

# Massachusetts Long-Term Services and Supports: Achieving a New Vision for MassHealth

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## **ABOUT THE MASSACHUSETTS MEDICAID POLICY INSTITUTE**

The Massachusetts Medicaid Policy Institute (MMPI)—a program of the Blue Cross Blue Shield of Massachusetts Foundation—is an independent and nonpartisan source of information and analysis about the Massachusetts Medicaid program, MassHealth. MMPI's mission is to promote the development of effective Medicaid policy solutions through research and policy analysis.

## **ABOUT MANATT HEALTH**

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is a fully integrated, multidisciplinary legal, regulatory, advocacy and strategic business advisory healthcare practice.

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## EXECUTIVE SUMMARY

Long-term services and supports (LTSS) enable hundreds of thousands of people of all ages in Massachusetts to live with independence and dignity in their daily lives, participate in their communities, and increase their overall quality of life. MassHealth, the Commonwealth's Medicaid program, is the largest payer of LTSS, spending \$4.5 billion (including federal Medicaid matching funds) on LTSS in 2015, representing nearly one-third of all MassHealth spending and 12 percent of the state budget. Although the demand for LTSS is projected to skyrocket, few people are aware of the likelihood they will need LTSS in their lifetime and few viable LTSS financing options exist beyond MassHealth.

The increasing demand for LTSS, rising costs, and building pressure on the workforce coupled with a care delivery system that is fragmented and lacks meaningful quality measures creates an LTSS system in Massachusetts that may be providing suboptimal care while simultaneously creating serious budget pressures on the MassHealth program. Additionally, the fragmented LTSS system is difficult to navigate, and may be increasing avoidable hospitalizations and ER visits and replacing much-needed functional supports with more expensive medical interventions. While Massachusetts is widely recognized as a leader among states in health care reform, it is near the middle of the pack on LTSS system transformation.

Massachusetts has a unique opportunity to address these issues and become a bellwether state on LTSS transformation, as state policymakers and stakeholders are coalescing around LTSS reform more than ever before. Not only have stakeholders unanimously identified LTSS reform as one of the top five priorities facing the MassHealth program, but demographic trends predicting increased LTSS demand and spending are also propelling LTSS closer to the center of MassHealth policy debates. State policymakers are incorporating LTSS and LTSS providers into broader discussions about MassHealth payment and care delivery reform, recognizing the interdependencies among medical care, LTSS, behavioral health services, and social support services in promoting health and well-being for some of MassHealth's most vulnerable members.

To become a leader on LTSS reform, Massachusetts must expand on its long-standing Community First policy vision and establish a quality-driven, affordable LTSS purchasing and delivery system strategy. Implementation of the strategy will require a multiyear commitment and should result in a system with the following features:

- **Person-centered.** It identifies and provides the services and supports that people prefer and need in locations of their choosing, is flexible to meet the diverse needs of diverse populations, and includes consumers and their families as integral parts of the care delivery team.
- **Integrated.** It has an infrastructure in which provider systems, funding streams, financial incentives, administrative agencies, regulatory structures, and contractual requirements are aligned such that medical and nonmedical providers share information and work together to coordinate and deliver comprehensive care.
- **Sustainable.** It employs purchasing strategies that encourage and reward high-quality, high-value care that ensures individuals receive the right care in the right place at the right time, thereby helping to support the long-term sustainability of the MassHealth program.
- **Accountable.** It designates entities at both the state agency and the delivery system level to be responsible for administering and managing the care of the LTSS population, actively monitoring provider

and plan performance and quality, and continually engaging stakeholders via transparent and publicly available program and data analyses.

- **Actionable.** It leverages technological solutions to collect real-time outcome, quality, and safety information from providers, in order for the state and consumers to make more informed decisions and appropriately intervene to improve processes, performance, and quality.

The LTSS system of the future likely can be achieved through various models, but the best vehicle is one in which a single entity or network of entities assumes financial responsibility and performance accountability for coordinating and delivering comprehensive care to LTSS populations and is vigorously monitored by the state. Options for such a vehicle could include Medicaid Accountable Care Organizations (ACOs), Senior Care Options (SCO) or One Care plans, consortia of community-based organizations, partnerships among such entities, or a combination of these. Regardless of the vehicle, community-based LTSS providers must be at its core, as they have the expertise needed to serve diverse LTSS populations. Such an entity, particularly one paid through a risk-adjusted global or shared savings payment arrangement and accessing Medicare financing for dually eligible populations, will have more flexibility than providers in the current system to creatively address people’s needs in a person-centered and cost-effective manner and to integrate and coordinate physical health care, behavioral health care and LTSS.

To successfully design, implement, and oversee this transformation, the Commonwealth must designate a senior health and human services official to be responsible and accountable for the LTSS system. It must also invest in hiring highly skilled contract management and analytic staff in order to vigorously monitor integrated care programs and hold them accountable for providing high-quality, effective, and accessible care. In addition, the state must monitor the financial performance of contractors, particularly those taking on financial risk and/or reward, to ensure effective stewardship of state and federal resources and instill a level of confidence that public dollars are being spent wisely.

To achieve this vision and advance its legacy of leadership and innovation, the Commonwealth must address seven fundamental reforms. In some cases, new investments or reallocation of existing resources will be required to achieve more lasting and sustainable improvements.

| REFORM AREA   | POLICY ACTIONS  |
|---|---|
| <b>1. Drive Integration of LTSS at the Provider Level</b> | <ul style="list-style-type: none"> <li>• Expand opportunities for physical health, behavioral health, and LTSS providers to participate in cross-provider education and training in order to enhance communication, understanding, trust, and information exchange across providers.</li> <li>• Align provider and program rules across state agencies and provider systems to minimize duplication, contradictions, and confusion, and standardize access to services to the extent possible.</li> <li>• Continue to invest in LTSS system infrastructure (e.g., capital, health information technology) as part of the state’s Delivery System Reform Incentive Payment (DSRIP) proposal or otherwise.</li> </ul> |

*continued*

| REFORM AREA  | POLICY ACTIONS   |
|--|--|
| <b>2. Assess and Learn from Existing Programs and Data</b>   | <ul style="list-style-type: none"> <li>• Inventory and comprehensively assess the multitude of existing LTSS programs in the Commonwealth to identify which models are worth expanding and which must be improved or eliminated.</li> <li>• Create the administrative infrastructure required to support ongoing data aggregation and analytics by continuing to invest in technology systems and data analytics staff at MassHealth.</li> <li>• Engage stakeholders in the process of continual program improvement by making these evaluations and analyses publicly available.</li> </ul>   |
| <b>3. Identify and Implement Meaningful Quality Measures</b> | <ul style="list-style-type: none"> <li>• Identify and require providers to report on a manageable set of measures that could be instituted uniformly across initiatives (e.g., FFS, managed LTSS, and Medicaid ACOs) in the near term, while simultaneously working with consumers and other stakeholders to develop a comprehensive set of agreed-upon LTSS metrics.</li> <li>• Make existing quality information more readily available to the public through an easily understandable, regularly updated LTSS dashboard.</li> </ul>   |
| <b>4. Improve Access to LTSS</b>                             | <ul style="list-style-type: none"> <li>• Conduct an in-depth assessment of how and when individuals and families currently seek out and receive information regarding LTSS to gain a better understanding of people's experiences with the LTSS system, their familiarity with available service and financing options, and how they currently access care to inform the design of information and referral resources, technological solutions, and education and awareness campaigns.</li> <li>• Fully implement existing options counseling programs in order to ensure that individuals and their families are properly supported when making decisions about where and how they will receive LTSS.</li> <li>• Simplify where and how consumers and their families access LTSS information, including standardizing terminology across agencies and harnessing technology to make accessing information more user-friendly.</li> <li>• Continue to streamline financial and clinical eligibility requirements across agencies and programs to ensure equitable access to all people who need LTSS.</li> </ul> |
| <b>5. Support Informal Caregivers</b>                        | <ul style="list-style-type: none"> <li>• Expand access to respite services for certain populations (e.g., family members who have been providing more than a certain number of hours of informal care per day for over a year).</li> <li>• Allow MassHealth to pay spouses as family caregivers (with appropriate protections to address concerns about fraud and abuse).</li> <li>• Work with public and private employers to provide paid family leave as a benefit.</li> <li>• Increase awareness of and enhance existing tax incentives for family caregivers.</li> <li>• Connect dedicated care coordinators with informal caregivers to help them navigate the system and coordinate appointments and transportation.</li> <li>• Partner with community-based organizations to provide peer support, offer financial or legal education, share best practices, and standardize training of caregivers.</li> </ul>  |
| <b>6. Enhance Direct-Care Workforce Capacity</b>             | <ul style="list-style-type: none"> <li>• Build on the state's commitment to increase wages for personal care attendants to \$15 an hour and set a goal to establish a minimum wage for all direct-service workers in all care settings.</li> <li>• Support or facilitate efforts to professionalize the LTSS workforce, including offering benefits (e.g., health insurance, travel reimbursement, paid time off, sick leave), full-time employment opportunities, and standardized orientation and ongoing skills trainings, while protecting consumers' need for person-centered care.</li> <li>• Construct and communicate a clear career ladder for the direct-care workforce to promote recruitment and retention of workers in this field.</li> </ul>  |
| <b>7. Expand Access to Affordable Housing with Supports</b>  | <ul style="list-style-type: none"> <li>• Implement cross-agency and cross-sector initiatives to craft viable housing solutions, including continuing the efforts of the state's Interagency Council on Housing and Homelessness.</li> <li>• Analyze the nursing home capacity required to meet future demand and assess how nursing homes could be repurposed.</li> <li>• Assess current housing pilots in place throughout the state to determine if there are any sustainable, affordable housing and supportive housing models that could be expanded and replicated.</li> </ul>  |

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## INTRODUCTION

In late 2014, Manatt Health (Manatt) authored a paper titled *The Future of MassHealth: Five Priority Issues for the New Administration* with support from the Massachusetts Medicaid Policy Institute (MMPI), a program of the Blue Cross Blue Shield of Massachusetts Foundation. The paper explored how the incoming governor and administration could strengthen MassHealth, the Commonwealth's Medicaid program and one of its largest health care insurers, and identified comprehensive long-term care reform as one of the highest priority areas to address.<sup>1</sup>

MMPI subsequently engaged Manatt to prepare the current report, which lays out a vision for MassHealth long-term services and supports (LTSS) that is person-centered, integrated, sustainable, accountable, and actionable, and presents options for Massachusetts policymakers to consider when tackling some of the most intractable challenges facing the Commonwealth's LTSS system. Achieving this vision will require reforming the system in seven foundational ways:

- Create an infrastructure that drives integration of LTSS with other services on the care continuum.
- Assess and learn from existing programs and data.
- Identify and implement meaningful quality measures.
- Improve access to LTSS information and services for consumers and their families.
- Increase support for informal caregivers.
- Enhance direct-care workforce capacity.
- Expand access to affordable housing with supports.

The vision and policy areas were identified through the development of a data chart pack and supplemental interviews with consumers, government officials, community and institutional LTSS providers, health plans, and workforce representatives (Appendix A).<sup>2</sup> Manatt developed this paper with the direction and guidance of a small advisory group (Appendix B).

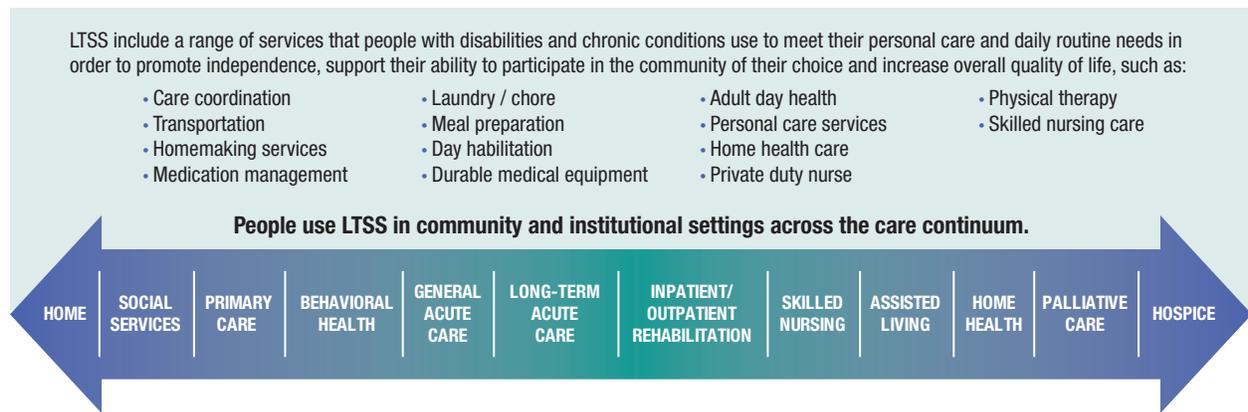
It is important to note that this paper does not include a discussion of LTSS financing options, a significant issue confronting people with low and moderate incomes and assets.<sup>3</sup> Addressing LTSS financing challenges involves other payers and issues beyond those facing just MassHealth, the focus of this paper.

**“Person-centered care”** refers to the delivery of health care and supportive services in a manner that addresses an individual's needs, goals, preferences, cultural traditions, family situation, and values. Person-centered care can improve care and quality of life by its focus on how services are delivered from the perspectives of the individual in need of care and, when appropriate, of the individual's family. Person-centered care both recognizes and supports the role of informal caregivers, who often are critical sources of support for individuals with chronic or disabling conditions.<sup>4</sup>

# THE IMPERATIVE FOR LONG-TERM SERVICES AND SUPPORTS (LTSS) REFORM

LTSS include a range of services and supports, including medication management, personal care services, rehabilitation, and skilled nursing care that elders and people of all ages with disabilities and chronic conditions access in community and institutional settings across the care continuum (Figure 1).

**FIGURE 1: WHAT ARE LONG-TERM SERVICES AND SUPPORTS?**



Source: Long-Term Services & Supports (LTSS): Opportunities for MassHealth Chart Pack

LTSS enable hundreds of thousands of people in Massachusetts to live with independence and dignity in their daily lives, participate in their communities to the fullest extent possible, and increase their overall quality of life. LTSS may also help reduce other health care costs by, for example, preventing or addressing adverse complications from medical conditions, thereby reducing hospital inpatient stays and emergency department use. Data from one of Massachusetts’ Senior Care Options (SCO) plans suggest that SCO enrollees spent 48 percent fewer days in the hospital than comparable dual eligibles in a fee-for-service (FFS) environment.<sup>5</sup>

In many policy and fiscal debates, however, LTSS are often primarily associated with high costs and large line items in state budgets. Indeed, spending on LTSS is reaching unsustainable levels. MassHealth LTSS already account for \$4.5 billion (including federal Medicaid matching funds), or about 12 percent of the state budget, and demand is continuing to grow. National estimates project the rate of spending growth for Medicaid LTSS to be more than three times that of Medicaid overall.<sup>6,7</sup> As LTSS spending continues to grow, spending on other state programs and priorities is being jeopardized. The Massachusetts Health Policy Commission found that government health care spending has increased over 58 percent over the past decade, while spending on all other taxpayer-funded priorities has decreased two percent.<sup>8</sup>

The increasing focus on LTSS is driven in part by the intersection of greater demand, higher costs, and mounting stress on the workforce. It is projected that the number of Americans needing LTSS will reach 27 million in 2050, more than double the number of Americans needing these services in 2010.<sup>9</sup> This explosion in demand is due to both an aging population—the population 65 years old and over is projected to more than double to almost 100 million by 2060, and the population 85 years old and over is projected to more than double to almost 15 million by 2040—and advances in medical research, new treatments, and new technologies that are

helping people live longer with disabilities and other chronic diseases.<sup>11</sup> In fact, individuals 65 years old and over are projected to account for nearly 22 percent of the U.S. population in 2040, up from 14 percent in 2013.<sup>12</sup>

Furthermore, LTSS can be expensive and, because few viable private financing options exist, many consumers incur high-out of pocket costs before spending down their assets to qualify for Medicaid coverage to pay for these services. This situation results in Medicaid assuming the role of default payer of LTSS.<sup>13</sup> Therefore, as demand for LTSS increases, so will Medicaid LTSS spending.<sup>14</sup>

The increasing demand for LTSS also increases the demand for both informal and formal caregivers. Informal caregivers (e.g., family members, friends, neighbors) provide the vast majority of LTSS care and are often unpaid, forced to leave jobs or reduce working hours to provide care, receive little training or other support, and face significant physical, emotional, and financial stress. And direct-care workers (e.g., personal care attendants [PCAs], home health aides [HHAs], and certified nursing assistants [CNAs]) face low wages, high turnover rates, unpredictable hours, and inconsistent training. Demand for these occupations is projected to skyrocket over the next decade—the Bureau of Labor Statistics estimates that over one million PCAs, HHAs, and nursing assistants will be added to the workforce by 2024—yet from 2003 to 2013 the rate of workers leaving direct-care occupations outpaced the rate of those entering.<sup>15,16</sup>

Addressing comprehensive LTSS reform remains a major gap in health and social policy and should command focused attention from policymakers and the public. LTSS are often excluded from major state and federal health care reform efforts because LTSS are viewed as too complex, too politically challenging, or on a separate spectrum from the rest of the clinical care continuum. For example, LTSS providers were left out of the Medicare and Medicaid electronic health record (EHR) meaningful-use program, and the new federal Medicaid managed-care regulations include a focus on LTSS for the first time.<sup>17,18</sup> LTSS also impact a wide range of stakeholders, and reform requires balancing a diverse set of interests and goals (Figure 2), even among people who use LTSS. There also is little transparency in the LTSS system due in part to a lack of agreed-upon quality metrics for both community-based and institutional LTSS. This opacity is caused by many

### How Are LTSS Currently Provided in Massachusetts?

MassHealth is the largest payer of LTSS in Massachusetts, spending about \$4.5 billion (including federal Medicaid matching funds) on LTSS in 2015.<sup>10</sup> MassHealth administers a number of programs that provide LTSS, many of which are operated by other state agencies, including the Department of Developmental Services (DDS), Department of Veterans Services (DVS), Executive Office of Elder Affairs (EOEA), Massachusetts Commission for the Blind (MCB), Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH), Massachusetts Rehabilitation Commission (MRC), Department of Mental Health (DMH), and Department of Public Health/Bureau of Substance Abuse Services (BSAS). These agencies also provide other critical health and social services designed to meet the needs of specific populations with LTSS needs, which are generally financed through state funds and federal grants.

Most of the 250,000 MassHealth beneficiaries who use LTSS receive care in a FFS delivery system, with about 19 percent enrolled in managed LTSS programs (e.g., SCO, PACE, and One Care). MassHealth spending on these services is split similarly, with approximately 80 percent of spending currently occurring on a FFS basis and 20 percent through managed LTSS programs. The state has begun to tighten management of its LTSS system as part of its recent efforts to transform MassHealth's delivery systems and payment models to ensure quality and value. This is evidenced by recent initiatives or proposals to develop Medicaid Accountable Care Organizations (ACOs) that will include people who use LTSS, significantly grow SCO and One Care, increase program integrity initiatives around LTSS starting with home health services, enhance the state's existing nursing home pay-for-performance program, and implement independent assessments of people's LTSS needs (also referred to as "conflict free" assessments). For further detail on how LTSS are provided and administered in Massachusetts, please refer to [Long-Term Services & Supports \(LTSS\): Opportunities for MassHealth Chart Pack](#) and [The Future of MassHealth: Five Priority Issues for the New Administration](#).

**FIGURE 2: LTSS STAKEHOLDERS' KEY INTERESTS AND GOALS**

| STAKEHOLDER                           | EXAMPLES OF INTERESTS AND GOALS   |
|---------------------------------------|---|
| <b>People Who Use LTSS</b>            | <ul style="list-style-type: none"> <li>• Receive quality care that meets individual care goals and preferences.</li> <li>• Remain as independent as possible in their daily lives.</li> <li>• Continue to live in and contribute to their community, to the extent possible.</li> <li>• Maintain or improve their functional status, to the extent possible.</li> <li>• Maintain financial stability and independence.</li> </ul> |
| <b>Government (State and Federal)</b> | <ul style="list-style-type: none"> <li>• Provide person-centered, quality care.</li> <li>• Provide efficient care in a financially sustainable manner.</li> <li>• Ensure the safety of those receiving and providing LTSS.</li> </ul>   |
| <b>Plans</b>                          | <ul style="list-style-type: none"> <li>• Provide care in the lowest-cost, most appropriate setting.</li> <li>• Maintain payment rates that encourage efficiency and only necessary utilization.</li> <li>• Achieve financial sustainability.</li> </ul>   |
| <b>Providers</b>                      | <ul style="list-style-type: none"> <li>• Maintain adequate payment rates to provide person-centered, quality, efficient care.</li> <li>• Achieve financial sustainability.</li> </ul>   |
| <b>Informal Caregivers</b>            | <ul style="list-style-type: none"> <li>• Ensure their loved one is receiving the highest quality care.</li> <li>• Ensure their loved one's safety.</li> <li>• Maintain financial stability.</li> <li>• Continue living their own lives and avoid caregiver “burnout.”</li> </ul>  |
| <b>Direct-Care Workers</b>            | <ul style="list-style-type: none"> <li>• Provide person-centered, quality care that meets individuals' needs.</li> <li>• Maintain adequate and predictable hours.</li> <li>• Feel respected and valued.</li> <li>• Earn commensurate pay.</li> <li>• Ensure personal safety and security (e.g., physical, financial).</li> </ul>  |

factors, including fragmented administrative oversight, provider systems, and payment structures, and makes evaluating the quality of LTSS providers and facilities extremely difficult for consumers.

The increasing demand, rising costs, and building pressure on the workforce coupled with a care delivery system that is disjointed and lacks meaningful quality measures creates an LTSS system that may be providing suboptimal care while simultaneously creating serious budget pressures on state Medicaid programs. Additionally, the fragmented LTSS system is difficult to navigate, and may be increasing avoidable hospitalizations and ER visits and replacing much-needed functional supports with more expensive medical interventions. The system will continue to provide care that is not always efficient or aligned with consumers' needs and goals unless Massachusetts focuses its attention on creating the LTSS system that it wants and needs. The stakes are too high for inaction.

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## WHY FOCUS ON LTSS IN MASSACHUSETTS?

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### **People of all ages use LTSS to live independently in the setting of their choice.**

- Estimates indicate that roughly 750,000 people—or 11% of the non-institutionalized population — report having a disability.
- MA's population is projected to age rapidly, with the rate of growth for those 65+ to increase by 46% in 20 years.



### **LTSS accounts for nearly one-third of all MassHealth spending and is expected to grow.**

- MassHealth is the largest payer of LTSS in MA—with 2015 LTSS spending of \$4.5 billion or 12% of the entire state budget.
- National estimates project the rate of spending growth for Medicaid LTSS to be more than 3 times that of Medicaid overall.



### **MA has expanded access to community LTSS, but there is more to do.**

- MA has aggressively shifted LTSS utilization and spending to the community, but institutional spending has yet to decline accordingly.
- While MA is testing several MassHealth managed care options that include LTSS, most people who use LTSS remain in a fee-for-service system.



### **MA has an opportunity to become a national leader in LTSS.**

- In a national ranking of states on twenty-five LTSS metrics, MA ranked 18th overall.
- MA scored in the 2nd quartile on affordability & access, choice of setting & provider, quality of life & quality of care, and effective transitions, but in the 4th quartile for support for family caregivers.

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Source: University of Massachusetts Medical School, 2013; MassHealth Office of Long-Term Services and Supports, Management Report, 2015; Eiken, S. et al., "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013," Truven Health Analytics, 2015; AARP/SCAN Foundation/Commonwealth Fund Long Term Scorecard, 2014.

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## THE FUTURE OF MASSHEALTH LTSS

Massachusetts is well known as a progressive state in terms of social policy and a leader in health care reform. The Commonwealth is a pioneer in implementing incremental Medicaid expansions, comprehensive coverage models for the uninsured, integrated care models for dual eligibles, and an all-payer quality improvement and cost containment law.<sup>19</sup> Massachusetts has shown that it can tackle complex systemic health care issues with a bold and cohesive vision, practical solutions, and broad stakeholder engagement and support.

Yet Massachusetts is near the middle of the pack on comprehensive LTSS reform, ranking 18th among states according to one national ranking.<sup>20</sup> Despite having a long-standing “Community First” LTSS policy and action plan and significantly advancing some of its objectives—particularly around expanding access to community-based LTSS and transitioning some people from institutional care to community-based settings—Massachusetts faces persistent challenges in its LTSS system that inhibit access to person-centered, high-quality services and supports and threaten the long-term sustainability of the system.<sup>21</sup>

In the past decade, Massachusetts has aggressively focused on shifting care from institutional to community settings. It is estimated that 65 percent of MassHealth LTSS spending in 2015 was on community-based LTSS, up from 43 percent in 2008—making Massachusetts one of the national leaders in rebalancing LTSS.<sup>22</sup>

Massachusetts has a unique opportunity to address these issues and become a bellwether state on LTSS transformation, as state policymakers and stakeholders are coalescing around LTSS reform more than ever before. Not only have stakeholders unanimously identified LTSS reform as one of the top five priorities facing the MassHealth program, but demographic trends predicting increased LTSS demand and spending are also propelling LTSS closer to the center of MassHealth policy debates. State policymakers are incorporating LTSS and LTSS providers into broader discussions about MassHealth payment and care delivery reform as the state advances accountable-care models, recognizing the interdependencies among medical care, LTSS, behavioral health services, and social support services in promoting health and well-being for some of MassHealth’s most vulnerable members. Further, burgeoning costs are forcing state leaders to recognize that LTSS are a major driver of MassHealth spending and to focus attention on LTSS within the context of a comprehensive MassHealth reform strategy for all MassHealth members.<sup>23</sup>

### A VISION FOR MASSHEALTH LTSS

Massachusetts must expand on its Community First policy vision and establish a quality-driven and value-based LTSS purchasing and delivery system strategy. Implementation of the strategy will require a multiyear commitment and should result in a system with the following features:

- **Person-centered.** It identifies and provides the services and supports that people prefer and need in locations of their choosing, is flexible to meet the diverse needs of diverse populations, and includes consumers and their families as integral parts of the care delivery team.
- **Integrated.** It has an infrastructure in which provider systems, funding streams, financial incentives, administrative agencies, regulatory structures, and contractual requirements are aligned such that medical and nonmedical providers share information and work together to coordinate and deliver comprehensive care.

- **Sustainable.** It employs purchasing strategies that encourage and reward high-quality, high-value care that ensures individuals receive the right care in the right place at the right time, thereby helping to support the long-term sustainability of the MassHealth program.
- **Accountable.** It designates entities at both the state agency and the delivery system level to be responsible for administering and managing the care of the LTSS population, actively monitoring provider and plan performance and quality, and continually engaging stakeholders via transparent and publicly available program and data analyses.
- **Actionable.** It leverages technological solutions to collect real-time outcome, quality, and safety information from providers, in order for the state and consumers to make more informed decisions and appropriately intervene to improve processes, performance, and quality.

To achieve this vision and manage rising costs, Massachusetts must change how it does business as a payer for and purchaser of LTSS. The state should start by thoroughly evaluating the current level of state resources in the LTSS system to understand where existing dollars are spent, if dollars can be better allocated, and/or if additional investment is needed in specific areas. To the extent that enhanced LTSS in one area leads to reduced costs elsewhere in the system (e.g., through reduced nursing facility use for dual eligibles or reduced hospital use for non-duals), program savings reinvestment strategies must also be developed.

The LTSS system of the future likely can be achieved through various models, but the best vehicle to accomplish the system goals is one in which a single entity or network of entities assumes financial responsibility and performance accountability for coordinating and delivering comprehensive care to LTSS populations and is vigorously monitored by the state. Options for such a vehicle could include Medicaid ACOs, SCO or One Care plans, and consortia of community-based organizations, partnerships among such entities, or a combination of these. Regardless of the vehicle, community-based LTSS providers should be at its core, as they have the knowledge and expertise needed to serve diverse LTSS populations.

Such an entity, particularly one paid through a risk-adjusted global or shared savings payment arrangement and leveraging Medicare financing for dually eligible populations, will have more flexibility than providers in the current system to creatively integrate and address people's medical and non-medical needs in a person-centered and cost-effective manner. For example, the entity could encourage the use of PCAs in hospitals to avoid having to transfer patients with spinal cord injuries to intensive care units over the weekend when hospital staff is pared down, or it could encourage the use of properly trained PCAs to manage tracheostomies and ventilators to avoid patient stays in higher-cost settings.

The Commonwealth should leverage technological solutions, potentially in conjunction with the state's recently launched Digital Health Initiative, to collect information from providers in as close to real time as possible and report that information in a digestible manner back to the accountable state official and agency.<sup>24</sup> Doing so will allow the state to intervene more quickly and on a much more granular level to reward providers, correct their actions, and/or enforce penalties. The state should also be transparent with its performance monitoring and provide consumers with regularly updated information in a digestible format so that when consumers are eventually faced with making difficult decisions during a stressful time, they can do so in an informed manner.

To successfully design, implement, and oversee this transformation, the Commonwealth must designate a senior health and human services official to be responsible and accountable for the LTSS system. It must also invest in hiring highly skilled contract management and analytic staff in order to vigorously monitor integrated care programs and hold them accountable for providing high-quality, effective, and accessible care. In addi-

tion, the state must monitor the financial performance of contractors, particularly those taking on financial risk and/or reward, to ensure effective stewardship of state and federal resources and instill a level of confidence that public dollars are being spent wisely.

Achieving this vision will require time and strong and focused leadership, but it is something the current administration can make its lasting legacy. It will require cross-agency/secretariat and public-private partnerships to foster innovative solutions, efficient allocation of public resources, and reinvestment of program savings. In order to achieve short-term gains and build momentum, the Commonwealth could focus first on high-need, high-cost LTSS populations who might benefit most from more effective care integration and management, such as individuals in nursing facilities and those with multiple co-occurring chronic and disabling conditions, and stage its implementation of a comprehensive and integrated LTSS purchasing and delivery system reform strategy.

While comprehensive LTSS reform has eluded many states due to the scope, complexity, and sensitivity around LTSS issues, the time is ripe for Massachusetts to apply its Yankee ingenuity to one of the most complex arenas in health care and social policy.

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## FOUNDATIONAL MASSHEALTH LTSS REFORMS

The balance of this report describes reforms that Massachusetts must pursue in order to achieve the long-term vision described above.

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“Today we’re just working on the fringes. The giant prize is in addressing underlying issues of the system—the rest of the pieces can be knit together after.”

— *Consumer advocate*

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### DRIVE INTEGRATION OF LTSS AT THE PROVIDER LEVEL

Like many states across the country, Massachusetts is embarking on initiatives to better coordinate or integrate people’s care needs across the care continuum in an effort to provide high-quality, person-centered, and cost-efficient care. In early 2015, MassHealth specifically identified a goal to “improve integration of physical, behavioral health and LTSS care across the Commonwealth” as one of its top priorities for MassHealth reform.<sup>25</sup> As described earlier, current efforts include initiatives to significantly expand the SCO and One Care programs, which integrate Medicare and MassHealth services for MassHealth members who are eligible for both programs (“dual eligibles”), as well as the development of Medicaid ACOs designed to make a single entity accountable for a person’s total cost of care, with strong financial and/or contractual linkages across providers on the care continuum.

Many MassHealth members with LTSS needs who lack another source of health insurance (e.g., Medicare) are currently enrolled in Medicaid managed care organizations or the Primary Care Clinician (PCC) plan and will be allowed to enroll in Medicaid ACOs. These populations are sometimes called “pre-duals,” because their care needs and patterns often mirror those of dual eligibles, even though they are not yet eligible for Medicare because they have not yet met Medicare’s requirement that they be disabled for 24 months. For these enrollees, ACOs will be required to coordinate with LTSS providers from the outset but will not be accountable for the enrollees’ LTSS costs until at least the second year of the program, after which financial risk will be phased in.

The Commonwealth plans to require ACOs to work with “Certified Community Partners” as a condition of the ACOs receiving infrastructure development funds through a Delivery System Reform Incentive Payment (DSRIP) waiver program.<sup>26</sup> Certified Community Partners, including LTSS providers and other community-based organizations with relevant experience, will lend expertise in managing high-risk member populations to ACOs and will directly receive some DSRIP funding to support start-up costs.

Many people laud the Baker administration for contemplating the role of LTSS in the state’s broader health system reforms and seeking to create an integrated care experience for people with LTSS needs and multiple chronic conditions, who may stand to benefit the most from coordinated or integrated care delivery models. However, some stakeholders assert that in addition to pursuing financial and contractual alignment across providers, the administration should address underlying infrastructure gaps and historical silos that are inhibiting true integration at the provider level. These gaps include:

- Cultural gaps between the medical and nonmedical LTSS provider communities, such as providers not generally being trained to fully understand one another’s practice areas, which inhibits communication, trust, and information exchange across providers.

- Fragmentation and lack of alignment across LTSS provider oversight agencies and regulatory structures, resulting in each agency having its own mission, constituency, and set of provider and program eligibility rules.
- Fragmentation of the LTSS provider system, in which many small providers lack the infrastructure to make capital, health information technology, and other needed investments, which may inhibit their ability to partner effectively with other LTSS, behavioral health, and physical health providers in integrated care models.

Lack of system integration adversely impacts people's care, particularly during care transitions, such as from a hospital to a person's home, when any gap in access to LTSS can be seriously detrimental to an individual's health or even life-threatening. These systemic barriers may also prevent MassHealth from achieving its programmatic and policy goals.

For example, One Care has experienced a high opt-out rate that has likely been due, in part, to a lack of strong engagement, education, and training among hospitals and primary care providers.<sup>27</sup> As of March 2016, nearly 29 percent of the approximately 102,000 individuals eligible for One Care chose to opt out of the program.<sup>28</sup>

Stakeholders urged the state to proceed thoughtfully in crafting or expanding integrated care models for people with LTSS needs by first creating an infrastructure for these care models that supports, rather than impedes, integration at the provider level. Integrating physical health, behavioral health and LTSS providers who have historically operated in separate silos will not be easy, but it is necessary. Education about and respect for one another's areas of expertise, the development of common language and business processes, and an explicit commitment to working differently—that is, collaboratively—are all critical. In order to achieve this type of cultural transformation, shared goals must be developed, roles clearly defined, policies and procedures agreed to, and measures and monitoring processes developed to ensure success.

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“...being able to partner and communicate across providers is extremely useful and that's a place the state could be helpful.”

— *Thought leader*

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### **The Commonwealth should:**

- Expand opportunities for physical health, behavioral health, and LTSS providers to participate in cross-provider education and training, as early in the development of new programs and as frequently as possible. Training and education should promote respect for one another's areas of expertise, focus on developing common language and aligned business processes, and enhance medical providers' awareness of the critical role LTSS providers can play in preventing or treating adverse complications from medical conditions and improving a consumer's functional status and overall health.
- Align provider and program rules across state agencies and provider systems to minimize duplication, contradictions, and confusion, and standardize access to services to the extent possible.<sup>29</sup>
- Continue to invest in LTSS system infrastructure (e.g., capital, health information technology) as part of the state's DSRIP proposal or otherwise. Doing so will enable LTSS providers to make necessary investments in their own care management and service provision capabilities and thus better position LTSS providers to demonstrate value to their partners across the care continuum.

## **ASSESS AND LEARN FROM EXISTING PROGRAMS AND DATA**

Transforming the LTSS system requires a deep understanding of the current state of the system and sound, data-driven strategies for improving it. As part of its reform efforts, MassHealth has identified its intent to “scale innovative approaches for populations receiving long-term services and supports” as a key priority.<sup>30</sup> Massachusetts has a number of innovative public and private LTSS programs and initiatives at the state level and in local communities that have yet to be meaningfully evaluated for quality, cost, or efficacy, or whose evaluation findings have not been used to inform programmatic, financial, and strategic decisions regarding LTSS or MassHealth reform. Examples of programs and initiatives warranting evaluation or more comprehensive, transparent assessment include:

- Care delivery models that expand access to community-based LTSS, such as Massachusetts’ 10 1915(c) home and community-based service waivers.
- Care delivery models that coordinate comprehensive services, such as SCO, One Care, and the Program of All-Inclusive Care for the Elderly (PACE).
- Supportive housing and shared living arrangement models, such as assisted living, adult foster care, and small group homes.
- Workforce development initiatives, such as the Personal and Home Care Aide State Training (PHCAST) program, and past wage increases.

Some programs, such as Money Follows the Person (MFP), have been evaluated at a national level, but these analyses do not focus on the Commonwealth’s specific program, unique features, or outcomes. While SCO has been evaluated periodically since its inception in 2004, most of the analyses are based on consumer and provider satisfaction and experience surveys, rather than quantitative program data, or they focus only on a discrete program impact, such as impact on long-term nursing facility stays.

Massachusetts holds a wealth of LTSS data spanning numerous services, provider types, and state agencies. Stakeholders also suggest the Commonwealth has not comprehensively or cohesively analyzed this data, particularly in conjunction with people’s non-LTSS services, or systematically used the data to evaluate the performance of key vendors or drive strategic and long-term program planning. The data include Medicaid and state-funded demographic, utilization, spending, quality, and trend data at MassHealth, Elder Affairs, and multiple agencies serving people with disabilities, and mostly sit in separate and sometimes outdated data systems. Through Elder Affairs’ Home and Community Based Services (HCBS) Policy Lab and recent MassHealth program integrity efforts to identify key cost drivers in the MassHealth fee-for-service LTSS system, the state is beginning to embrace more robust data analytics and data-driven decision-making around LTSS than it has in the past.<sup>31</sup> However, efforts to date have occurred in isolation, ostensibly with a short-term cost management view, and few of them have been shared with stakeholders.

### **The Commonwealth should:**

- Inventory and comprehensively assess the multitude of existing LTSS programs in the Commonwealth to identify which models are worth expanding. Massachusetts needs to better understand both what is and what is not working in meeting people’s needs and also where system gaps may exist and need to be filled—particularly for people under age 65 with disabilities, as stakeholders suggest that this population’s provider and social support network is more fragmented than the network for seniors. More robust and transparent evaluations of LTSS programs may offer insights into program models or features that have

the greatest impact on people's care quality, outcomes, and costs, and they may identify which models are worth replicating or scaling regionally or statewide and which models must be improved or eliminated.

Specifically, Massachusetts should prioritize a comprehensive and rigorous evaluation of SCO to determine if the program is achieving its expected health-related outcomes, such as impact on hospital and nursing facility utilization, per-member costs, participant and family experience, and end-of-life care quality. An evaluation should also examine variations in SCO performance and determine key drivers in delivering improved outcomes.

- Create an infrastructure to support ongoing data aggregation and analytics by continuing to invest in technology systems and data analytics staff around LTSS. Robust data analytics is critical for day-to-day program planning, monitoring and evaluation of provider and plan performance, and making strategic decisions about the future of the MassHealth program as a whole. As the Commonwealth increasingly transitions to accountable models of care and value-based purchasing across MassHealth's care continuum, more sophisticated and transparent data analytics could provide insights into the highest-value services and programs in the system. Such analyses could enable the state to better assess provider and facility rates and, if necessary, adjust them in a way that drives people and dollars to high-quality, person-centered systems of care and bolsters the long-term sustainability of the program. Collection of data on the functional status of members will also be critical for supporting effective risk-adjusted payment systems envisioned for the new accountable, integrated care models.<sup>32</sup>
- Engage stakeholders in the process of continual program improvement by making evaluations and analyses publicly available.

#### **Examples from the Field: LEVERAGING THE LONG-TERM CARE MINIMUM DATA SET**

The Minimum Data Set (MDS) is a standardized primary screening and assessment tool that serves as the foundation of the comprehensive assessment for all residents in a Medicare- and/or Medicaid-certified long-term care facility. The MDS measures physical, psychological, and psychosocial levels of function. CMS requires that an assessment be completed for each resident upon admission and at least quarterly thereafter. Available data management systems can audit the accuracy of the assessments, adjust for case mix, and produce predictive analytics for each resident (e.g., likelihood of hospitalization, falls, pressure ulcers). Stakeholders believe that for approximately \$2 million, the state could provide every nursing home with a uniform data management system that utilizes the MDS data the institutions are already producing, to provide meaningful performance benchmarks and real-time provider performance and quality data.

For more information, visit <https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/IdentifiableDataFiles/LongTermCareMinimumDataSetMDS.html>.

## **IDENTIFY AND IMPLEMENT MEANINGFUL QUALITY MEASURES**

The challenge to create meaningful, accepted quality measures is pervasive throughout the LTSS system. It remains nearly impossible for laypeople or for LTSS policy experts to discern the quality of a given provider or facility, increasing the stress and confusion experienced by individuals and their families who may be seeking information during a crisis or trying to choose among various LTSS options.

Part of the challenge of creating meaningful measures is that the LTSS care continuum spans many different care settings, provider types, payment structures, and payers. In 2008, CMS implemented the Five-Star

Quality Rating System on its Nursing Home Compare website to report on three main domains of quality (health inspections, staffing, and quality measures) and assist consumers in selecting a nursing home.<sup>33</sup> A recent analysis found that nursing home ratings vary widely within and across states and noted that nursing homes continue to deal with serious quality issues, such as inadequate staffing, high rates of preventable conditions, and fire safety hazards.<sup>34</sup>

CMS expanded the star rating system to home health agencies in July 2015 and added patient experience star ratings to the Home Health Compare website in January 2016.<sup>35</sup> These dual home health star ratings may help consumers, but may also lead to greater confusion. According to one source, 41 percent of patient star ratings are unreliable owing to low response rates, and there are discrepancies between a home health agency's patient star rating and its clinical quality star rating owing to different rating formulas.<sup>36</sup> These measures are a start, but they have yet to be adopted industrywide and the data remain generally unreliable and inconsistent.

Massachusetts has been working for several years to create meaningful LTSS quality measures and incorporate them into new and existing programs, including several of its HCBS waivers, its MFP demonstration, and One Care. To date, however, the Commonwealth still lacks a coherent set of agreed-upon measures, particularly around safety and outcomes. However, the state is making progress toward a solution. The Executive Office of Health and Human Services has convened a number of work groups as part of the ongoing effort to advance broad MassHealth payment and care delivery reforms, one of which is focusing solely on quality measurement.<sup>37</sup> The quality work group is focusing on LTSS measures as part of its work, and a large slate of potential metrics is still being culled.<sup>38</sup>

Stakeholders noted that measures must include clinical and non-clinical measures, be standardized across care settings and provider types to the extent possible, and connect to current efforts in hospital admissions and population health. They also stressed that consumers and caregivers need to be involved in the development of measures and that “quality” should extend to include organizational capacity, incentives, and preparation of the workforce. Stakeholders also pointed out that as the push for mandatory enrollment (i.e., passive enrollment with opt-out arrangements) in managed LTSS programs (i.e., SCO and One Care) increases, so will the imperative for better, more accessible information on the quality of care settings and providers that individuals can access.

### **The Commonwealth should:**

- Identify and require providers to report on a manageable set of measures that could be instituted uniformly across initiatives (e.g., FFS, managed LTSS, and Medicaid ACOs) in the near term, while simultaneously working with consumers and other stakeholders to develop a comprehensive set of agreed-upon LTSS metrics. The market has clearly signaled the need to demonstrate greater value and quality, and therefore the Commonwealth should spur movement in this area by selecting a small and manageable number (i.e., five) of key measures to begin tracking.
- Make existing quality information more readily available to the public through an easily understandable, regularly updated LTSS dashboard. Some states, including Minnesota and California, have created public-

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“Without agreed-upon metrics, we should be uncomfortable merging LTSS into an ACO or provider culture with little to no LTSS experience.”

— *Provider*

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facing quality dashboards that focus on specific pieces of the LTSS system. Massachusetts created an Early Indicators Project (EIP) work group in 2013 to assess perceptions and experiences of One Care enrollees, which planned to develop and publish a quarterly dashboard beginning in 2014.<sup>39</sup> Despite the plan, only one dashboard was published, and it focused solely on enrollment trends.<sup>40</sup> Massachusetts should begin tracking and reporting a number of LTSS-related metrics publicly via a dashboard as a way to increase transparency and awareness. The dashboard should evolve as quality measurement becomes more advanced and/or focused, and it should collect and report information in as near to real time as possible.

## IMPROVE ACCESS TO LTSS

Improving access to LTSS requires action on multiple fronts, including increasing individuals' awareness of the potential need for LTSS in their lifetimes and what services and programs are available if they do need it, as well as encouraging individuals to consider financial options for offsetting some of the cost of care. Improving access also requires making navigation of the system more straightforward and user-friendly, and streamlining program eligibility rules.

“People are living longer and didn’t necessarily need to think about long-term care before. But now that they do, it is still not a big part of the conversation—we jump from middle age to end-of-life care without talking about how we are going plan or pay for LTSS.”

— *Thought leader*

only about half know where to go to access information on long-term care.<sup>41</sup> In Massachusetts, 22 percent of people ages 65 and older are not confident they will be able to pay for their future care, and 11 percent of elders in poorer health report spending all or most of their personal savings to cover large medical bills.<sup>42</sup> Many individuals falsely believe that Medicare will cover LTSS, when in fact it covers only a limited set of benefits for a limited amount of time.<sup>43</sup>

Furthermore, few viable coverage options exist, as private long-term care insurance is often prohibitively expensive and provides limited benefits. In Massachusetts, only 15 percent of those ages 65 and over

Few people adequately plan for, or even think about, LTSS until they need it. Roughly two-thirds of Americans ages 40 and older report doing little to no planning for ongoing living expenses in older years, and

### Examples from the Field: PERFORMANCE DASHBOARDS

#### Cal MediConnect Performance

**Dashboard**—California’s Department of Health Care Services (DHCS) and CMS are working to track performance data related to the state’s duals demonstration program, Cal MediConnect. The dashboard tracks six metrics: health risk assessments, appeals by determination, hospital discharge, emergency utilization, LTSS utilization, and case management. Data are reported to DHCS by the health plans, and the dashboard is updated quarterly.

For more information, visit <http://www.calduals.org/wp-content/uploads/2016/03/CMC-Performance-Dashboard-March-2016-Release.pdf>.

#### Minnesota Department of Human Services Dashboard

—Minnesota’s Department of Human Services (DHS) maintains an interactive dashboard that tracks metrics across four broad categories: people, innovation, equity, and integrity. In addition to displaying the data, each metric includes an overview, and a description of the measure; goal; progress (as indicated by a simple red, yellow, or green symbol); DHS’s role; key strategies, initiatives, or programs affecting the measure; and what outcomes the metric influences. The dashboard includes a number of LTSS-related categories, each with its own set of measures:

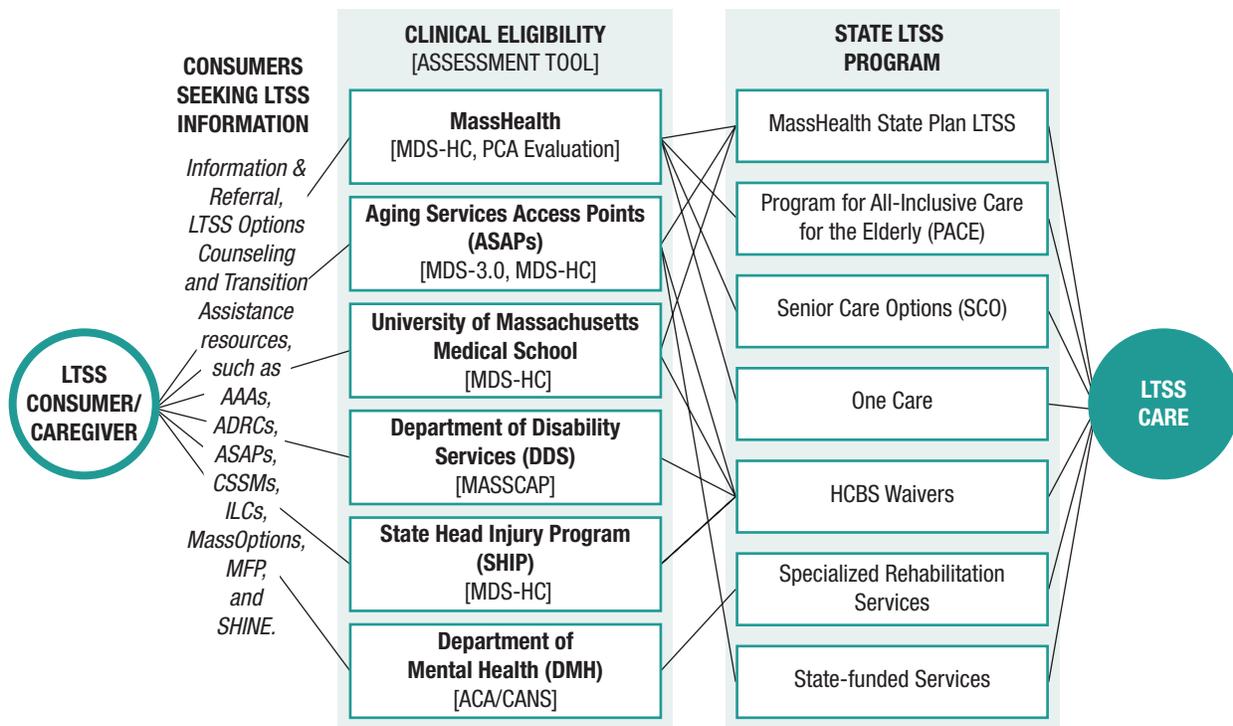
- People are safely supported in their homes and communities.
- People with disabilities have choices in how they live, work, and play.
- More people are planning for long-term care.
- Primary care, behavioral health care, and long-term care are integrated.

For more information, visit <http://dashboard.dhs.state.mn.us/default.aspx>

reported having long-term care insurance even though 73 percent had heard of it.<sup>44</sup> These factors lead to many individuals “spending down” assets quickly while paying for LTSS and ending up on Medicaid. Researchers found that nationally, nearly 13 percent of people ages 65 and over spent down savings and became eligible for Medicaid within 10 years, and more than half of these people did so to pay for LTSS.<sup>45</sup> This overall disconnect between individuals’ awareness of their LTSS needs and viable financing options, along with the likelihood they will actually need LTSS at some point in their lives contributes to Medicaid acting as the default provider of and payer for LTSS.

Indeed, many individuals and families only consider long-term care at the moment when they need it, which is often following a serious medical incident (e.g., an accident, fall, stroke). Whether born with a disability that requires lifelong LTSS or entering the LTSS system during a crisis, people who need LTSS face a dizzying web of information, needs assessments, state agencies, services, program eligibility rules, and providers (Figure 3). Although Massachusetts is dedicated to implementing a “no wrong door” approach, conflict-free case management and standardized LTSS needs assessments as part of its Balancing Incentive Program initiative, currently where and how one enters the system very much impacts what services and the level of services one receives.

**FIGURE 3: NAVIGATING THE LTSS SYSTEM IN MASSACHUSETTS: AN ILLUSTRATION**



Note: AAA = Area Agencies on Aging, ACA = Adult Comprehensive Assessment, ADRC = Aging and Disabilities Resource Consortia, CANS = Child and Adolescent Needs and Strengths, CSSM = Comprehensive Screening and Service Model, ILC = Independent Living Center, MASSCAP = Massachusetts Comprehensive Assessment Profile, MDS = Minimum Data Set, MDS-HC = Minimum Data Set-Home Care, MFP = Money Follows the Person, PCA = Personal Care Attendant, and SHINE = Serving the Health Information Needs of Everyone.  
 Source: Massachusetts Balancing Incentive Program Application, January 2014 and Long-Term Services & Supports (LTSS): Opportunities for MassHealth Chart Pack

## **The Commonwealth should:**

- Conduct an in-depth assessment of how and when individuals and families currently seek out and receive information regarding LTSS. In doing so, Massachusetts would gain a better understanding of people's experiences with the LTSS system, their familiarity with available service and financing options, and how they currently access care. An in-depth study would allow the state—and possibly the private sector—to design resources, technological solutions, and education and awareness campaigns that better respond to consumers' information needs.
- Ensure that individuals and their families are properly supported when making decisions about where and how they will receive LTSS. Massachusetts enacted the Equal Choices law in 2006, mandating that anybody eligible for LTSS would be given the “choice of care setting that is the least restrictive and most appropriate to meet [his or her] needs.”<sup>46</sup> The law further stipulates that individuals seeking admission to a long-term care facility paid for by MassHealth will receive pre-admissions options counseling, including an assessment of community-based service options.<sup>47</sup> This law is not being fully implemented, according to some stakeholders, particularly as people transition from hospitals to LTSS settings. The Commonwealth should ensure this law is fully supported and implemented and could look to expand options counseling to a broader set of individuals.
- Simplify where and how consumers and their families access LTSS information. As part of its “no wrong door” policy, Massachusetts needs to ensure not only that people “find the door” but that information is clear, accurate, and consistent no matter what “door” is opened. According to stakeholders, the number of different Web pages, phone numbers, and organizations providing information and referrals is overwhelming, and many are not user-friendly. In addition, terminology for very similar services or programs varies from agency to agency, and the sheer number of programs and provider types is overwhelming for consumers.

The state's newest information resource, MassOptions, was launched in November 2015 and, like several other efforts, is designed to provide information and link people to community-based LTSS through a website, online chats, and a toll-free number. As a centralized resource, MassOptions is a step in the right direction. But stakeholders suggested the state could also look to the private sector for creative ideas that harness technology and mobile apps to make accessing information and services faster, simpler, and more intuitive. Several stakeholders mentioned that a Yelp-like application could be useful to consumers and their family members for identifying LTSS resources and accessing consumer reviews and recommendations of LTSS programs and providers.<sup>48</sup> Technology will become even more critical as the baby boomer and younger generations begin to access LTSS more. In 2012, 72 percent of Internet users were already looking for health information online, 52 percent of smartphone users were using their phones to look up health or medical information, and 20 percent were consulting online reviews and rankings of health care providers and treatments.<sup>49</sup>

- Continue to streamline financial and clinical eligibility requirements across agencies and programs to ensure equitable access for all people who need LTSS. Massachusetts has made some progress in this area by implementing One Care, which expanded access to a broad array of community-based LTSS, and by expanding income eligibility for its home- and community-based services (HCBS) waivers to 300 percent of the federal Social Security benefit rate (roughly 224 percent of the federal poverty level [FPL]). Still, many people with similar functional needs or disabilities experience disparate access to programs based on their income or assets, age, or type of disability. For example, elders can access community-

based Medicaid state plan LTSS only if their income is below 100 percent FPL unless they are clinically eligible for one of the HCBS waivers. Those who are younger (ages 64 and below) can access these services and have incomes up to 133 percent FPL or in some cases their incomes can be even higher.<sup>50</sup> Additionally, only people who need physical assistance with at least two activities of daily living (ADLs) currently qualify for self-directed PCA services in the fee-for-service system. People who may need only cueing and monitoring supervision to complete an ADL, such as an individual with dementia or Alzheimer's, may access PCA services only if they are in a special demonstration program for dual eligibles, such as One Care.

## INCREASE SUPPORT FOR INFORMAL CAREGIVERS

Nationwide, the LTSS workforce is overwhelmingly built on a foundation of informal, unpaid caregivers. In 2009, it was estimated that 86 percent of Americans who need long-term care received it from informal caregivers.<sup>51</sup> Family caregivers are estimated to have provided over \$470 billion worth of unpaid care in 2013, and many are forced to leave the workforce to care for a parent, resulting in average wage and benefit losses of over \$300,000 over a lifetime.<sup>52,53</sup> Not only do these workers face physical, emotional, and financial stressors, but the availability of family caregivers is declining. In 2010, the ratio of potential family caregivers to those ages 80 and over was 7:1. This ratio is expected to drop to 4:1 by 2030 and to less than 3:1 by 2050.<sup>54</sup>

In 2013, nearly 850,000 family caregivers (13 percent of all Massachusetts residents) provided 786 million hours of care. It is estimated that the total economic value of care provided in the state was \$11.6 billion; only two other states provided a greater economic value of unpaid care per capita than Massachusetts.<sup>55</sup> Because this care currently is being provided without compensation, many stakeholders believe the state is receiving a great bargain.

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“The era of the [informal] caregiver is upon us, and they are a necessary component of a high-functioning LTSS system.”

— LTSS provider

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However, as discussed in the following section, the Commonwealth is facing an oncoming workforce crisis as the demand for formal caregivers will quickly exceed supply, forcing informal caregivers to fill the void. Massachusetts must create ways to better prepare and support informal caregivers. In 2014, Massachusetts ranked near the bottom of states for overall support of family caregivers, the number of health maintenance tasks able to be delegated to LTSS workers, and the prevalence of family caregivers who do not have much worry or stress, have enough time, and are well rested.<sup>56</sup> Stakeholders reported that family caregivers often do not want monetary compensation but rather need better care coordination support, training, or simply to be connected to other family caregivers so they can support one another.

### The Commonwealth should:

- Expand access to respite services for certain populations (e.g., family members who have been providing more than a certain number of hours of informal care per day for over a year). Currently, respite services are covered only through a small number of state-funded programs or MassHealth waiver or demonstration programs and therefore benefit only a small number of informal caregivers.
- Allow MassHealth to pay spouses as family caregivers (with appropriate protections to address concerns about fraud and abuse). Currently, Massachusetts does not qualify spouses, parents of a minor (including

an adoptive parent), or any legally responsible relative as a caregiver, making them ineligible for direct payment.<sup>57</sup> While Massachusetts is not one of the 17 states that allow spouses to be paid as PCAs, there is proposed legislation that would allow family caregivers to receive a monthly stipend.<sup>58</sup> In addition, there is proposed legislation that would allow spouses to be categorized as caregivers, making them eligible for payment through the Adult Foster Care program.<sup>59</sup>

- Work with public and private employers to provide paid family leave as a benefit. To date, Massachusetts has not enacted paid leave legislation.<sup>60</sup>
- Increase awareness of and enhance existing tax incentives for family caregivers.<sup>61</sup> For example, the state could create non-refundable tax credits for out-of-pocket family caregiving expenses, such as transportation costs, home modifications, and medication management services. Federal legislation to create such benefits is pending before Congress.<sup>62</sup>
- Link dedicated care coordinators with informal caregivers to help them navigate the LTSS system and coordinate appointments and transportation.
- Partner with community-based organizations to provide peer support, offer financial or legal education, share best practices, and standardize training of caregivers.

#### Examples from the Field: PAID FAMILY LEAVE PROGRAMS

##### California's Paid Family Leave (PFL) Program

In 2002, California became the first state to create an insurance program that provides a portion of a worker's income so that he or she may care for a newborn or ailing family member. The program is financed through a payroll tax levied on employees, which is added to the California State Disability Insurance fund (there is no direct cost to employers).<sup>63</sup> To be eligible for PFL, employees must have paid into the fund and may receive up to 55 percent of their weekly wages up to a maximum benefit amount. Workers are entitled to six weeks of leave, which can be taken on an hourly, daily, or weekly basis. Utilization has grown steadily since the program began, with paid claims exceeding 202,000 in FY 2012–2103, and 12 to 13 percent of claims related to care for a sick family member (between 87 and 88 percent of claims were for “bonding” with a newborn).<sup>64</sup> Studies found that while only about half of workers in California were aware of the program, the law significantly increased leave-taking.<sup>65</sup> The law originally applied only to employees with a sick child, spouse or domestic partner, or parent but was expanded in July 2014 to include care for siblings, grandparents, grandchildren, and parents-in-law. Recently passed legislation will increase reimbursement rates beginning in 2018 from 55 to between 60 and 70 percent of weekly wages, depending on an individual's level of income, and will eliminate the weeklong waiting period that was required before becoming eligible for benefits.<sup>66</sup>

For more information, visit <http://paidfamilyleave.org/>.

##### New York's Paid Family Leave Program

In April 2016, New York passed a law to become the fourth state in the country with a paid family leave program. Beginning in 2018, employees will be able to take leave to bond with a new child or care for a seriously ill child, parent, parent-in-law, spouse, domestic partner, grandchild, or grandparent. The program will provide up to eight weeks of leave in 2018, 10 weeks in 2019 and 2020, and 12 weeks in 2021 and beyond. Similarly, reimbursement rates will increase over four years, beginning at 50 percent of weekly wages in 2018 and increasing to 67 percent by 2021, and wages will be capped in relation to a statewide average weekly wage. The program will also provide job protection and continuation of health care benefits.

For more information, visit <http://assembly.state.ny.us/2016budget/enacted/A9006C.pdf>.

## ENHANCE DIRECT-CARE WORKFORCE CAPACITY

Like the informal workforce, the formal workforce faces tremendous pressures. The numbers of PCAs, HHAs, and nursing assistants are projected to grow rapidly over the next decade, and these occupations have the

highest, third-highest, and sixth-highest projected change in employment, respectively.<sup>67</sup> It is estimated that the direct-care workforce will add 1.6 million new jobs by 2020, totaling nearly five million people and becoming the largest occupational group in the country.<sup>68</sup>

Even though their skills are in high demand, HHAs and PCAs had the two lowest median annual wages of the 30 fastest-growing jobs in the country in 2014.<sup>69</sup> While average wages for both positions are somewhat higher in Massachusetts than the national average—\$26,800 for HHAs and \$26,120 for PCAs versus \$22,400 and \$21,210 nationally—both positions are still underpaid.<sup>70,71</sup> At these income levels, many direct-care workers likely qualify for subsidized health insurance in Massachusetts, as \$26,000 is just above 200 percent FPL for a single individual, 160 percent FPL for a couple, and roughly 100 percent FPL for a family of four. In Massachusetts, PCAs are the 14th-lowest paid occupation, and HHAs are the 24th lowest.<sup>72</sup>

Direct-care workers also often have trouble finding affordable housing, work less than 40 hours a week, and experience high rates of turnover. According to a 2009 survey, two-thirds of PCAs in Massachusetts reported working less than 30 hours a week.<sup>73</sup> In addition, a third of PCAs reported working more than one job and six percent reported working two additional jobs, often citing the need to supplement their income as the motivation for taking on other work. The Commonwealth has taken steps to address some of the wage issues, agreeing to boost PCAs' pay from \$13.38 to \$15 an hour by July 2018.<sup>74</sup> While this was a welcome move, most stakeholders pointed out that the agreement does not provide \$15 an hour for all direct-care workers (including HHAs) and stated that \$15 an hour still falls short of a living wage in Massachusetts.<sup>75</sup>

Many stakeholders also cited the lack of a clear career path as a major challenge to sustaining the direct-care workforce. Stakeholders discussed that workers often see few career options in caregiving beyond their current position. This lack of a clear career ladder, coupled with low wages and unreliable hours, presents recruitment challenges and may result in the direct-care workforce being viewed as a career of last resort. Stakeholders also reported a wide range in the quality of workers and discussed difficulties in finding and retaining good workers.

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“We need to make caregiving a career people want to enter, not one they fall into.”

— *Consumer advocate*

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The Commonwealth has taken some steps to better support the direct-care workforce. In addition to the recent PCA wage increase, Massachusetts was one of six states awarded grant funds available through the federal PHCAST Program, receiving \$2.2 million over a three-year period (FY2010–2012) from the U.S. Department of Health and Human Services.<sup>76,77</sup> The program provided funding to states to develop core competencies and training curricula, and establish certification programs for personal and home care aides. Within the first two years, PHCAST provided enhanced training to over 500 individuals at 20 locations.<sup>78</sup> In addition, the Home Care Aide Council, which served as a lead partner for PHCAST in Massachusetts, recently received a grant worth approximately \$180,000 from the Tufts Health Plan Foundation to study the home-care workforce.<sup>79</sup> However, much remains to be done to properly support and grow the workforce.

### **The Commonwealth should:**

- Build on the state's commitment to increase PCA wages to \$15 an hour and set a goal to establish a minimum wage for all direct-care workers in all care settings.
- Support or facilitate efforts to professionalize the workforce, including offering benefits (e.g., health insurance, travel reimbursement, paid time off, sick leave), full-time employment opportunities, and standardized orientation and ongoing skills trainings. Many stakeholders cautioned the Commonwealth,

as it moves in this direction, to carefully balance consumers' individual needs and desire to train their own caregivers with ensuring a minimum level of quality and adequately protecting workers themselves.

- Construct and communicate a clear career ladder for the direct-care workforce to promote recruitment and retention of workers in this field. The career ladder must include the opportunity for upward mobility to advance to positions such as a medical technician or CNA. As part of this effort, the Commonwealth may need to address scope of practice constraints, whereby regulations may prevent the delegation of certain tasks to workers down the career ladder. For example, Massachusetts regulations explicitly prohibit nurses from delegating the task of administering medication, and in one national ranking the Commonwealth ranked 40th in the number of health maintenance tasks that registered nurses can delegate to LTSS workers.<sup>80,81</sup> Targeted changes to scope of practice laws can help ensure that all workers are performing at the top of their license, optimize the use of all health care workers, enhance people's access to LTSS, and create cost offsets for the state. The Commonwealth could work with and invest in local high schools, technical/vocational schools, and community colleges to train the workforce earlier and provide incentives to enter the profession (e.g., earning credits toward a CNA). There is also ample opportunity to engage community-based organizations to support the development of a stronger direct-care workforce as a way to strengthen local economic development.

#### **Examples from the Field: NEW YORK'S MANAGED LONG-TERM CARE WORKFORCE INVESTMENT PROGRAM**

In 2014, CMS approved New York's Medicaid Redesign Team Waiver Amendment. The waiver provides \$245 million in funding to managed long-term care and fully integrated duals Advantage plans to contract with newly created managed long-term care workforce Centers of Excellence to retrain, recruit, and retain professionals in the long-term care sector. New York will require plans to:

- Invest in initiatives to attract, recruit, and retain long-term care professionals in the areas they serve.
- Develop plans to address reductions in health disparities by focusing on the placement of long-term care workers in medically underserved communities.
- Train needed workers to care for currently uninsured populations who will seek care under the Affordable Care Act expansion.
- Support the expansion of home care and respite care, enabling those in need of long-term care to remain in their homes and communities and reduce New York's Medicaid costs associated with long-term care.

For more information, visit

[https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/waiver\\_amend\\_prog\\_implem\\_spa\\_and\\_mc.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/docs/waiver_amend_prog_implem_spa_and_mc.pdf).

## **EXPAND ACCESS TO AFFORDABLE HOUSING WITH SUPPORTS**

The lack of affordable housing is a problem that faces much of the Commonwealth's population. The cost to construct new housing in most of Massachusetts remains almost prohibitively high owing to factors such as restrictive zoning laws and very expensive land.<sup>82</sup> This high cost of construction means supply cannot meet demand, and as a result, home prices and rents skyrocket for all. The homeowner vacancy rate in greater Boston was 1.2 percent in 2010, less than half the U.S. average for metro regions, and it fell to just 0.7 percent by 2015.<sup>83</sup> In addition, the median price of a single-family home increased more than 14 percent from 2010 to 2015, from just over \$354,000 to over \$405,000.<sup>84</sup>

Stakeholders unanimously identified housing as one of the greatest needs for people needing LTSS and were quick to point out that a lack of affordable housing also adversely impacts the LTSS workforce, compelling workers (who often do not receive reimbursement for travel) to live far from those for whom they provide care.

A 2013 survey of non-institutionalized adults in Massachusetts found that 77 percent of respondents identified housing as a “big problem” for the disability community in Massachusetts and 85 percent of respondents with disabilities identified housing as a significant health need.<sup>85</sup> Although many Bay Staters face issues securing affordable housing, persons needing LTSS services face unique housing challenges. Stakeholders reported that as the state continues to transition care to community-based settings, appropriate housing arrangements linked with necessary services and supports are needed to allow individuals to continue to live independently and safely in their communities. So-called “supportive housing” options enable individuals to participate and remain in their communities as they age. Housing solutions will require creativity from both the public and the private sector (e.g., repurposing nursing facilities, group homes, mixed-use buildings).

Massachusetts provides some housing supports through its MFP program to about 2,000 people transitioning to the community from institutional settings. MFP transition coordination entities work to identify and assess individuals and transition them back into the community. They also help coordinate a search for appropriate housing and assist with the transition into a home- or community-based setting.<sup>86,87</sup> Although this program is a step in the right direction, it supports only a fraction of the people who indicate they need this support.

### **The Commonwealth should:**

- Implement cross-agency and cross-sector initiatives to craft viable supportive housing solutions. MassHealth will need to work and coordinate with Elder Affairs, the Department of Public Health, the Department of Transitional Assistance, the Department of Housing and Community Development, the private sector, and others. In 2015, Governor Baker took a critical step by appointing a new executive director to the long-standing Interagency Council on Housing and Homelessness (ICHH) to lead and coordinate statewide efforts to end homelessness. The state should continue to support and build off the ICHH’s work, which has included a focus on ending homelessness among older adults.<sup>88</sup>
- Analyze the nursing home capacity required to meet future demand and assess how nursing homes could be repurposed to meet the housing needs of some people in a community. As more individuals and dollars transfer out of institutions and into homes, stakeholders acknowledged the need to think through how nursing homes might be updated to be more homelike (e.g., the Green House Project) and/or converted for mixed use (e.g., co-location of adult day care, respite, other services). Currently, there is proposed legislation in Massachusetts that would establish a zero interest loan trust fund to help convert nursing homes to community-based residences.<sup>89</sup> There is also proposed legislation to create a 15-member special commission to more effectively manage nursing home licensing, de-licensing, and closures.<sup>90</sup> The special commission would be charged with responsibilities including developing policy recommendations regarding nursing home closures, creating a plan to address excess capacity, and reform quality care criteria to assess nursing home beds prior to being de-licensed or closed.
- Conduct an assessment of current pilots in place throughout the state to determine if there are any sustainable models that could be supported and replicated. Stakeholders identified the Green House Project and H.E.A.R.T. Homes as good examples, and surely there are others.

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“Housing just may not have risen to the top yet, but it is timely because...we now have the social-science research showing that if we don’t address the social determinants of health, it is really hard to control underlying medical issues.”

— *Health plan administrator*

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## Examples from the Field: INNOVATIVE LTSS SUPPORTIVE HOUSING MODELS

- **The Green House Project**—A Green House home is a self-contained home for 10-12 people located in clusters of homes and designed to be similar to the homes or apartment buildings in the surrounding community. While still licensed as nursing homes, they are so mostly in name only. Each resident has a private bedroom and bathroom and shares a central living area, open kitchen, and dining room. Homes are staffed by a team of universal workers known as “Shahbazim,” clinical teams, and other support staff. Daily routines are not predetermined; instead, residents are allowed to shape their own daily activities. Research shows that the Green House model can potentially save \$1,300 to \$2,300 over 12 months in total Medicare and Medicaid costs per resident when compared with traditional nursing homes. As of September 2015, over 179 Green Houses have been opened in 33 states, with 150 more in development. Currently there are two Green House projects in Massachusetts: Leonard Florence Center for Living in Chelsea and White Oak Cottages at Fox Hill Village in Westwood.

For more information, visit <http://www.thegreenhouseproject.org/>, <http://www.chelseajewish.org/senior-living-and-short-term-rehabilitation/short-term-rehabilitation/short-term-rehabilitation-green-house-chelsea/>, <http://whiteoakcottages.com/>.

- **H.E.A.R.T. (Housing Elders At Residences Together) Homes**—H.E.A.R.T. Homes provide an opportunity for frail older adults to live as independently as possible while remaining safe and secure. H.E.A.R.T. Homes house four to six older adults who require assistance with routine care and offer an alternative to long-term nursing home placement. Residences receive 24-hour care and assistance with activities of daily living, and they can arrange for additional services such as nursing visits and transportation through Elder Home Options.

For more information, visit <http://elderhomeoptions.com/default.htm>.

- **Illinois’ Supportive Living Program**—The Supportive Living Program is an assisted living model that “seeks to promote independence, dignity, respect and well-being for residents in the most cost effective manner” for individuals who would otherwise need nursing home care.<sup>91</sup> As part of the program, the Department of Healthcare and Family Services (HFS) oversees supportive living facilities (SLFs), which are required to meet certain structural requirements and include houses, apartments (if the entire apartment is devoted to SLF residents), and long-term care facilities (a nursing home may be certified as an SLF only if a distinct part of the existing facility is dedicated to SLF residents).<sup>92</sup> HFS operates the program via a Medicaid waiver that allows for payment of services that are otherwise not reimbursable, including personal care, homemaking, laundry, medication supervision, social activities, recreation, and 24-hour staff to meet residents’ scheduled and unscheduled needs. Residents are responsible for paying for room and board. In 2015, there were nearly 11,700 supportive living sites across almost three-quarters of the state, and the state has committed over \$135 million of general revenue funds to the program as part of its 2016 Housing Production Plan.<sup>93</sup>

For more information, visit <http://www.sfillinois.com/>.

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## CONCLUSION

MassHealth's mission is "to improve the health outcomes of our diverse members, their families and their communities, by providing access to integrated health care services that sustainably promote health, well-being, independence, and quality of life." To fulfill this mission, the administration must continue to engage stakeholders in developing LTSS purchasing and delivery system reforms that help create a person-centered, integrated, sustainable, accountable, and actionable LTSS system that is fully aligned with the rest of the care continuum. The Commonwealth may ultimately need to contract with a single entity or network of entities through a global or shared savings payment arrangement to coordinate or deliver individuals' acute, behavioral health, LTSS, and social support needs. Regardless of the approach taken, the state must vigorously and transparently monitor provider and plan quality and financial performance.

To achieve this new vision for LTSS, Massachusetts must take foundational steps to remove barriers to integration, enhance its program evaluation and data analytics capabilities, implement LTSS quality measurement, improve access to information and services, support informal caregivers and direct-care workers, and expand available supportive housing options. Massachusetts has demonstrated its ability to lead in health care system reform and should continue to lead by taking on comprehensive LTSS reform and advancing its legacy of leadership and innovation.

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## APPENDIX A: INTERVIEWEES

**Christine Bishop**

Brandeis University

**Alice Bonner**

Executive Office of Elder Affairs

**Jessica Costantino**

AARP

**Rebecca Gutman, James Willmuth,  
and Herbert Jean-Baptiste**

1199SEIU

**Dennis Heaphy**

Disability Policy Consortium

**Bill Henning**

Boston Center for Independent Living

**Sophie Jones**

VINFEN

**Jeff Keilson**

Advocates

**Pat Kelleher**

Home Care Alliance of Massachusetts

**Jean McGuire**

Northeastern University

**Ned Morse, Gary Abrahams, and Tara Gregorio**

Mass Senior Care Association

**Al Norman**

Mass Home Care

**Tom Riley and Rachel Richards**

Seniorlink

**Leo Sarkissian**

The ARC of Mass

**Elissa Sherman**

LeadingAge Mass

**Lois Simon**

Formerly of Commonwealth Care Alliance

**Dan Tsai and Scott Taberner**

Executive Office of Health and Human Services/  
MassHealth

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## **APPENDIX B: ADVISORY GROUP MEMBERS**

**Len Fishman**

Gerontology Institute at University of Massachusetts Boston

**David Grabowski**

Harvard Medical School

**Bob Master**

Founder of Commonwealth Care Alliance

**Nancy Turnbull**

Harvard T.H. Chan School of Public Health

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## END NOTES

1. For purposes of this report, the terms “long-term care,” “long-term services and supports,” and “LTSS” will be used interchangeably and refer to MassHealth-covered LTSS.
2. Massachusetts Medicaid Policy Institute. *MassHealth Matters II: Long-Term Services & Supports: Opportunities for MassHealth*. December 2015. Available online at <http://bluecrossfoundation.org/event/join-us-masshealth-matters-ii-long-term-services-supports-ltss-opportunities-masshealth>.
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10. Massachusetts Medicaid Policy Institute. *MassHealth Matters II: Long-Term Services & Supports: Opportunities for MassHealth*. *Op. cit.*
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14. Truven Health Analytics and CMS. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services Were a Majority of LTSS Spending*. June 2015. Available online at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>.
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21. Massachusetts laid out a policy vision for its LTSS system in its Community First Olmstead Plan, aiming to “[e]mpower and support people with disabilities and elders to live with dignity and independence in the community by expanding, strengthening, and integrating systems of community-based long-term supports that are person-centered, high in quality and provide optimal choice.” The plan sets out seven guiding principles, six goal areas, and specific objectives for each goal to achieve this vision. The plan acknowledges that it must evolve over time based on ongoing stakeholder engagement, program evaluation, and revisions to meet changing needs and resources.

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  23. Massachusetts Executive Office of Health and Human Services. *MassHealth Innovations*. Available online at <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/>.
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  25. Massachusetts Executive Office of Health and Human Services. *Summary of Stakeholder Listening on MassHealth Restructuring*. August 2015. Available online at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/stakeholder-summary-aug-2015.pdf>.
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  31. The University of Massachusetts Medical School partnered with the Massachusetts Executive Office of Elder Affairs in 2012 to develop a customized data solution to analyze longitudinal data sets with the goal of determining the value of home- and community-based services provided to an elderly population. In July 2014, the Massachusetts state legislature authorized and funded a Home and Community-Based Services Policy Lab to study the outcomes and effectiveness of public investment in the system. Early results indicate that linking multiple data streams can give stakeholders a better understanding of population health and costs. Public University Medicaid Partnerships. *Home and Community-Based Services Policy Lab Aims to Give Stakeholders a Better Understanding of Population Health and Costs*. Available online at <http://www.universitypartnerships.org/success-stories/home-and-community-based-services-policy-lab-aims-give-stakeholders-better>.
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