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FMAP Moves, Brown Doesn't

In early August, the U.S. Senate revisited the issue of providing extended Medicaid funding to states to help pay for their health programs for the indigent. Earlier attempts to pass an "FMAP" extension failed, when the Senate was unable to muster a 60 vote majority to end a filibuster on the measure.

The 'cloture' vote to end debate finally came in the Senate in early August, but Massachusetts U.S. Senator **Scott Brown** (R-MA) continued to vote against ending the filibuster. As a direct consequence of Congressional gridlock, budget makers in Massachusetts were forced to excise hundreds of millions of dollars in programs that rely on Medicaid funding. Among the line items in the budget that were affected by the loss of Medicaid funding were the home care accounts, and protective services, which suffered a $12 million loss.

In late June, a coalition of human services groups and organized labor formed The Coalition For Massachusetts, which began applying pressure to Senator Brown to change his vote to favor FMAP funding. The Coalition, which includes Mass Home Care,

sent the following letter to Senator Brown in late July: "Dear Senator Brown:

The undersigned organizations represent thousands of Massachusetts residents who are concerned about the economy, job creation, health care, and public services in our state. Together we urge you to pass a jobs bill that includes a six-month extension of the increased federal Medicaid match (FMAP) contained in the American Recovery and Reinvestment Act (ARRA). With state budgets in crisis, hundreds of thousands of public and private sector jobs threatened, and health care for millions of low-income Americans hanging in the balance, Congress must act now.

If the FMAP extension is not passed, Massachusetts will face another $608 million in cuts or new revenue solutions to close a shortfall totaling $2.7 billion. Medicaid is one of state's largest budget items, with low-income families, hospitals and providers depending on reliable federal support, especially during tough economic times. In Massachusetts, critical funding is at stake, including child care funding for 1,750 children, 100 shelter beds for homeless people, the loss of home care services for more than 2,400 senior citizens, along with cuts in health care services and state public safety programs. The Recovery Act's enhanced FMAP provided a funding lifeline that helped to minimize devastating cuts in Medicaid, education, public safety and other public services. Ending it prematurely would be a major setback for our local and national economic recovery.

Investing in our communities and community services is important to our national economy and jobs. Economists project that as many as 900,000 workers in both the private and public sectors could lose their jobs in the next year, including 2,000 education jobs in Massachusetts as states and localities continue to grapple with lower revenues, budget cuts and loss of federal funding. Hospitals and other health care providers that would be directly impacted by a failure to fund FMAP are often the largest employers in communities. Moreover, state and local governments are key employers in rural areas, accounting for 18% of earnings; compared to roughly 10% in urban areas.

The United States Department of Commerce reported that the real Gross Domestic Product (GDP) lost .5% in potential growth in the first quarter of 2010 due to cuts in state and local government spending, a loss of $71.5 billion in growth and jobs. This trend is expected to worsen in the latter part of 2010. Allowing the enhanced FMAP to expire on December 31, 2010 – in the middle of states' current fiscal years – would be devastating to the national economy and to the large majority of states. The six-month extension is vital to the annual budgets of every state, including Massachusetts.

As a state legislator and senator, you had previously advocated for access to health care and education and helped Massachusetts make real gains for its residents. We want to work with you to ensure Massachusetts does not lose ground on the progress it has made, even in these uncertain economic times. We would like to meet with you as soon as possible to discuss how we can work together to protect the Commonwealth and extend FMAP funding. We are available at any time that is convenient to you and will follow up with your office.

Again, all of the undersigned organizations urge you to pass a six-month extension of the enhanced FMAP to protect Massachusetts. Our fragile economic recovery depends upon it."

Among other groups, the letter was signed by Mass Home Care, Mass Senior Action, and the Silver and Golden Advocates of the Massachusetts Legislature.

On the morning of August 4, 2010, the U.S. Senate voted to end the filibuster on FMAP extension funding. This cleared the way for a vote on the FMAP package, which to pass the Senate only need-

ed a simple majority vote. The measure went back to the U.S. House for reconciliation, where it was passed and sent to President Barack Obama for his signature. The enhanced FMAP funding then was sent to the states. More than $14 million in home care funding for the elderly is at stake in this debate.

Congress approved $87 billion in emergency Medicaid funding to help states weather the economic downturn that's squeezed local budgets nationwide. The provision increased Medicaid's Federal Medical Assistance Percentage (FMAP) — which represents Washington's share of the state-federal program — by at least 6.2 percent for all states. That extra funding expires at the end of 2010 — halfway through the budget year of most states, prompting Democrats to push for an extension. The original plan to keep the 6.2 percent increase through June 2011 went nowhere in the face of Senate budget hawks. Instead, Democratic leaders adopted a plan to scale out the extra funding over the six months. The measure that passed on August 4th provides a 3.2 percent FMAP bump for the first quarter of next year, and a 1.2 percent hike in the second quarter.

In breaking the filibuster on a 61-38 vote, Senators **Ben Nelson** (D-Neb), **Susan Collins** (R-Maine) and **Olympia Snow** (R-Maine) joined to vote Aye on the measure---but Senator Scott Brown continued to vote against the funding. Brown earned the nickname “FiliBuster Brown” for his refusal to end the filibuster on FMAP money.

After the FMAP vote, the Coalition for Massachusetts released the following statement to the media:

“We are deeply disappointed in Sen. Brown’s ‘no’ vote on cloture for legislation that would bring more than $400 million in desperately needed federal relief funding to Massachusetts through the Federal Medicaid Assistance Program. Once again, the senator who promised that he’d remember the people of Massachusetts at every roll call has let the people down. Although Sen. Brown did not succeed in his effort to block passage of this crucial federal funding, he still did everything he could to keep this jobs-creating funding from reaching the Bay State. With his cloture vote, he played partisan politics with the lives and livelihoods of thousands of Massachusetts families. Sen. Brown was voting no to everything he promised to stand for when he was elected. He was voting ‘no’ to protecting and creating jobs, ‘no’ to health care for the sick and disabled, ‘no’ to services for seniors and children, and ‘no’ to safer cities and towns. Scott Brown hasn’t been in Washington long, but he’s already forgotten where he came from.

“Sen. Brown voted against the extension of unemployment insurance that would have kept thousands of Massachusetts families going. He has done nothing to further jobs creation legislation. He has blocked financial sector reform—taking huge sums in campaign funding from Wall Street, but forgetting Main Street. Now he’s attempted to block funding that was originally paid to the federal government by Massachusetts taxpayers and that those taxpayers desperately need back.

“We urge Sen. Brown to remember where he came from and the promise he gave to the people of this Commonwealth that jobs would be his first priority.”

In early August, the U.S. House passed the FMAP funding, and President **Barack Obama** signed it within days of passage. According to estimates from the Center on Budget & Policy Priorities, the FMAP money will mean for Massachusetts an additional $506 million in Medicaid funding, plus $204 million in educational funding, for a total of $710 million in new funding. The funding was soon on its way to Massachusetts.

On August 10th, the State House News quoted Senate Ways and Means Chairman **Steven Panagiotakos** (D-Lowell) as saying the FMAP funds were aimed at funding programs in the second half of this

fiscal year and don't need to be spent immediately. "Until we have that conversation with the administration, I would think right now it's more of a wait and see approach," Panagiotakos told the State House News. "It's certainly some great news. We really need the money, and we can certainly put it to use."

As of mid August the home care waiting list had exceeded 3,700 elders. These seniors are the ones who have learned most painfully what 'wait and see' really means.

The Fiscal Fallout In Massachusetts

In late July, the Mass Budget and Policy Center issued a report on budgetary impacts on the Commonwealth's ailing public services network. Here are excerpts from that report, titled FISCAL FALLOUT: The Great Recession, Policy Choices, and State Budget Cuts:

Since the passage of the FY 2009 General Appropriations Act (GAA), state funding for human services has been reduced, despite increased demand for these services as families experience hardships as a result of the fiscal crisis. The FY 2009 GAA provided $3.5 billion in total funding for human services. After accounting for approximately $35 million in information technology transfers to the Executive Office of Health and Human Services, the FY 2010 GAA reduced Human Service appropriations to $3.4 billion. Most recently, the FY 2011 budget reduced state funding even further, to $3.3 billion. Since passage of the FY 2009 GAA, total state funding for human services has been cut by $170 million. When adjusted for inflation, these cuts total close to $269 million, representing a 7 percent reduction. Detailed below are some of the major cuts to human services programs, which include services for children and families, transitional assistance for low-income families, services to the adults with developmental disabilities, and other human services, since FY 2009:

• **Elder Home Care:** $21.7 million cut: Since the beginning of FY 2009, elder home care has been cut by 14 percent, when adjusted for inflation. With this reduced funding, approximately 2,500 fewer frail elders each month are able to receive the community-based long term care services that allow them to stay in their homes. At one point, there was hope that a waiting list for services might be reduced or eliminated. Instead, there are now more than 2,700 elders each month on a waiting list for home care.

• **Elder Protective Services:** $1.5 million cut: The FY 2009 GAA provided $16.2 million for services to protect vulnerable elders from neglect and abuse. In FY 2010, elder protective services were reduced by $1 million through the Governor's 9C cuts, and in the FY 2011 budget funding has been further reduced to $15.3 million. After adjusting for inflation, this is a $1.5 million, or 9 percent, cut since FY 2009. This reduction in funding means that more cases of elder abuse will go uninvestigated and unserved, that more elders are at risk of financial exploitation, and that fewer guardians could be granted to the Commonwealth's most vulnerable elders.

• **Elder Housing Programs:** $1.8 million cut: The FY 2009 GAA provided $3.2 million for elder housing programs, including support for congregate housing. The FY 2011 budget reduces funding to $1.5 million, which includes the elimination of a program for homeless elders (funded at $450,000 in nominal dollars in FY 2009). After adjusting for inflation, this is a $1.8 million, or 55 percent, cut since FY 2009. Councils on Aging: $957,000 cut: The FY 2009 GAA appropriated $8.6 million for councils on aging. These locally-based programs provide a wide variety

of recreational and support services to elders in the community. In the FY 2011 budget, this funding has been reduced to $7.9 million. When adjusted for inflation, councils on aging have been cut by $957,000, or 11 percent, since the beginning of FY 2009.
• **Geriatric Mental Health;** Family Caregivers: Programs eliminated ($225,000 and $250,000 cut): Geriatric mental health services, which received $225,000 in the FY 2009 GAA, and the family caregivers program, which received $250,000 in the FY 2009 GAA, have been completely eliminated in the FY 2011 budget.
• **Cuts to MassHealth (Medicaid) & Health Reform:** The fiscal crisis has led to deep and significant cuts to the Commonwealth's MassHealth and health reform programs. Looking at budget numbers alone, however cannot tell the full story of these cuts, because the state's health care budget has increased during this time due to both enrollment and health care cost increases. Outlined below are among the cuts to MassHealth and other health programs since FY 2009.
• **Elimination Of Adult Restorative Dental Care** In FY 2011: $56.3 million cut: Close to 700,000 adults rely on the MassHealth program for oral health care, including 130,000 elders, and they will no longer receive insurance coverage for such services as fillings. (This is a "gross savings" because it does not take into account that any reduction in Medicaid spending also reduces the amount of federal Medicaid reimbursement revenue the Commonwealth receives.)
• **Reductions In Reimbursement Rates Paid To Providers:** estimated $600 million cut: The mid-year 9C cuts in FY 2009 of more than $235 million focused on cuts to provider reimbursements. Cuts to provider rates in the FY 2010 budget were an estimated $200 million, and an estimated $175 million more is cut in the FY 2011 budget.
• **Reduction In The Number Of Hours For Day Services Provided To Disabled Adults** ("Day Habilitation"): $15.3 million cut: The FY 2011 budget cuts the number of hours available to disabled adults – many of whom are severely cognitively disabled – from six to five a day. The gross spending reduction associated with this cut would be approximately $15.3 million, and the net savings to the Commonwealth would be closer to $6.8 million.
• **A Limit On Who Would Be Eligible For Personal Care Attendant (PCA) Services:** $5.5 million cut: Currently, MassHealth will pay for help for disabled adults who need assistance with activities of daily living (getting in and out of bed, dressing, bathing, etc.), even if those adults need only a few hours of help each day (for example, getting dressed for work in the morning). The FY 2011 budget establishes a "floor" for these services, so that only persons requiring 14 hours of service a week would be eligible for MassHealth coverage for PCA services. This cut is expected to reduce MassHealth costs by $5.5 million, for a net savings of $2.4 million.
• **Prescription Advantage Program:** $26 million cut: Between FY 2009 and FY 2011, $26 million has been cut from the Prescription Advantage program, eliminating some subsidies to low-income elders for prescription drug costs not covered by Medicare Part D.

Other measures taken to control costs or implement savings within the state's health care programs include:
• **Restrictions in the way certain services are provided** (such as the expansion of coordination of care in "appropriate" settings, or the requirement for preauthorization for certain types of medications, with estimated savings of at least $38 million in FY 2010 and an additional estimated $23 million in FY 2011).
• **Assumed savings of a total of $17 million from disease management strategies** ($10 million assumed savings in the original FY 2011 Conference Committee budget proposal, along with an additional $7 million savings assumed in the FY 2011 Post-Veto Budget using more aggressive savings assumptions.) A disease management program could save money by better coordinating care for MassHealth members with certain chronic conditions such as asthma or diabetes. Because of reduced federal reimbursements associated with lowered MassHealth spending, however, the net savings to the Commonwealth of these programs would be less than half of the gross program cost reductions.

Care Transitions Grant

The Massachusetts Executive Office of Elder Affairs, in partnership with Aging and Disability Resource Consortium of the Greater North

Shore (ADRCGNS), Massachusetts Rehabilitation Commission and MassHealth, have submitted a grant for federal funding to implement a project called *Navigating Across Care Settings: Choices for Successful Transitions (NACS)*. Several Mass Home Care member agencies helped write this grant, including North Shore Elder Services and Greater Lynn Senior Services.

The goal of this grant is to provide the Care Transitions Intervention (CTI) to 300 people with congestive heart failure, chronic obstructive pulmonary disease or diabetes. CTI is an evidence-based model that helps keep people being discharged from hospitals from being re-admitted unnecessarily.

The project will expand community partnerships to bolster CTI's effectiveness by connecting participants with peer supports, evidence-based programs and Options Counseling. The goal is to expand capacity to promote healthy, successful care transitions by:
1) strengthening communications around consumer health issues across settings;
2) fostering consumer health self-management;
3) increasing awareness among professionals about care transitions;
4) reducing consumer and caregiver stress; and
5) reducing hospital re-admissions, preventable hospitalizations, and premature nursing facility placements.

NACS will retain six trained CTI coaches, enhance agency partnerships and develop a formal evaluation in order to gauge these outcomes: 1) lower rates of re-hospitalization within 30- and 90-day periods; 2) greater consumer and caregiver satisfaction and awareness regarding choice, supports and control surrounding health routines and regimens; 3) more effective communication between consumers and health providers; 4) more positive feeling among consumers about their health and well being; 5) greater caregiver confidence in problem solving abilities and ability to cope with stress and manage their lives; and 6) integration and awareness of Care Transitions supports into provider practice and referral networks.

NACS is particularly critical for consumers with disabilities who typically experience significant health inequities and disparities, higher incidences of secondary conditions, and greater barriers to care. NACS, which creates a web of best practice transition supports around an evidence-based transition intervention, is designed to provide consumers with skills for effective health selfmanagement; and to strengthen the availability and accessibility of community-based long-term supports. CTI has demonstrated results in promoting consumer health self-management and lower hospital readmission rates.

AoA funding for NACS will significantly expand the numbers of consumers served (to over 300); provide consumers with more support options; more actively engage caregivers and providers; and offer consumers more time in which supports are provided to stabilize transitions.

By dovetailing the CTI coaching component with a broader array of existing consumer support choices, and creating greater availability of those choices, AoA funding will strengthen NACS' capacity to offer a more seamless, more sustained, and ultimately more powerful intervention. Focusing on the partnership between the partners in this grant will broaden present hospital-based collaborations and expand the web of partners, particularly our disability and mental health agencies, committed to successful consumer-centered care transitions.

Grant funding would come from the Affordable Care Act law passed by Congress earlier this year. More than 70 ASAP staff across the state have been trained in the CTI program.

Medication Management Bill Overdoses

On July 28, 2010, the Administration of Governor **Deval Patrick** came out in opposition to legislation that would have helped consumers who need in-home help taking their medications. The bill allows home health aides to administer certain medications, under the supervision of a nurse. Although the Adminsitration withdrew its opposition several days later, the medication administration bill did not pass during the formal legislative session.

Currently, only a nurse can perform these medication-related tasks, which adds considerably to the cost of the service. The Administration's opposition came as a surprise to groups like Mass Home Care, and the Home Care Alliance of Massachusetts, who have been working on the measure for almost two years. Within days after writing the memo, the Administration recanted, and withdrew their opposition to the legislation---but not before their criticism had reached Beacon Hill. The bill, S. 860, sponsored by Senator **Richard T. Moore** (D-Uxbridge), ended up passing in the Senate, but dying in Third Reading in the House---just short of the goal line.

The need for this bill is compelling. In one recent case cited by Mass Home Care, an elderly woman with mild dementia was returning home from cataract surgery, and required by doctor's orders two weeks of eye drops applied three times a day. The woman was unable to do her own eye drops, and needed reminding that the drops were even needed. The cost of bringing in a registered nurse to apply the eye drops was $70 a visit, or more than $2,900 over a two week period. The elder's nephew was able to pay for $2,100 of the bill, but needed help with the $800 balance. The medication administration bill, S. 860, would have cut the cost of this service by more than half.

The memo below, written on July 28th, outlines the objections the Administration had to the bill (*in italics*), and the response to these objections (**in bold**) were prepared by the Home Care Alliance of Massachusetts, a group which represents the home health agencies in the state:

"The Executive Office of Health and Human Services (EOHHS) has significant concerns about the anticipated costs and the lack of enforceability and protections for consumers and home health aides associated with Senate Bill 860, An Act Relative to Home Health Aides. EOHHS has been reviewing options, including certification and delegation, to expand the home health and other direct care workers who can administer medications. However, we have serious concerns with the bill and the following includes comments from the Department of Public Health, Executive Office of Elder Affairs and MassHealth:

- *Cost: Even though this bill does not include any provisions for oversight or enforcement, the Department of Public Health (DPH) estimates that there will be substantial infrastructure costs associated with the necessary regulatory development and ongoing review which is critical for patient protection. At this time, we estimate that it will cost approximately $500,000 to establish the regulations and a review process.*

In addition, there will be a substantial need for new training by the home health agencies for home health aides. The increased costs associated with training and supervision could result in home health agencies requesting additional funds to offset the provider overhead component of their MassHealth payments. There may or may not be offsetting cost reductions because reimbursement rates for home health aides are lower than rates for nurses. More information is needed to estimate the likely impact on MassHealth expenditures."

Home Care Alliance: It is unclear to me where the figure of $500,000 to write regulations comes from, but I think it a bit of a stretch to suggest that Administration cannot afford to craft enabling regulations to support a policy change that the Administration has been supporting – at least on paper (Olmstead Plan) for at least two years. Yes, agencies will train and establish aide competencies – as we are already required to do for all services that aides perform in a delegated model (wound care, suctioning for patients with neuro-muscular diseases, etc.). All of these costs are borne by agencies – or in some cases aides who attend classes in order to seek work in the field. These costs have never and

will not be borne by payors, under this change in scope of practice – MassHealth or otherwise. Even if home care agencies were to "request additional funds" to do these trainings, the Administration does not need to actually budget for these at this time. Consistent and yearly requests for an update in home health aide rates, which continue to be set at 2007 levels, have not been successful, so it would be foolhardy for agencies to assume that there is a possibility of such a request being regarded favorably. In regard to the support that we thought we had from state officials – in all previous briefings on this bill, including the latest to EOEA in June 18th, that tentative support for the bill was predicated on the state's presumption that there would be some corresponding cost savings in Masshealth were this to be enacted. This could be a win-win situation for everyone – the state reduces costs while the industry is allowed to better instruct vulnerable elders how to get their medications correctly.

"• *Enforceability: We are concerned that the bill is unenforceable due, in part, to the lack of licensure or certification requirements for home health agencies. According to this bill, home health agencies will be allowed to establish medication administration programs and employ individuals who will be "accountable for their own actions". Licensure or certification is the standard in the Commonwealth for holding entities or individuals accountable for actions related to medication administration. We believe that there are approximately 430 home health agencies operating in the Commonwealth [NOTE: This number could be higher but we do not have an estimate of how many private agencies are in operation]. Approximately 144 participate in Medicare and have to adhere to Medicare regulations pertaining to certification and oversight. The remaining agencies (at least 286) do not participate in Medicare and therefore, do not have to adhere to any licensure or certification regulations. It is our understanding that no governmental body within the Commonwealth has jurisdiction over home health agencies that do not participate in the Medicare program. This bill does not give us the jurisdiction to require licensure or certification of these non-Medicare agencies and limits the Commonwealth's ability to act as an oversight authority."*

Home Care Alliance: The fact that the state does not license private care home care agencies (NOT HOME HEALTH AS IS STATED ABOVE) is an issue that is separate and distinct from this bill. It is NOT TRUE that no governmental body has jurisdiction of home care agencies. They are registered and licensed by the Division of Occupational Safety. The state has significant authority over a large percentage of the HOME CARE agencies via their activities as ASAP (Aging Service Access Point) contractors. The state has significant authority to oversee HOME HEALTH agencies pursuant to its federal survey role. The state has licensing authority over nurses which is the central licensing authority at issue in this bill, and statutory authority to investigate and enforce activity of paraprofessionals via the home health aide/CNA registry.

Conclusively, the state does have authority – and could strengthen this in the enabling regulations to regulate and enforce compliance with delegation activities.

Side note: we find it somewhat ironic that the Administration is concerned about "enforceability" or oversight of this scope of practice change in agencies that operate in a regulatory framework (see above) when in fact it allows PCAs to administer medications to thousands of consumers with no regulatory framework, no nursing involvement, and no organized delegation, supervision or training. Additionally, the medication tech

programs in DMH homes function in this regard – while servicing an equally or far more vulnerable population - and operate with less nurse involvement and oversight than is envisioned here.

"In addition, SB 860 uses terms "delegation" and "supervision" imprecisely as they relate to nursing activities, thereby contributing to the unenforceability of the bill. Current regulations require that a licensed nurse provide a nursing assessment and allow them to make the final decision regarding whether delegation is appropriate for the specific patient."

Home Care Alliance: It is true that the current regulations permit the nurse to use her/his nursing assessment skills to determine when delegation is appropriate – and this model is one under which home health has always operated, with limited problems. Nurses teach and delegate aides different tasks depending on specific patient diagnoses and needs. Expansion of this same nurse assessment process for administration of medications is precisely the model that is working in other states with specific enabling regulations (which we have already shared with state officials). This would allow the state to establish the parameters of Delegation such as when (in instances where patients' condition is stable and predictable), and how (e.g., with documentation in plan of care of aide competency and training, sign off by the patient/family, frequency or revaluation, etc….)

- *Lack of Protections for Consumers and Home Health Aides: Other states that have allowed similar practice by home health aides to administer medications have a regulatory framework that requires licensure or certification of the home health agency and in some cases the home health aide as well. This bill lacks any protections for our most vulnerable population. Additionally, the only responsibility for home health agencies in the bill is to train patients and families in self-administration and it appears that home health agencies are not liable with regard to non-self-administration. Thus, this bill would not only expose vulnerable consumers to potential harm but also unknowing home health aides to potential loss of their assets and livelihood (i.e., from civil suits). .*

Home Care Alliance: Virtually everything in this paragraph is incorrect. In regard to final statement – "this bill would expose … unknowing home health aides to potential loss of their assets and livelihood" - there is absolutely no data in any states that allowing nurses to delegate medication administration would result in this outcome. Published studies from Washington state totally rebut this; and evidence from New Jersey's RWJ pilot – which was presented at a State House briefing attended by Administration officials on April 26 - also refute this. Historical experience in states like Oregon and Texas do likewise.

"Additionally, the only responsibility for home health agencies in the bill is to train patients and families in self-administration and it appears that home health agencies are not liable with regard to non-self-administration."

Home Care Alliance: Teaching patients and families to administer medications is a central skill of all home health agencies. The point of this language is that that basic function will be unaltered when agencies can also delegate this function to aides.

"it appears that home health agencies are not liable with regard to non-self-administration."

Home Care Alliance: This is a totally untrue statement. You cannot legislate away a patient's right to sue. If there is any liability, it does rest with agencies – precisely why nurses and agencies will exercise extreme discretion and caution in adhering to regulatory framework of delegation. If there are to be patient lawsuits (which has not occurred in states that allow this), they would be directed at agencies who carry liability insurance, not aides.

"This bill lacks any protections for our most vulnerable population."

Home Care Alliance: Of all the claims, this is perhaps the most troubling. Again the state already allows medication administration by unlicensed, unsupervised personal care attendants and seems to actively support expansion of the scope of this program to include "vulnerable" elders. By failing to pass this bill, the state is again stating its preference for institutional care over community care. The decision to stay at home with an acute or chronic illness is the ultimate act of consumer self determination and always car-

ries with it some risk, which is balanced by an appropriate degree of consumer protection. The Administration is essentially saying that because it cannot afford to write enabling regulations – for which there are many existing and successful state models - elders who cannot administer their own medications should continue to have to be institutionalized, which is paternalistic and wrong.

Strengthen Social Security---Don’t Cut It

As Social Security turns 75 years old Aug. 14, the nation's most successful social program likely will be under attack by the federal Budget Deficit Commission, which, by all accounts, is considering benefits cuts and raising the retirement age.

In early August, more than 60 groups announced the creation of a new coalition, *Strengthen Social Security - Don't Cut It.* The group is launching a national mobilization to push back the Commission's assertions, that claim Social Security is a major component of the budget deficit and is on the brink of disaster.

In a press conference at the National Press Club in Washington, D.C., the group outlined plans to build support in Congress to fight benefits cuts and to ask candidates this election to pledge to fight any move to raise the retirement age, and oppose any privatization scheme.

“Social Security belongs to the workers and their families who have worked hard, paid taxes in, and earned its benefits,” the group says. “Social Security did not cause the federal deficit, and its benefits should not be cut to reduce the deficit. The federal government found the money to bail out Wall Street; it must find the money to pay what it owes to Social Security. Today’s and tomorrow’s beneficiaries – children, people with disabilities, widows, widowers, and retired workers – deserve no less.”

Speaking at the press conference, AFL-CIO President **Richard Trumka** said that raising the retirement age is a benefit cut, plain and simple. It is a cut that is unnecessary and one that Americans can ill-afford. He also said it unfairly singles out workers in demanding physical occupations, “workers like my father who spent his life in the mines, and couldn't work another day by the time he qualified for Social Security-and those older workers who may no longer be able to find work due to age discrimination.”

Social Security benefits are the largest source of retirement income for most retirees. For six of 10 seniors, Social Security represents more than half of their income. In addition, nearly one-half of older unmarried women and widows, and one-third of all beneficiaries, have little other than Social Security and rely on its monthly benefit for 90 percent or more of their retirement income.

Terry O'Neill, the president of the National Organization for Women (NOW), told the media, “Social Security is the mainstay for millions of older women. Every year, a major share of the nearly 24 million women age 62 and older who receive benefits are kept out of poverty because of Social Security. Often that monthly Social Security check is their only income.”

A recent Gallup Poll found that Americans oppose raising the retirement age by a two-to-one margin, and, by an even bigger margin, say the best way to strengthen Social Security is to ensure the wealthiest pay their fair share. Under current Social Security rules, workers pay into the Social Security system through a payroll tax on the first $106,000 of their earnings. Earnings above $106,000 are exempt from the Social Secu-

rity payroll tax. That means a lower wage worker pays a higher percentage of their income to Social Security than a wealthy investment broker. The Gallup poll found that the public supports raising the Social Security payroll tax to cover all earnings, by a 67 to 30 percent margin.

Social Security currently has a $2.6 trillion surplus, which is projected to grow to $4.3 trillion by 2023, and is not considered to be part of the government's current deficit problem.

Strengthen Social Security issued the following 7 "common sense" principles:

1. Social Security has a surplus of $2.6 trillion, which it has loaned to the federal government. Social Security did not cause the federal deficit. Its benefits should not be cut to reduce the deficit.
2. Social Security, which has stood the test of time, should not be privatized in whole or in part.
3. Social Security is insurance and should not be means-tested. Because workers pay for it, they should receive it regardless of their income or savings.
4. Social Security is fully funded for more than 25 years; thereafter it has sufficient funds to meet 75 percent of promised benefits. To reassure Americans that Social Security will be there for them, Congress should act in the coming few years outside the context of deficit reduction to close this funding gap by requiring those who are most able to afford it to pay somewhat more.
5. Social Security's retirement age, already scheduled to increase from 65 to 67, should not be raised further. That would be a benefit cut that places the greatest hardship on older Americans who are in physically demanding jobs, or are otherwise unable to find or keep employment.
6. Social Security, whose average benefit is $13,000 in 2010, provides vital protection against the loss of wages as the result of disability, death, or old age. Those benefits should not be reduced, including by changes to the cost of living adjustment or the benefit formula.
7. Social Security's benefits should be increased for those who are most disadvantaged. The benefits, which are very important to virtually all workers and their families, are particularly crucial to those who are disadvantaged.

For more information about this effort to protect Social Security, and prevent benefit cuts go to www.strengthensocialsecurity.org.

Americans With Disabilities Act 20 Years Old

On July 26, 2010, several hundred activists gathered on the Boston Common to mark the 20th. Anniversary of the federal Americans With Disabilities Act (ADA), landmark legislation in the disability rights field which prohibits discrimination against persons with disabilities in employment, public services, public accommodations and communication.

Governor **Deval Patrick** spoke at the ADA event in Boston. "The Americans with Disabilities Act is one of the most significant pieces of civil rights legislation of the 20th century," Patrick said in a prepared statement. "But as long as people with disabilities still face barriers to independence, our work is not done."

Photo Credit: BCIL

According to the Governor's office, the Department of Housing and Community Development has been asked to prepare a plan by October to expand accessible housing opportunities with Local Housing Authorities. Expanding publicly and privately funded accessible and universally designed housing units is a major component of the state's Olmstead plan, because of the importance of housing access to community living for people with disabilities. The state also recently applied to the U.S. Department of Housing and Urban Development for 200 housing vouchers that will be dedicated to people with disabilities.

"We know that housing affordability, like accessibility, is a serious problem, and we are committed to

ensuring that people with disabilities will have the services and supports they need in housing settings across the Commonwealth," said **Jean McGuire**, EOHHS Assistant Secretary for Disability Policies and Programs.

Another crucial arena in public accommodations is accessibility of medical settings. The Governor continued to acknowledge the ADA anniversary with several upcoming events, including receipt of a private industry report on improving employment of people with disabilities; completion of an 18-month effort by the Governor's Long Term Care Financing Advisory Committee; and the launch of the state's captioned telephone and video relay services for people who are deaf and hard of hearing.

The Governor listed "significant disability accomplishments" over his last three years in office, including a landmark appellate case that opened the way to long overdue institutional closures, the launch of new community services for people with brain injuries and the successful transition of over 150 people with mental illness from psychiatric hospitals to the community. No elderly accomplishments were on that list.

"This is a time to celebrate and reflect on the many gains that the disability community has made over the past 20 years," said Massachusetts Rehabilitation Commissioner **Charles Carr.** "There is a full generation of young adults who have grown up with the protections of the ADA, and it is this very generation that must carry the torch for the next 20 years to safeguard our gains and push for further equality."

Nothing in the Governor's prepared statement referred to the elderly disabled, or quoted accomplishments of the Executive Office of Elder Affairs.

One of the seniors who spoke at the event was **Sybil Feldman**. "I am a Boston Center for Independent Living member," she told the crowd. "I will be seventy years old in three months. When I was a child, I wasn't able to go to a regular school. I spent 21 years and two weeks of my life at Fernald. I hated it. I fought to get out on my own and I did, on my own. After I got out, I lived in a group home and I didn't like that either. Now, I live in my own apartment in Brookline Village. I use personal care attendants to stay independent. I use the MBTA because it is accessible now. I ride the Green Line. I have been arrested eight times with ADAPT fighting for our civil rights. The ADA is great! Being on my own is great!"

Mass Home Care was represented at the Aniversary event by **Marian Sabal**, a board member at Boston Senior Home Care. "People with disabilities come in all ages," Sabal said, "and today in Massachusetts---as we celebrate the Americans with Disabilities Act---I regret to tell you that several thousand disabled older adults are unable to get the home care services they need to remain living at home. Their civil rights are being violated as we speak."

EOHHS Secretary JudyAnn Bigby and Marian Sabal
Photo Credit; BSHC

"Four years ago in August, this state passed the Equal Choice law, designed to ensure that Medicaid funds would help disabled adults to live in the most integrated setting possible," Sabal continued. "But where are we today? Just last week the Executive Office of Elder Affairs cut $6.5 million from home care, and lowered the home care caseload to 29,000 elders a month--the lowest point it's been at in 30 years."

"How is it that we can give wealthy banks a hand out, but we can't give poor seniors a hand out of bed?" Sabal asked. "How is it that Wall Street speculators got billions, while seniors with no savings at all cannot get into home care? There will be no 'troubled asset relief program' for the disabled. But I am 'troubled' by the way this state, and this nation, are treating older citizens."

"They say that in Massachusetts, only two populations remain in institutions: prisoners and the

elderly," Sabal concluded. "So as we celebrate the Americans With Disabilities Act, let us keep fighting for the equal choice to live at home, and make a pledge together that we will not stop fighting for the disabled until every person who wants to stay at home has the support and the funding to do so."

Mass Gets Second Chance To Make Money Follow the Person

In July, the federal Center for Medicare and Medicaid Services (CMS) announced $2.25 Billion in Grants to Extend the *Money Follows the Person* Rebalancing Demonstration.

"Americans with disabilities will have more help to live independently and remain in their homes and communities instead of in institutional long-term care facilities, such as nursing homes," CMS said. The new grant encourages states like Massachusetts that are not yet part of the Money Follows the Person Rebalancing (MFP) Demonstration to apply for grant funds.

On a recent conference call, federal officials all but guaranteed states that have not yet applied for these grants, that the government's goal is to have all 20 states get grants. They are even offering planning grants to help states that are short on staffing to write proposals.

With passage of the Affordable Care Act, states now ave a second chance to compete for this federal funding. "The Money Follows the Person Rebalancing Demonstration has been critical to our efforts to deliver on the promise of the Americans with Disabilities Act and expand access to community living services," said U.S. Health and Human Services Secretary **Kathleen Sebelius**.

In a letter sent to Governors, celebrating the 20th anniversary of the Americans with Disabilities Act, Secretary Sebelius encouraged states to take advantage of the numerous community initiatives within the Affordable Care Act, including Money Follows the Person (MFP).

Under the MFP demonstration, states will receive an enhanced Federal Medical Assistance Percentage (FMAP) match for a one-year period for each individual they transition from an institution to a qualified home and community-based program. One of the qualified placements for such individuals would be a home with up to four unrelated people residing. Massachusetts currently has no such program for the elderly, because the Administration shut down Mass Home Care's "Going Home/Back to the Ranch" proposal two and a half years ago, and that program today has not yet been re-started.

States will be able to transition multiple population groups including the elderly, people with intellectual, developmental or physical disabilities, mental illness or those who have a dual diagnosis. The enhanced FMAP funding will then be used by states to expand services and supports. In addition, states receiving a MFP grant award will focus on rebalancing their long-term care systems needs by increasing the use of home and community-based services and decreasing the use of institutional care.

The MFP Rebalancing Demonstration Program was authorized by Congress in section 6071 of the Deficit Reduction Act of 2005 (DRA) and was designed to provide assistance to States to balance their long-term care systems and help Medicaid enrollees transition from institutions to the community. The MFP Demonstration Program reflects a growing consensus that long-term supports must be transformed from being institutionally-based and provider-driven to "person-centered" consumer directed and community-based.

Congress initially authorized up to $1.75 billion in Federal funds through fiscal year (FY) 2011 to: 1) Increase the use of home and community based services (HCBS) and reduce the use of institutionally-based services; 2) Eliminate barriers and mechanisms in State law,

State Medicaid plans, or State budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice; 3) Strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and, 4) Ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS.

In the first round of funding, 29 States and the District of Columbia implemented a MFP Demonstration Program. Elder advocates criticized the Commonwealth for not submitting a proposal in the first funding round. As of December 2009, almost 6,000 individuals across the nation have returned to the community as a result of these demonstrations—none of them in Massachusetts.

On March 30, 2010, President **Barack Obama** signed into law the Affordability Care Act (ACA). The ACA provisions reflect a long-awaited commitment to independence, choice, and dignity for countless Americans who want to live and receive long-term care services in their own homes and communities. Section 2403 of the ACA provides an opportunity for additional States to participate in the MTP. The law amends section 6071 of the DRA to make the following changes:
1. Extends the MFP Demonstration Program through September 30, 2016, and appropriates an additional $450 million for each FY 2012-2016, totaling an additional $2.25 billion. Any remaining MFP appropriation at the end of each FY carries over to subsequent FYs and is available to make grant awards to current and new grantees until FY 2016.
2. Under the Affordable Care Act, individuals that reside in an institution for more than 90 consecutive days are now eligible to participate in the demonstration. Days that an individual was residing in the institution for the sole purpose of receiving short-term rehabilitation services that are reimbursed under Medicare are not counted toward the 90-day required period.

The Executive Office of Health and Human Services has indicated that this time around, Massachusetts will follow the Money Follows the Person initiative. The state must submit a Notice of Intent by August 25th, followed by an applicantion for a Planning Grant by September 7th. A full grant will be due by January 7, 2011. The feds hope to see actual services begin shortly after grants are awarded. The Medicaid agency in Massachusetts must be the applicant agency.

For more background on MFP, go to http://www.cms.gov/CommunityServices/20_MFP.asp.

Universal Voluntary Retirement Accounts

Thousands of workers without retirement savings could benefit from a new state-based mechanism for creating retirement savings outside of the workplace. This new tool is described by the Massachusetts Budget & Policy Center in a report released in July. Here are excerpts from the Universal Voluntary Retirement Account study:

A generation ago, workers could count on being able to participate in a pension plan provided by their employer. In the mid-1970s, almost three-quarters of American workers had plans that guaranteed a certain percentage of their income, providing a secure savings plan to rely on for the future. Upon retirement, workers could be sure that their hard work would pay off and that they would be able to pay for their needs and enjoy a decent quality of life. However, these types of retirement plans, known as “defined benefit” plans, have been on the decline in the decades since, making them increasingly scarce. In fact, by 2007, only about a third of employees had access to defined benefit plans.

As defined benefit plans have declined, an-

other type of retirement plan—"defined contribution" plans—has taken their place. The structure of defined contribution plans is significantly different from defined benefit plans; rather than guaranteeing a portion of the employee's income, these plans require workers to make their own contributions that are then invested in the market. Employers can choose to make contributions toward their employees' plans, but are not obligated to. As of 2003, only 45 % of employees (at firms of more than 100 employees) participated in defined contribution plans with employer contributions. Consequently, the burden of saving and investing is shifted mostly onto the employee, whose investments in their retirement funds are subject to economic fluctuations.

Whether a defined benefit or defined contribution plan, overall 67% of workers still have access to some kind of retirement planning opportunity through their workplace. But this still leaves out a large segment of the workforce that has no access to employer-sponsored retirement plans at all. Many employers do not provide pension plans, leaving workers to plan and save for their retirement on their own. This not only jeopardizes the retirement security of individual workers, but also raises the question of how we, as a society, will care for the elderly who do not have enough resources to provide for their own needs. Currently, people aged 65 and older comprise about 14% of the Commonwealth's population; by 2030, they will comprise 21%. As this population grows, the issue of retirement savings and the financial security of retirees will become essential to the health of our citizens and the state as a whole.

The key to solving this issue will be expanding retirement savings opportunities to those who have been excluded. Establishing a statewide Universal Voluntary Retirement Account (UVRA) program — a state-sponsored retirement system that businesses can easily participate in at low cost—can be a solution. In light of the current state of retirement savings among American workers, UVRA has the potential to expand access to many thousands of workers. Personal savings are usually not sufficient to support even the basic needs of people as they age. A look at how much people save for retirement shows that 40% of retirees have saved less than $10,000 for retirement, and over half of them have saved less than $25,000. This includes savings and investments (including defined contribution plans), but does not include the value of homes or defined benefit plans. Workers who do participate in an employer-sponsored defined contribution plan are three times as likely to report savings of at least $50,000, compared to workers who do not participate.

As a result of low savings, and because many workers are not offered the opportunity to participate in retirement plans offered through employers, more and more people are relying on Social Security as their primary retirement income source. Low-and moderate-income individuals, in particular, rely heavily on Social Security. For those in the lowest-income quintiles, Social Security comprises roughly 80% of retirement income. Though Social Security is a stable source of income, it does not provide enough of an income to support a stable quality of life. For many individuals in the higher-income quintiles, pensions,

earnings, and income from assets comprise a larger share of retirement income, providing a more diversified income source and greater financial stability. Some individuals in these quintiles are still working full- or part-time out of necessity and will move to lower quintiles when they stop working. Pensions comprise 24% of retirement income for individuals in the fourth quintile and 18% for individuals in the fifth quintile.

As of December of 2008, the average annual Social Security benefits in the state was approximately $12,844—between 13% and 54% lower than the amount needed for elderly residents to cover their basic

needs and expenses. However, in addition to a more heavy reliance on Social Security, those with lower and moderate incomes do not have enough in personal savings to significantly increase their retirement income. On average, asset income is only 3.3% and 5% of the retirement income of the individuals in the first and second income quintiles, respectively, translating to an additional $346 to $931 annually—hardly enough to bolster retirement incomes and provide economic security.

It is clear that retirement planning plays an important role in the financial security and quality of life for retired workers, while personal savings and Social Security alone are not enough. Being able to participate in retirement plans is a key component of building up an adequate savings. However, if the plans are not offered through employers, then as the research shows, many workers are excluded from the opportunity to adequately plan for their future.

A Universal Voluntary Retirement Accounts (UVRA) system would be a state-operated retirement plan program, parallel to the state's existing defined contribution program, in which small employers could opt to participate. It would create a pathway for small businesses to provide retirement plans to their employees. In Massachusetts, 17% of the workforce is employed at firms with fewer than 20 employees. Removing barriers such as cost and complexity would provide a simple and low- to no-cost retirement option for small business owners, thus expanding access to retirement savings to thousands of people.

A UVRA program would allow small employers to opt into a larger retirement system that would be administered alongside the state's defined contribution retirement program, referred to as a "deferred compensation" plan. Employees would enroll in the UVRA program through their employers, and employers could elect to make contributions toward their employees' plans. Employers would be relieved of many of the burdens of setting up retirement plans on their own. They would incur some administrative fees; however, because the program would be operated by the state at a large scale, the fees would be much lower than a typical retirement plan. Once an employer has enrolled in the UVRA, the state would design the package of investment options and handle the majority of administrative and legal tasks, including managing individual accounts and investments, as well as maintaining compliance with federal legislation. This way, the burden on employers would be greatly reduced, while the state would take on the bulk of the management and administration of the plans.

An effective UVRA system would help fulfill three broad goals, or principles: coverage, adequacy, and security. In terms of coverage, the UVRA system should provide access broadly, to the largest number of people possible. By casting a wide net, UVRA would make a change in the lives of those who have been excluded from the opportunity to save for retirement. Once access is expanded, however, the system should be adequate, or actually provide workers with a viable means of setting aside money to meet their basic needs and secure a reasonable quality of life for their retirement. Though broader changes would be necessary to have a more meaningful impact and for the retirement system to really achieve adequacy, a UVRA program would be a step toward an adequate retirement system for workers.

Finally, UVRAs should provide a set of secure options for investing retirement funds. In private retirement plans, an individual's contributions to a retirement account are invested in the market. It is typically understood that these investments will grow and yield positive returns over the long term; nevertheless, retirement investments are subject to the ups and downs of the economy and the risk is assumed entirely by the individual. The current economic recession, which caused an average 30% drop in retirement assets, provides a prime example of the potential risks inherent in private retirement plans, such as 401(k) plans. While a UVRA system would not eliminate risk, it should be designed to provide stable options—including both high risk-high-return as well as more secure low-risk-low-return options — and to help workers and employers make educated decisions about their future. Reducing the complexity of the investment options would allow people to better understand both the risks and benefits of their retirement plan.

Using the Commonwealth's existing deferred compensation program for state employees, the state would be able to create a low- to no-cost, straightforward retirement plan option that small businesses could easily opt into. Because the state already administers

and maintains a large public sector pension system of its own, it would be able leverage its size and scale to obtain lower costs from providers. Ideally, the program could be designed to use federal funds to cover start-up costs, thus incurring no cost to the state. If, however, federal funding is not used, the state would incur an initial start-up cost, which would be recouped over time through the plan's fees and individual contributions.

Contributions to UVRA retirement plans should be automatically deducted from workers' paychecks. By making it much easier for employers and employees to establish and contribute to 401K and IRA tax-deferred retirement accounts, UVRA plans would allow employees to take advantage of existing federal tax benefits. For the employee, reducing the amount of income that is taxed lowers their overall tax bill in the year the income is earned. In addition, by contributing to their retirement account, low- and middle-income taxpayers can receive the Saver's Tax Credit of up to $1,000 (or $2,000 for couples). Finally, the money that would have been paid in taxes is instead invested in the retirement account to yield benefits in the long run. This not only reduces the immediate impact but also generates more savings for the future.

The final component of UVAs is to enable workers to keep their retirement accounts if they change employers. It is estimated that the average worker holds about 11 jobs during his or her working life. It is essential to ensure continuity in workers' retirement savings contributions as they move from job to job.

Retirement security will only become more pressing as the Commonwealth's population continues to age. Employer-sponsored retirement plans are a key component of ensuring that workers are able to achieve financial security during their retirement. Without this, people will continue to rely heavily on inadequate and unstable resources, such as Social Security and personal savings—which is not enough to cover even basic needs. Despite the benefits of providing retirement options at the workplace, most small businesses do not offer such plans. Administrative costs and the often convoluted nature of retirement plans prohibit these employers from devoting the financial resources and time needed to establish and maintain plans.

Many states have begun to study the impact and potential of establishing UVRA programs, which provide a viable and cost-effective option for businesses that do not provide retirement plans for their employees—particularly small business, which employ thousands of workers but face the highest barriers in providing plans."

Mass Scores Low on Elder Waiver Enrollment

According to a new report released in early August by the Rockefeller Institute, Massachusetts has the 37th lowest enrollment in community based waivers per 1,000 people, and the 7th highest nursing facility payment per day in the country.

The study, *Medicaid Policy and Long-Term Care Spending: An Interactive View,* was designed to help states in developing new policies to enhance care for elderly and disabled, while limiting costs.

The report found that Massachusetts is one of the most 'generous' states for overall long term care spending, but much of this spending is tied to spending for nursing facilities, and for the developmentally disabled.

States' wide variation in Medicaid spending on long-term care services for their elderly or disabled residents is best explained through an approach that considers multiple factors, including coverage policies, nursing home reimbursement the rates and other variables, according to a new re-

port from the Rockefeller Institute of Government.

The new study applies a measure dubbed the "Long-Term Care Policy Generosity Index," which proved better at explaining variations in states' long-term care spending than individual policy measures analyzed in previous research. The index may assist states in developing new policies to enhance care for the elderly and disabled, while limiting costs. It combines measures such as resident eligibility, nursing home bed capacity, use of waivers to spend Medicaid dollars on home- and community-based care, and nursing home reimbursement rates.

"Individual state policies governing eligibility, rates, or services do not exist in a policy vacuum, but interact with each other in ways that are frequently not obvious, but exert a considerable influence on spending nonetheless," the authors explain in the report. "A given change in a nursing home rate, for example, can vary widely in its impact on total spending, depending on the number of clients covered by the change and the number of nursing home beds for which it can be paid. Expanding a home- and community-based waiver program might be expected either to reduce nursing home and total long-term care spending or to increase total spending depending on the clientele and the services covered by the waiver. Traditional approaches to measuring the effects of state policies on spending typically do not test for these interactions."

The report comes as state officials across the country seek new ways to limit growth in Medicaid costs, a major element in every state budget. Medicaid plays a key role in financing long-term care for the elderly and disabled, supporting care for about two-thirds of nursing facility residents. States' Medicaid long-term care spending varies widely, however. Using the Long-Term Care Policy Generosity Index, New York's long-term care policies were determined to be the most generous in the nation, followed by Connecticut, Minnesota, Massachusetts and Louisiana.

Variations in this measure may have important implications for understanding the differences in states' use of home- and community-based waiver programs, according to the report. These waivers allow states to claim Medicaid reimbursement for services outside institutional settings, some of which may be covered under a state's conventional Medicaid program and some of which are not. Unlike conventional Medicaid, where coverage of a service makes it available to all Medicaid clients, waivers allow services to be limited to a specified population and limited in duration. States such as Wisconsin and Minnesota have both large waiver programs and generous policies overall, while others such as Washington, Oregon and Kansas have large waiver programs but less generous policies overall. "This pattern suggests that Washington, Oregon, and Kansas may have managed their waiver programs with the express intent of using community-based programs as a means of holding down nursing home spending, while Wisconsin and Minnesota may have been more interested in expanding services for elderly residents who are at less risk for institutionalization," the authors note.

In terms of nursing facility rates, the report noted that most of the states that pay high daily nursing home rates are relatively wealthy states in the Northeast and the Midwest, while the bulk of the states that pay lower fees are poorer states in the Southeast. In New England states, Connecticut had the 2nd highest average nursing facility rates at $165 per day; Massachusetts was 7th highest at $141 per day; Rhode Island was 10th highest at $134 per day; Maine 12th at $132 per day; and Vermont 16th at $128 per day. The lowest nursing facility cost per day was Louisiana at $82 per day.

Another metric used in the report was the number of home and community based waiver clients per 1,000 persons as of 2003. For this metric, Massachusetts ranked only 37th in the nation for the total number of waiver enrollees. Two-thirds of the Massachusetts waiver enrollees were developmentally disabled, and one-third were seniors. In terms of total numbers of people in the aged and disabled waiver, Massachusetts' enrollment was weak compared to most states. Oregon, for example, has 10 times as many enrollees in its elderly waiver compared to Massachusetts, per 1,000 people. Vermont and Connecticut have 3 times as many elderly waiver enrollees as Massachusetts; Rhode Island had 2.5 times as many enrollees as Massachusetts, New Hampshire 2 times as many; Maine 1.2 times.

For a full copy of the report, visit www.rockinst.org.

Question 2: Affordable Housing On the Line

This November, Massachusetts voters will decide whether to keep the primary law promoting development of housing affordable to seniors and working families, known as Chapter 40B. The following is a statement prepared by the Vote No on 2 Committee that is working on to defeat this question. Mass Home Care is a member of this coalition:

"Question 2 would repeal the law that has created 80 percent of the affordable housing built in Massachusetts, outside of the major cities, over the last decade. Despite such enormous success, there is an uninformed and reckless attempt to repeal this law on the ballot in November. We cannot let the affordable housing law be taken away from our seniors and working families.

The affordable housing law creates homes, greater equity among communities, and opportunities for working families. Residents in these homes work in health care, education, construction, financial services, retail, human services, and in other occupations critical to our state's workforce. The law has enabled builders to create 58,000 new homes in cities, suburbs, and small towns. The affordable housing law is our most important tool for keeping families in the Commonwealth.

All families should have a choice about where to live. The affordable housing law sets a reasonable goal for each and every city and town to require at least 10 percent of its homes to be affordable. It encourages construction of new homes by providing a comprehensive permit and flexible zoning for developers who build affordable homes. The number of cities and towns above the 10 percent threshold more than doubled from 24 in 1997 to 51 today, with an additional 40 communities above 8 percent.

Massachusetts needs the affordable housing law today more than ever. Home prices and rents remain out of reach for many, and because of the recession many families struggle to get by. There are 12,000 homes in the pipeline that will not be built if the repeal succeeds. This is the worst time to give up jobs, economic activity, and homes for working families and seniors.

The **Vote No on 2 Campaign** has come together to ensure the law is not repealed. We are a grassroots coalition of more than 350 organizations and thousands of individuals committed to protecting this law. Our coalition includes civic, business, religious, and academic leaders as well as senior, environmental, housing, and civil rights groups.

All three major candidates for governor agree we should all vote NO to support this existing law.

For more info or to get involved, go to www.protectaffordablehousing.org, call 617-933-5275 or email info@protectaffordablehousing.org.. And remember in November, Vote "NO on 2" to protect the affordable housing law.

Sisson Receives National Award

The Executive Director of New Bedford-based Coastline Elderly Services, Charlie Sisson*, was honored with a national award on July 20th at a meeting in St. Louis of the National Association of Area Agencies on Aging (n4a). Here are the remarks made at the event presenting Sisson with the n4a 2010 President's Award by* Lynn Kellogg*, current n4a President:*

"One of the honors of being President of n4a is to bestow the n4a President's Award of excellence to

a colleague in the field who helps to advance the mission of n4a. I am proud to announce that this year's recipient is Charles N. Sisson. Let me tell you why.

"Charlie Sisson is Executive Director of Coastline Elderly Services in New Bedford, Massachusetts. Under Charlie's leadership Coastline has been recognized as one of the premier agencies in the state. He has served as President of the Massachusetts Association of Home Cares and Area Agencies on Aging and was instrumental in working with the Massachusetts legislature to create Aging Services Access Points which today are single points of entry for area services and supports. For his efforts Charlie received the "No Care Like Home Care" Award from his peers.

"Beginning in 1998 Charlie was elected to the n4a Board of Directors where his service has continued to this day—with his long tenure concluding tomorrow at the n4a Business Meeting when he will rotate off the Board. During his tenure he has held numerous chairmanships, all offices of the Executive Committee and served as President in 2006-2008.

(L-R) n4a President Lynn Kellogg, Matt Sisson (Charlie's son), Charlie Sisson, and Sandy Markwood, n4a Executive Director.

"Charlie is an outstanding advocate for human rights, believing the network must provide access to services while assuring availability of housing, food and socialization. He is committed, practical and creative. When a lack of affordable housing became an obvious need, Coastline purchased and renovated an old warehouse into 32 units of affordable housing which it continues to manage.

"In his advocacy for access to services he discovered the profound impact of discrimination on LGBT seniors and became a champion of their cause. Likewise, Charlie embraced partnerships with disability advocates well before the term ADRC was known. With his disability partners he produced a CD video to fight discrimination and champion the common causes between aging and disability.

"Beyond the hard work of the Area Agency on Aging and its affiliations—working with Charlie is simply a pleasure. He knows no strangers, cares deeply about people and loves to instill a sense of fun amidst the long hours. And, his infectious love of baseball and the Red Sox has won over many an AAA colleague to the fun of the game. "Please join me in recognizing Charlie Sisson as winner of the 2010 n4a President's Award."

Mass Home Care joins n4a in congratulating Charlie Sisson for this national recognition of his outstanding work with older people.

REGISTER NOW!

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