release of the regulations and the very recent formation of the Administration on Community Living are both viewed by ADAPT as positive developments.

In Massachusetts, the Administration of **Deval Patrick** has indicted that it is interested in exploring the Community First Choice Option, but does not have enough staffing to finalize the plan. The CFC Option and the Balanced Incentive Payments Program (BIPP) are both piece of the Affordable Care Act that Mass Home Care and other advocacy groups have urged the Administration to pursue, with no definitive response.

$105 M In Housing Awards

On May 9, 2012, Lieutenant Governor **Timothy Murray** announced $105 million in affordable housing resources and tax credits to support the construction of 36 housing developments in 28 communities across the Commonwealth. The announcement was made at the Pleasant Street Apartments for veterans in Beverly, which is receiving $2.5 million. According to the Patrick Administration, the projects will build or preserve 2,196 housing units and create an estimated 3,000 construction jobs.

"Creating affordable housing helps to generate jobs, grow local businesses and strengthen our communities," said Governor **Deval Patrick** in a prepared statement. "Government's role is to help people help themselves, and investing in affordable housing will build a better Commonwealth for generations to come."

"Investing in affordable housing for our veterans, elderly residents and low-income families is critical to strengthening our neighborhoods and ending homelessness in the Commonwealth," said Lieutenant Governor Murray, Chair of the Interagency Council on Housing and Homelessness. "By partnering with the state's congressional delegation, we are delivering greater resources and creating significant construction jobs as we increase our stock of affordable housing for families and individuals in Massachusetts."

The $105 million investment includes more than $23 million in federal low-income housing tax credits; $20 million in state low-income housing tax credits and $61 million in state and federal housing program subsidies.

The Coolidge At Sudbury

Of the 2,196 units, 2,062 will be affordable to low and moderate income working families and individuals--including 279 for extremely low-income families and individuals. This funding will support projects across the Commonwealth, including the following six elderly projects:
* Benfield Farms (Carlisle): will create 26 units of elderly housing, 22 units will be reserved for low-income households and five will be reserved for extremely low-income households. It is expected to create 60 jobs.
* Stevens Memorial Senior Housing (Ludlow): will create 28 units of affordable elderly housing. Seven units will be reserved for extremely low-income individuals or households. It is expected to create 50 jobs.
* Paxton Senior Housing (Paxton): will create 50 units of affordable housing for elderly residents, with five units reserved for extremely low-income households. It is expected to create 69 jobs.
* The Coolidge at Sudbury (Sudbury): will create

64 units of affordable housing for elderly residents, with eight units reserved for extremely low-income individuals or households. It is expected to create 88 jobs. * Westhampton Woods Senior Housing Phase II (Westhampton): will create eight units of affordable housing for seniors, with two units reserved for extremely low-income households. It is expected to create 10 jobs. * Simpkins School Residences (Yarmouth): will create 65 units of housing for seniors, with 58 affordable units and seven units reserved for extremely low-income households. It is expected to create 93 jobs.

Caring Across Generations

Ai-Jen Poo

Massachusetts will be the host of a "Care Congress" in Boston on June 16th, as part of a new national campaign, Caring Across Generations. The demand for long-term care and support service workers is projected to nearly double by 2050, and workforce density is already lagging far behind. At the same time, we're faced with one of the most severe economic downturns in decades, with unemployment rates remaining high. Care workers and care consumers have long been active natural allies in the struggle to achieve a working care economy - and now, the heat is on.

Caring Across Generations is a new campaign to transform long-term care that unites seniors, people with disabilities, and care workers. The campaign is introducing federal legislation to create 2 million quality jobs in home care and support services, improve access to care and services, develop career advancement models and a pathway to citizenship for domestic workers, home care workers, and personal attendants, and improve and expand Medicare and Medicaid as part of a solution to affordability challenges for those paying out-of-pocket for care.

Care Councils comprised of diverse stakeholders in the care economy are cropping up across the country to share stories and create a vision about affordable quality care, and a solution to the jobs crisis. A preliminary "messaging bill" is scheduled to be briefed in Washington on May 14th, and the national campaign co-director, **Ai-Jen Poo,** was recently named one of Time Magazine's 100 most influential people of the year. Local partners in the Massachusetts Caring Across Generations campaign include Mass Senior Action, the Boston Center for Independent Living, the Massachusetts Domestic Workers Alliance, and other community groups.

For more information, contact Mary at (617) 524-8778 or email maryh@massjwj.net.

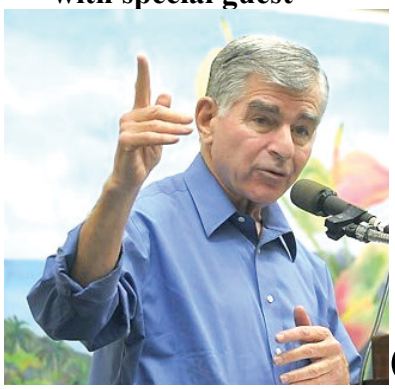
Make Your Reservations Now

"40 Years of Home Care"

Mass Home Care's Annual Meeting

June 18th in Burlington

with special guest



Governor Michael Dukakis

Reserve now: info@masshomecare.org