Maura Healey
Governor

Kimberley Driscoll
Lt. Governor

Kathleen Walsh
Secretary, EOHHS

Robin Lipson
Secretary, EOEA

ANNUAL LEGISLATIVE REPROT

FISCAL YEAR 2024

EXECUTIVE OFFICE OF ELDER AFFAIRS
One Ashburton Place, Boston, MA 02018
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INTRODUCTION

The Executive Office of Elder Affairs (EOEA) presents its Annual Report for the Fiscal Year 2024 (FY24) to the Massachusetts General Court pursuant to M.G.L. c. 19A, §12.

> *The Secretary shall prepare and submit to the Governor and the General Court a full and complete report on the activities carried out under this chapter. Such annual reports shall include statistical data reflecting services and activities provided individuals during the preceding fiscal year.*

This report provides information about the services EOEA provided in FY24 and the people who received those services.

OVERVIEW OF EOEA

During FY24, EOEA used a combined state and federal budget of over $800 million to help over 1.7 million older adults in Massachusetts live and thrive in their communities of choice.[1] The Agency's work supports a population that will experience diverse needs beginning at age 60, into the centenarian years.

EOEA's federal partners, the Administration for Community Living (ACL) and the Department of Labor, provide approximately $100 million in annual funding through the Older Americans Act and periodic grants to Massachusetts for services that EOEA procures and implements through community organizations.

EOEA PROGRAMS/FUNCTIONS

By statute, EOEA does not employ care managers, social workers, nurses, home care workers, and others who deliver human services. Instead, EOEA contracts with 24 regional Aging Services Access Points (ASAPs), which are independent non-profit organizations designated by EOEA to provide state-funded services for specific regions of the Commonwealth (Figure 1). Most of EOEA's federal funding come from the Older American's Act and must be contracted to federally-designated entities called Area Aging Agencies (AAA). Nearly all ASAPs are also AAAs.[2]

[1] This 2022 estimate, the most recent available, is from the U.S. Census Bureau's American Community Survey, and is available at: https://data.census.gov/table/ACSDP1Y2022.DP05?q=older%20adults%20massachusetts%202022

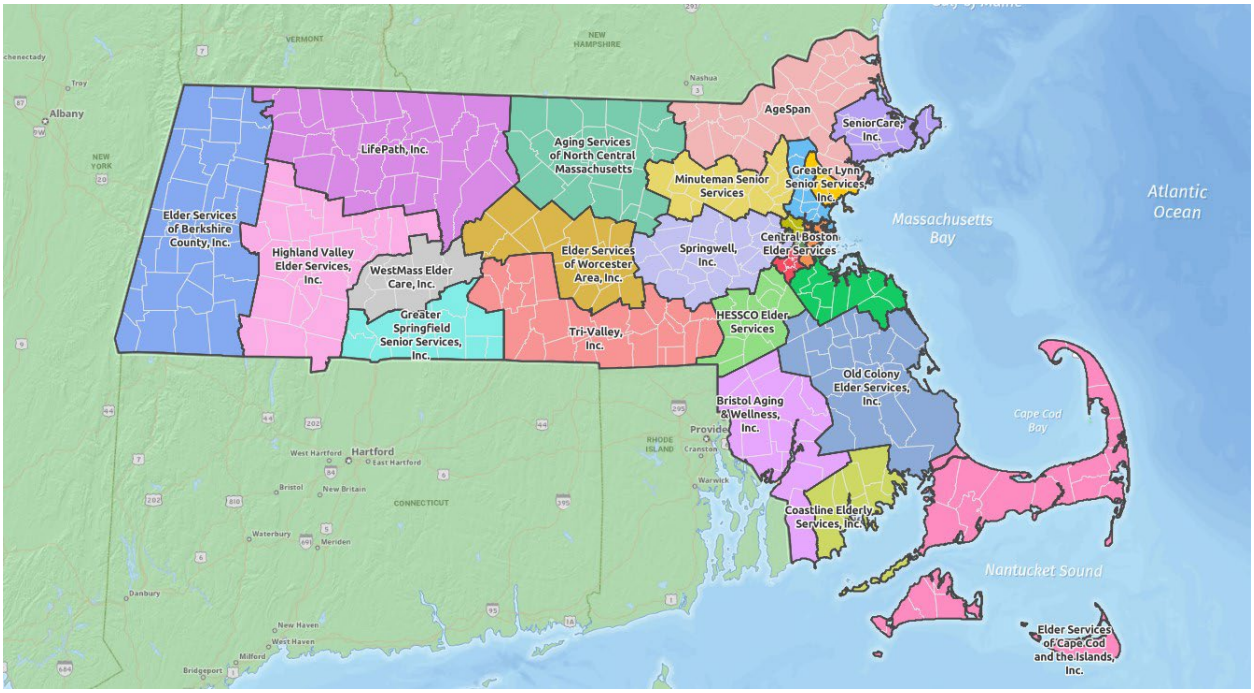
[2] The AAAs that are not ASAPs are: Boston's Age Strong Commission, Central Massachusetts Agency on Aging, and Old Colony Planning Council. The ASAPs that are not AAAs are: Aging Services of North Central Massachusetts, Boston Senior Home Care, Central Boston Elder Services, Elder Services of Worcester Area, ETHOS, Old Colony Elder Services, and Tri-Valley.

The Agency's combined state and federal budget supports services that:

1. **Help older adults remain at home and in the community of their choice by**:
    - Delivering nutritionally appropriate home-delivered meals to over 40,000 individuals during the federal fiscal year.
    - Offering case management, advocacy, maintaining a network of high-quality providers, and providing in-home support to over 70,000 individuals who need help with Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL) through the *Home Care Programs*.
        - Over 30% of EOEA Home Care consumers are eligible for nursing facility placement and choose to receive care at home instead.
        - EOEA administers the largest *MassHealth Home and Community Based Services waiver, the Frail Elder Waiver*, assisting over 10,000 older adults who are eligible for nursing facility placement live at home.
    - Funding Resident Services Coordinators through *Supportive Housing* and *Congregate Housing* models in older adult subsidized apartment communities.
2. **Protecting older adults from abuse, neglect, exploitation, and self-neglect** by screening and investigating over 55,000 allegations referred to *Adult Protective Services*.
3. **Supporting informal caregivers** by connecting caregivers with community resources, providing opportunities to connect with other caregivers for support, and providing funding for caregiver respite.
4. **Encouraging behavioral health and emotional wellness** for older adults and their caregivers through community-based, interdisciplinary outreach teams in 188 communities**.**
5. **Informing decision-making** through informational programs such Serving the Health Insurance Needs of Everyone (*SHINE*) program for Medicare plan enrollment; *Options Counseling* for whether to relocate to another setting;[3] and *Prescription Advantage for* making medications affordable.
6. **Regulating 270 Assisted Living Residences (ALRs)**, which house and care for over 17,000 residents across the Commonwealth. Roughly 30% of residents are over age 90.
7. Providing programming and outreach to **encourage social and community engagement, wellness, and serve as a trusted referral source for individualized care.** These efforts are largely delivered through adult community centers, commonly referred to as senior centers, operated by each municipality's *Council on Aging*.

[3] EOEA submits a separate report on Options Counseling to the Massachusetts General Court which can be found on page 26.

Figure 1. Map of ASAP Regions



Click on the map to explore the interactive version available online.

PROGRAMS AND SERVICES

Unless otherwise noted, all reported statistics are for the Massachusetts state fiscal year 2024.

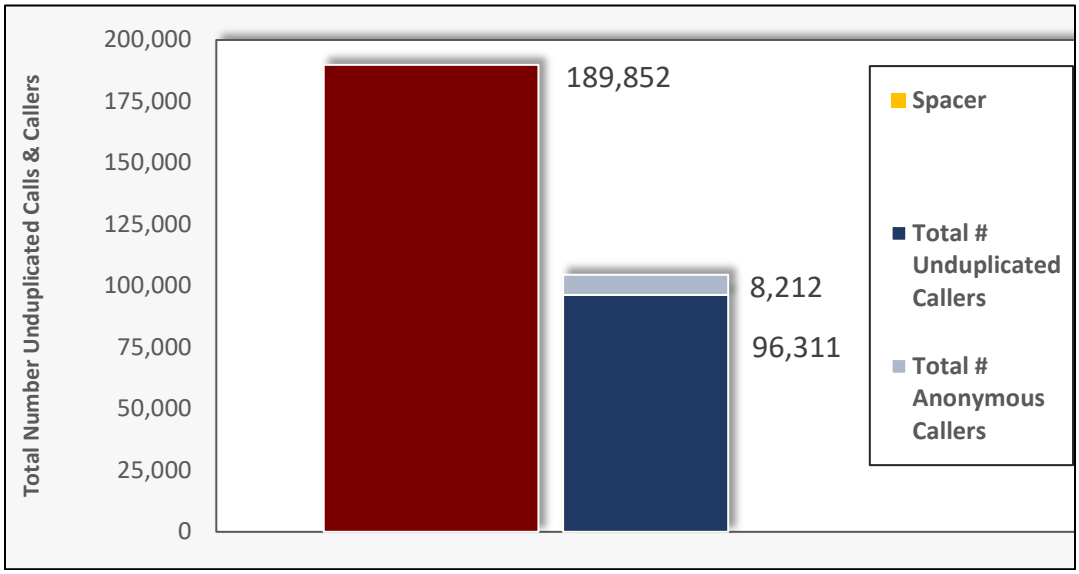
INFORMATION & REFERRAL (I&R)

I&R connects older adults, individuals with disabilities, families, and caregivers with information, resources, and other supports necessary to make informed choices. Consumers can directly contact their regional ASAP or AAA I&R departments via phone, email, or walk-ins. Residents can also connect to I&R via MassOptions, a statewide I&R service (residents can contact MassOptions via phone, email, or text).

SERVICES PROVIDED AND PEOPLE SERVED

ASAPs and AAAs provided I&R services during almost 190,000 calls made by more than 100,000 unique callers (Figure 2).

Figure 2. Total Number of Calls and Unique Callers

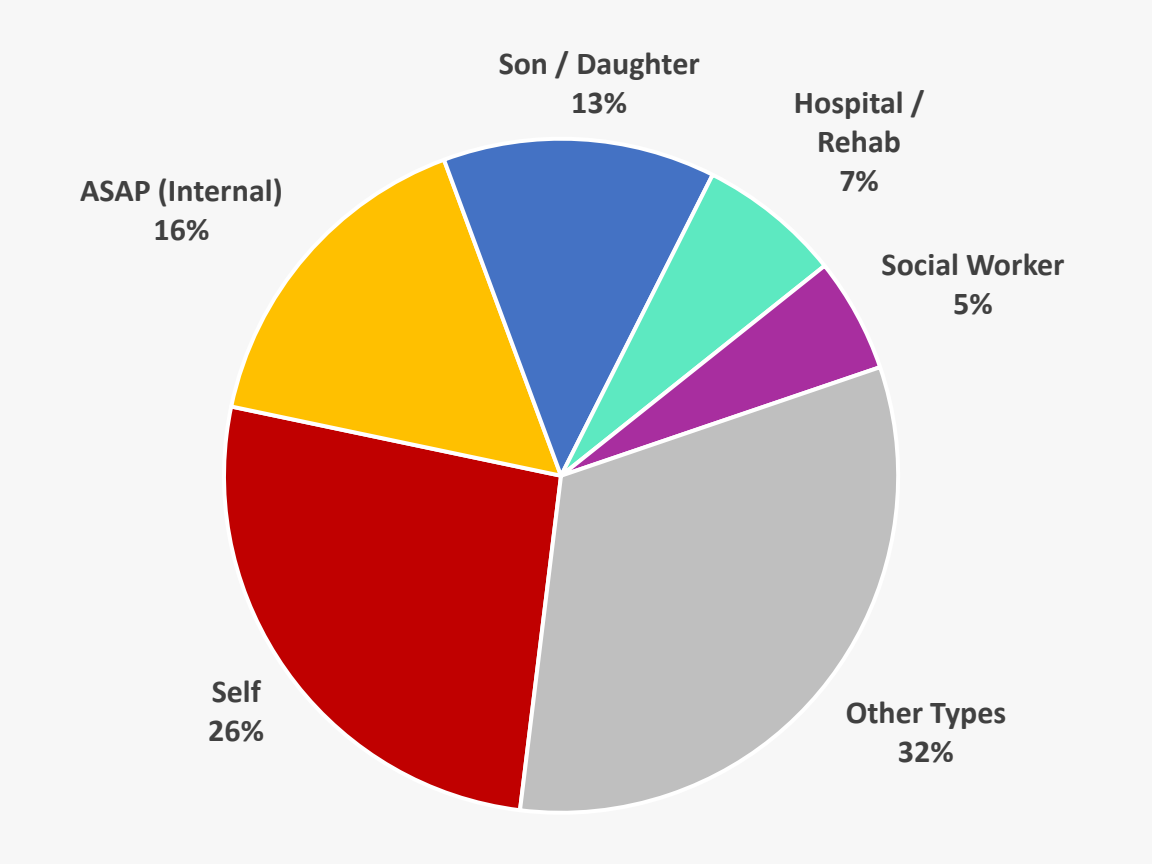


Notes: If a rehab center calls an ASAP for eight different consumers, that is reported as one unique caller and eight unduplicated calls (assuming the rehab center called once for each consumer). Unique callers are identified based on individual caller records (each individual caller record has a unique Client ID number). Staff are asked to create a new caller record when they have the caller's full name (first and last name). However, duplicate records for the same caller can result when staff enter names incorrectly or search for names incorrectly; when this occurs, the reported statistic overestimates the number of unique callers. Staff should label callers as anonymous when they refuse to provide their full name. Callers can have diverse reasons for not identifying themselves when calling an

Notes Cont.: agency (such as a child concerned that their parent will view calling as a betrayal of trust). Calls to MassOptions are not included in this figure, unless MassOptions forwards the call to an ASAP or AAA.

The most common I&R callers were older adults followed by their children (Figure 3).

Figure 3. I&R Percentage of Calls by Caller Type



Notes. The caller type is unknown for anonymous callers. The Top 5 caller types made approximately 67% of all calls. The denominator for these percentages is the total number of all calls (189,748)

HOME CARE

Home Care programs provide critical support for residents to age safely and proactively in their communities.[4] ASAPs provide resident advocacy and case management,[5] maintain a network of provider agencies, and authorize and coordinate long-term support services delivered to consumers in their homes by the provider agencies. ASAPs also conduct an interdisciplinary review of consumer needs to develop service plans, reassess the consumer's status at mandated intervals, and respond to consumer/caregiver concerns. The five home care programs are managed together as one portfolio.[6]

There are no income limits to access EOEA home care program services. Services are provided at no cost to consumers who are MassHealth members with annual income below 300% of the Federal Benefit Rate (FBR), or $33,948 for a single person household. Individuals with income above 300% FBR, whether or not insured by MassHealth, share the cost of services scaled to income. For example, the cost sharing for a single person household with an annual income of approximately $36,000 is 50% of the cost of services per month and rises to 100% for a single person household with income above approximately $63,039.[7]

FRAIL ELDER WAIVER (FEW) PROGRAM

The FEW Program is one of Massachusetts's 10 Home-and Community-Based Service (HCBS) Waiver programs that provide community supports to individuals who otherwise require facility-based care. EOEA is responsible for the day-to-day operation of the FEW program, which supports MassHealth individuals with diverse needs ranging from basic to intensive. Individuals enrolled in the FEW program can age safely in their communities with ASAP oversight, advocacy, case management and provider management, as well as access MassHealth State Plan benefits and services. FEW makes such supports available to Massachusetts residents aged

[4] Approximately 69% of participants are female, 86% speak English as their primary language, 56% live alone, 80% are not married, and the median household income is approximately $24,000 (42% of all participants make between $10,000-$19,999).

[5] Case management care includes onsite visits, advocacy, community education, and support.

[6] The five programs are: Enhanced Community Options Program (ECOP), Home Care Basic/Waiver (part of FEW), Community Choices (part of FEW), Home Care Basic/Non-Waiver, and Home Care Percent Based, previously referred to in past legislative reports as Home Care Over Income, and Respite Over Income. In 2024, to better serve constituents across the Commonwealth, two programs were consolidated into a single Home Care Percent Based Program.

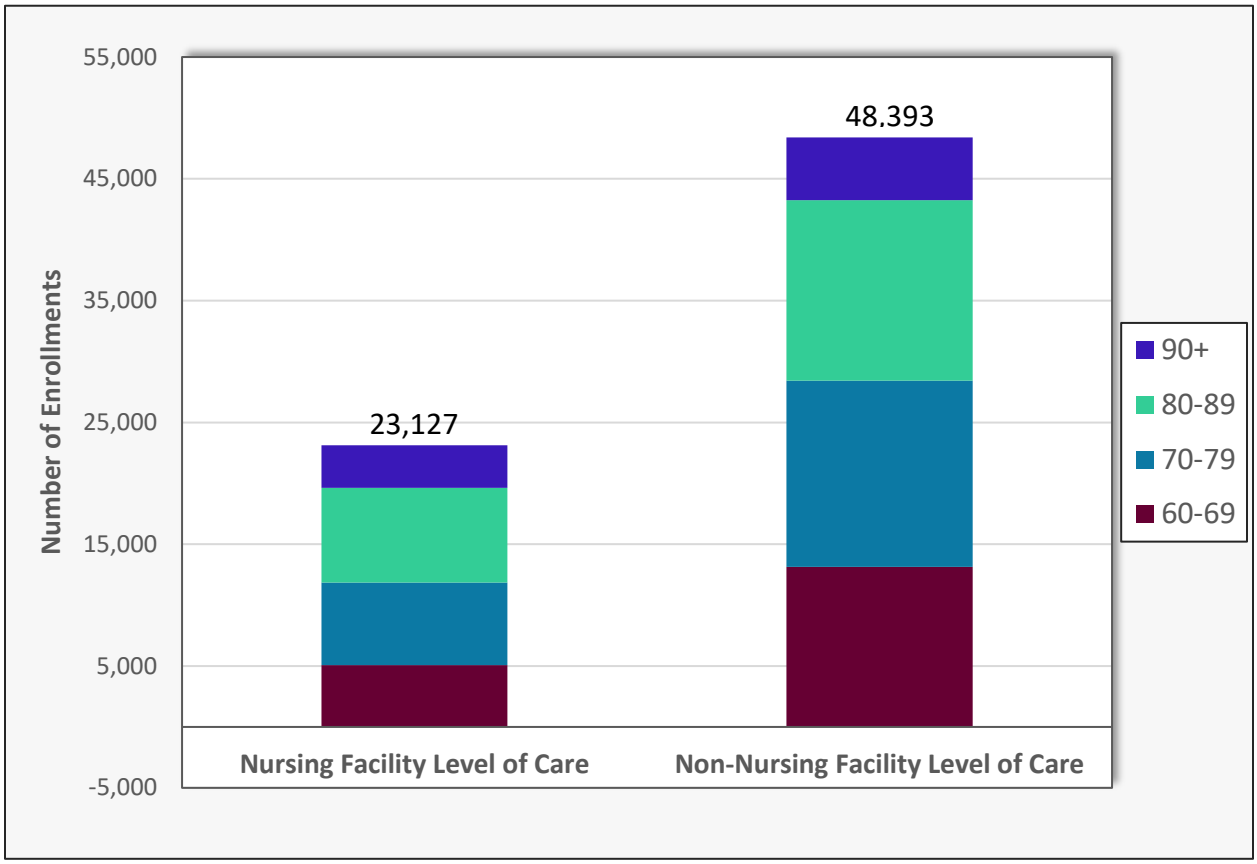
[7] Some services do not require copays.

60 and older who meet clinical eligibility requirements for Nursing Facility Level of Care (LOC) and Community MassHealth Standard financial requirements.[8]

SERVICES PROVIDED AND PEOPLE SERVED

Collectively, the five Home Care Programs enrolled over 70,000 consumers in FY24, over 25,000 of these consumers were eligible for nursing facilities (Figure 4).

Figure 4. Number of Home Care Enrollments, by Nursing Facility Level of Care and Consumer Age

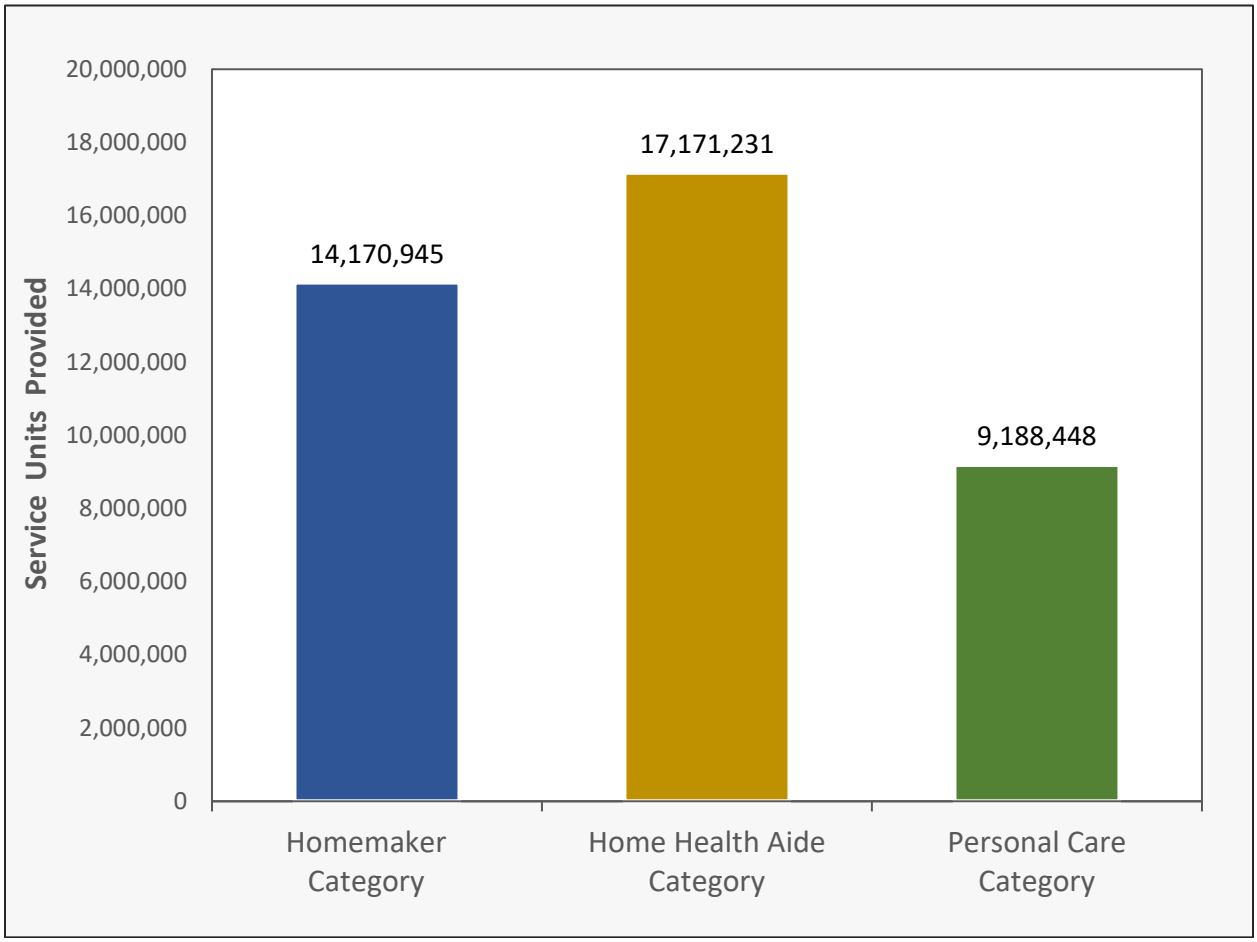


Notes: ASAPs reported that 71, 624 consumers were enrolled in a Home Care program during FY24. A small number of consumers are under age 60 and not displayed. To estimate the number of nursing facility eligible consumers, EOEA calculated the number of consumers in three programs that require eligibility (Enhanced Community Options Program-ECOP, Home Care Basic Waiver, and Community Choices) and added the number of consumers in other programs (Home Care Basic/Non-Waiver, Home Care Over Income, and Respite Over Income) who had a nursing facility assessment and were determined clinically eligible for a nursing facility. Most of the consumers in the other programs were not assessed for nursing facility eligibility.

[8] The Frail Elder Waiver provides expanded income eligibility requirements for applicants up to 300% SSI Federal benefit Rate (FBR) as well as asset and if applicable spousal asset limitations.

The programs provided essential services to help older adults who need assistance with ADLs and IADLs remain in their communities (see Figure 5).

Figure 5. Number of Services Units Provided, by Service



Notes: A service unit is 15 minutes of the service. The services presented are based on billing by ASAPs. Each of the reported categories encompasses several billing codes. For example, Homemaker includes the following billing codes: Homemaker, Homemaker - 42+, Homemaker - Alt Rate 1, Homemaker - Alt Rate 2, Homemaker – Cluster, Homemaker – Complex, Homemaker – Nights, Homemaker - Supportive Housing, Homemaker - Weekends. Personal Care includes the following categories: Personal Care, Personal Care - 42+, Personal Care - Alt Rate 2, Personal Care – Cluster, Personal Care – Complex, Personal Care - Supportive Housing, Personal Care – Weekends. The Home Care programs provide other services not presented in the figure, such as companions, meals, transportation, and chores.

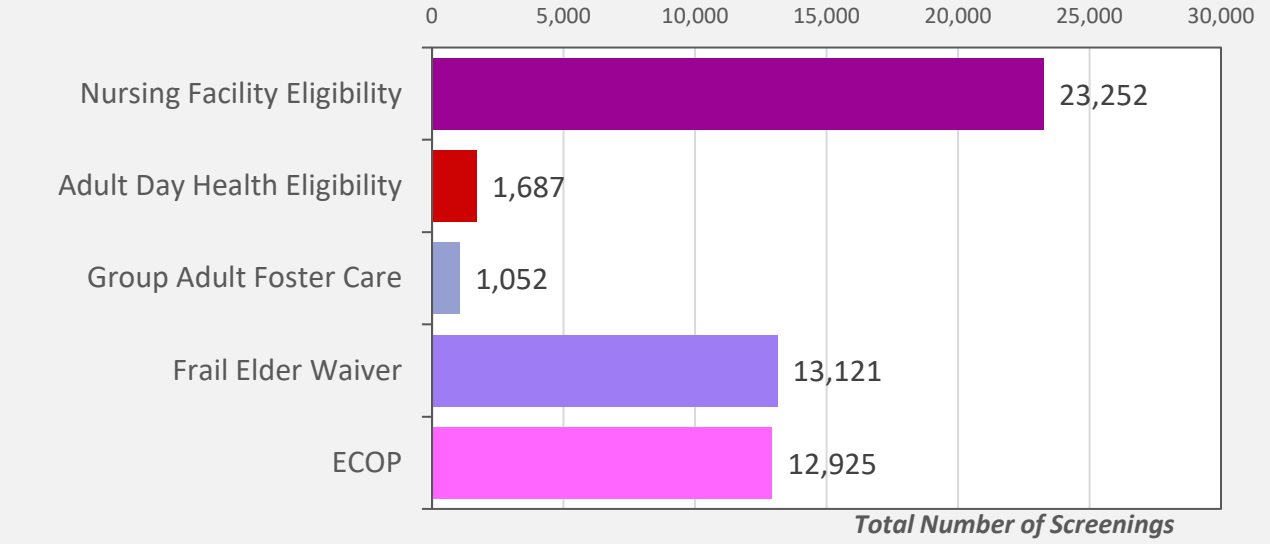
CLINICAL ASSESSMENT AND ELIGIBILITY

In Clinical Assessment and Eligibility (CAE), an ASAP-employed Registered Nurse (RN) assesses consumers and evaluates whether they are eligible for nursing facility care or community-based services reimbursed by MassHealth and state-funded programs (such as Adult Day Health, Group Adult Foster Care, the Frail Elder Waiver, and Enhanced Community Options Program). ASAPs must follow specific requirements for each program. For example, ASAPs have five business days to complete a referral for MassHealth programs.

SERVICES PROVIDED AND PEOPLE SERVED

Collectively, EOEA conducted over 50,000 screenings in FY24.

Figure 6. Number of Eligibility Screenings Conducted, by Service or Program



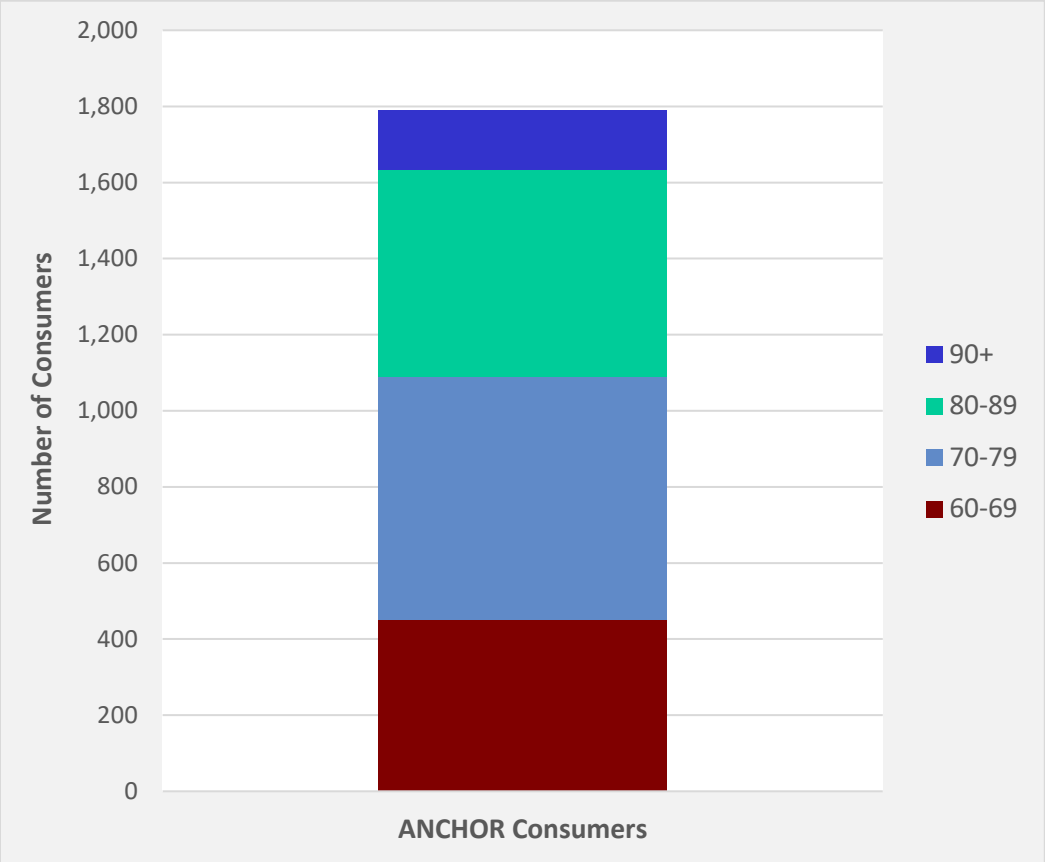
Notes. For the Frail Elder Waiver and Enhanced Community Options Program (ECOP), the numbers include both initial and re-determination screenings.

ADVOCACY & NAVIGATING CARE IN THE HOME WITH ONGOING RISKS

The Advocacy and Navigating Care in the Home with Ongoing Risks (ANCHOR) program, which launched in 2019, is designed to support older adults who have difficulty accepting on-going, consistent in-home services. The ANCHOR program offers focused, goal-oriented care management to help individuals consistently receive services through the EOEA Home Care Program. Through the collaboration of ASAPs, Protective Services, Housing, Council on Aging's,

and Elder Mental Health Specialists, the ANCHOR program allows for increased engagement to connect, build rapport and advocate for the individuals served. ANCHOR enrolls older adults aged 60+ who are suspected or confirmed to have behavioral health needs (not a requirement for enrollment), at risk or resistant to accepting services, in need of extra time/efforts or reassurances, and have identified goals.

Figure 7. ANCHOR Consumers, by Age Group

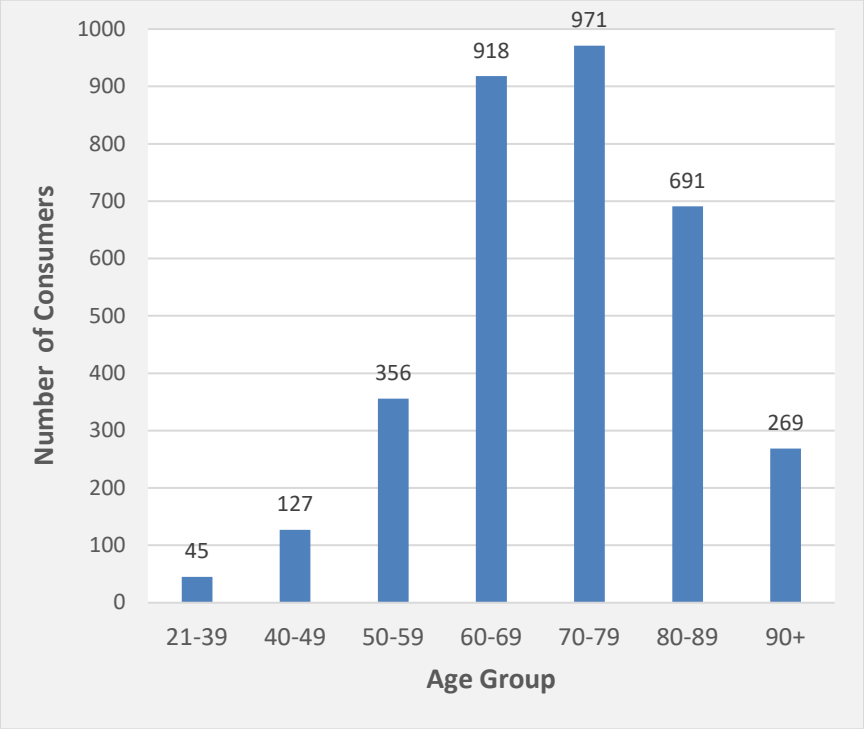


COMMUNITY TRANSITION LIAISON PROGRAM (CTLP)

The Community Transition Liaison Program (CTLP), launched July 1, 2023, assists Massachusetts Nursing Facility (NF) residents understand, explore and transition back to community settings through person-centered engagement, education and advocacy. EOEA contracts with ASAPs for CTLP teams to provide dedicated liaisons and case assistants who complete weekly NF visits in their region. CTLP teams provide transition options and resources to NF residents and

assistance in overcoming barriers through the discharge planning process. In addition to working directly with the NF resident, CTLP teams collaborate with NF staff, families, local community resources, HCBS Waivers, Money Follows the Person Demonstration and other state programs and organizations to ensure successful transitions back to the community. CTLP is available to all NF residents aged 22 years or older, regardless of insurance type, who are interested in learning about and pursuing a transition to the community.

Figure 8. CTLP Consumers, by Age Group



SENIOR NUTRITION PROGRAM

The Senior Nutrition Program administers and coordinates 24 local nutrition programs throughout the Commonwealth, serving approximately 10 million nutritionally balanced meals each year.[9] Using state and federal funding, this program addresses multiple issues faced by older adults, including food and nutrition insecurity, chronic disease, malnutrition, and social isolation. Meals are provided at more than 350 sites for group dining (such as senior centers, churches, schools) or are delivered to older adults in their homes. The program provides

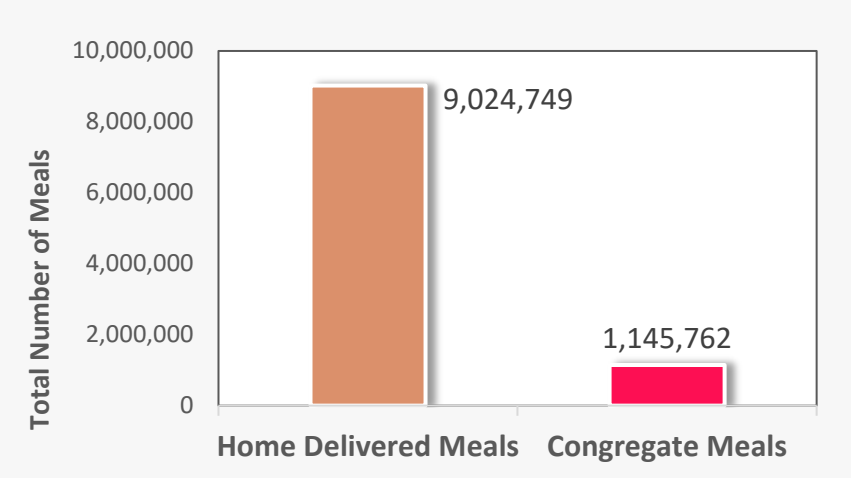
[9] The number of meals is for federal fiscal year 2022.

multiple culturally relevant meals including Kosher, Russian, Latino/Hispanic, vegetarian, Chinese, Caribbean, Southern, regular, Italian, Haitian, and Vietnamese; as well as medically tailored meals including heart-healthy/diabetes-friendly, renal, lactose free, and texture-modified meals such as soft, chopped, or pureed.

SERVICES PROVIDED AND PEOPLE SERVED

The Senior Nutrition Program served almost 10 million nutritionally balanced meals during the 2023 federal fiscal year (Figure 9).

Figure 9. Number of Meals Served (Federal Fiscal Year), by Home-Delivered and Group Dining (Congregate) Programs



Notes: This data is for the federal fiscal year (October 1, 2022 – September 30, 2023). Federal fiscal year 2024 data were not available when this report was created.

SUPPORTIVE AND CONGREGATE HOUSING

The Supportive Housing Program provides services to residents living in subsidized housing for older adults and people with disabilities. The program seeks to help residents live in-community by providing on-site service coordinators and supportive services such as program referrals, 24-hour on-call assistance, meals, and structured social activities.

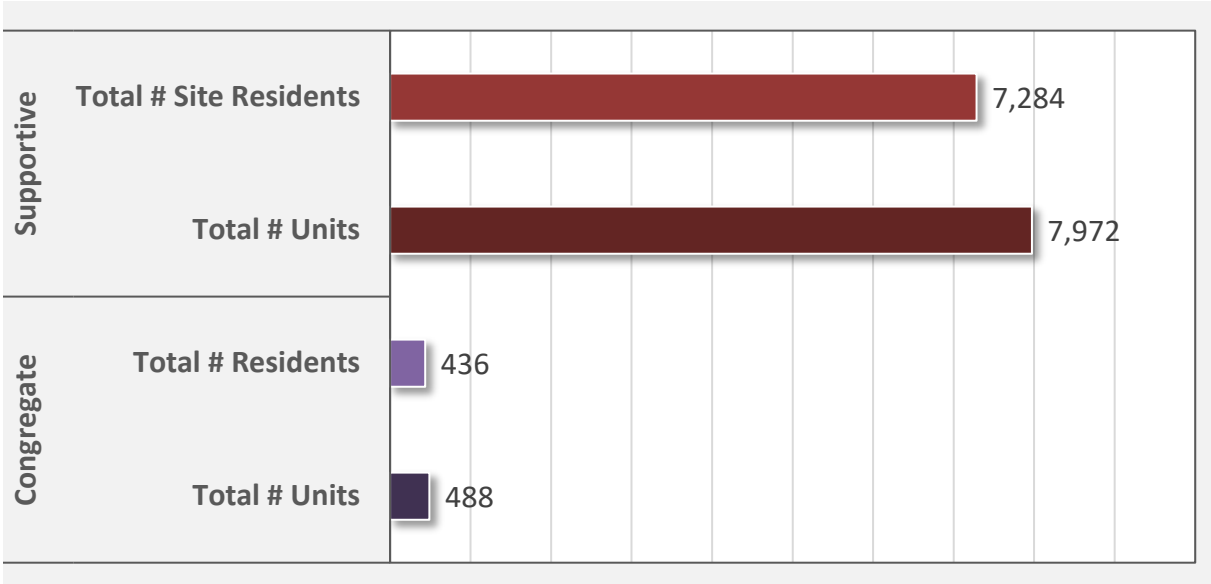
Similar to Supportive Housing, the Congregate Housing Program integrates housing and support services for older adults and individuals living with disabilities. However, Congregate Housing involves a shared living environment—each resident has a private bedroom, but shares one or more of the following: kitchen facilities, dining facilities, and/or bathing facilities. A Congregate

Housing Coordinator provides group living support, referrals to services, and structured social activities.

SERVICES PROVIDED AND PEOPLE SERVED

Supportive Housing and Congregate Housing services are available to over 7,500 residents in older adult subsidized housing (Figure 10).

Figure 10. Supportive and Congregate Housing Residents



Notes: Supportive and Congregate Housing sites submitted data. Statistics are as of June 30, 2024.

WORKFORCE TRAINING

PERSONAL AND HOME CARE AIDE STATE TRAINING (PHCAST)

To help train more home care professionals, EOEA contracts with the Institute for Community Inclusion at UMass Boston to develop and administer the Personal and Home Care Aide State Training (PHCAST), which is free and available online. PHCAST offers two courses: (1) the Homemaker course composed of 10 modules, and (2) Personal Care Homemaker course composed of six modules.[10] Learners must score 80% or higher to progress from one module to the next. PHCAST is available self-paced, so students can learn when it is convenient for them.

[10] Homemakers help with shopping, cooking, laundry, and tasks around the home like cleaning, doing dishes, and vacuuming. Personal Care Homemakers help with activities of daily living ADLs, such as bathing, dressing, hair care, and getting around

Courses are offered in a total of seven languages – English, Spanish, Haitian Creole, Brazilian Portuguese, Mandarin (Simplified and Traditional), Cantonese (Simplified and Traditional), and Russian (added in FY2024).[11]

SERVICES PROVIDED AND PEOPLE SERVED

PHCAST had over 11,000 active learners in FY24 (Figure 11).

Figure 11. PHCAST number of enrollments (active and to-date) and certification issued.

Notes. Homemaker certificate earners must also complete an additional three-hour agency specific orientation/agency specific training (such as, how to fill out forms, who to contact in an emergency). Personal Care Homemaker certificate earners must complete an additional 10-hour in person training to showcase learned skills.

ADVANCED TRAINING FOR AGING SERVICES NETWORK EMPLOYEES

To help develop the Council on Aging (COA) and ASAP staff who serve older adults, EOEA contracts with Boston University's Center for Aging & Disability Education & Research (CADER) to provide certifications for ASAP and COA staff. EOEA funded two distinct online, college-level certificate programs in FY24 (Table 2). Participants expressed high satisfaction rates (greater than 90%) for most courses on course applicability, relevance, and enhancement of knowledge and skills in their practice with older adults.

[11] The most common languages spoken by Home Care participants are: English (86%), Spanish (4%), Russian (2%), Portuguese (2%), and Haitian Creole (1%).

Table 2. CADER Certificates Funded by EOEA for the Aging Services Network

Course Name	ASAP Participants	Council on Aging Participants
Behavioral Health in Aging	136	21
Person Centered Case Management	135	36

Notes: In FY24 254 (94%) ASAP participants completed certificates, as did 42 (74%) COA participants.

EOEA also contracts with the ASAP Old Colony Elder Services to provide advanced skill training for the Home Care Aide workforce. During FY24, Old Colony facilitated the following trainings:

- Mental Health Supportive Home Care Aide (60 students participated in three 2-day sessions)
- Alzheimer's Supportive Home Care Aide (71 students participated in four 2-day sessions)
- Home Care Aide Substance Misuse (57 students participated in three 2.5-hour sessions)
- Social Isolation (47 students participated in three 2.4-hour sessions)

BEHAVIORAL HEALTH

Elder Mental Health Outreach Teams (EMHOTs) play a unique role as a community-based behavioral health program for individuals aged 60+.[12] EMHOTs serve older adults in 188 of the 351 Massachusetts municipalities. Each program is staffed by social workers and Master's-level interns who assist older adults with immediate needs as well as long-term supports.[13] EMHOT team members meet with older adults to establish trusting relationships and provide services including:

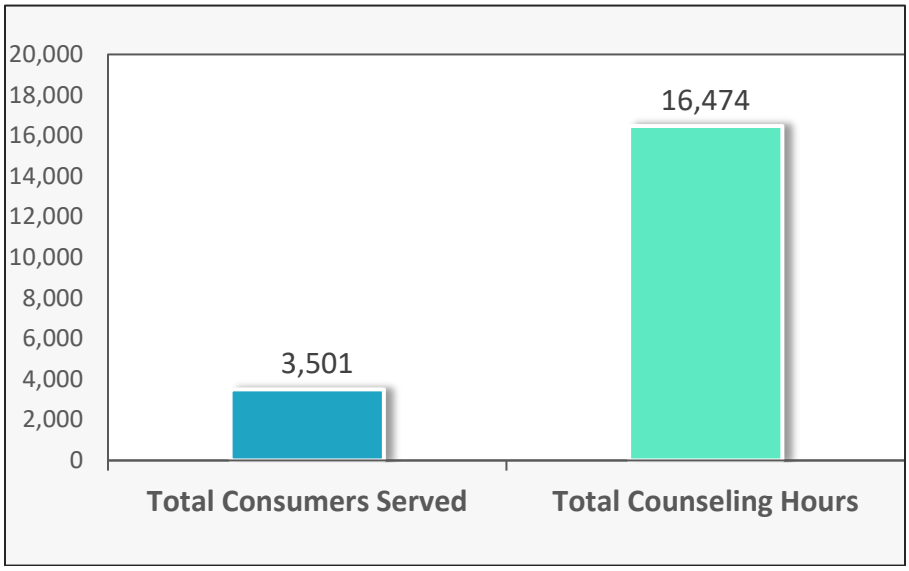
- Assessment of needs and addressing barriers to access
- In-home visits, counseling, and therapy
- Coordination and collaboration with family caregivers and medical providers
- Warm hand-offs to other community-based services and programs, including aging services, housing, financial, and physical and behavioral health care supports. EMHOTs often act as a bridge between older adults and the behavioral health care system, including provision of or referral to "wraparound" services and resources and supporting older adults in accepting, seeking, and navigating to behavioral health care services

[12] EMHOTs were managed by MCOA in FY24. This program was rebranded in FY25 as the Behavioral Health Outreach for Aging Populations (BHOAP) program and was brought under EOEA oversight.
[13] The most common behavioral health diagnoses were: depression (41%), anxiety (26%), and Post Traumatic Stress Disorder (6%).

SERVICES PROVIDED AND PEOPLE SERVED

The EMHOT Program served roughly 3,500 consumers, providing over 15,000 one-one counseling hours (Figure 12).

Figure 12. EMHOT total consumers and counseling hours



Notes: The Total Counseling Hours reported are individual counseling hours; EMHOT also provided 512 group counseling hours in FY24.

PROTECTIVE SERVICES

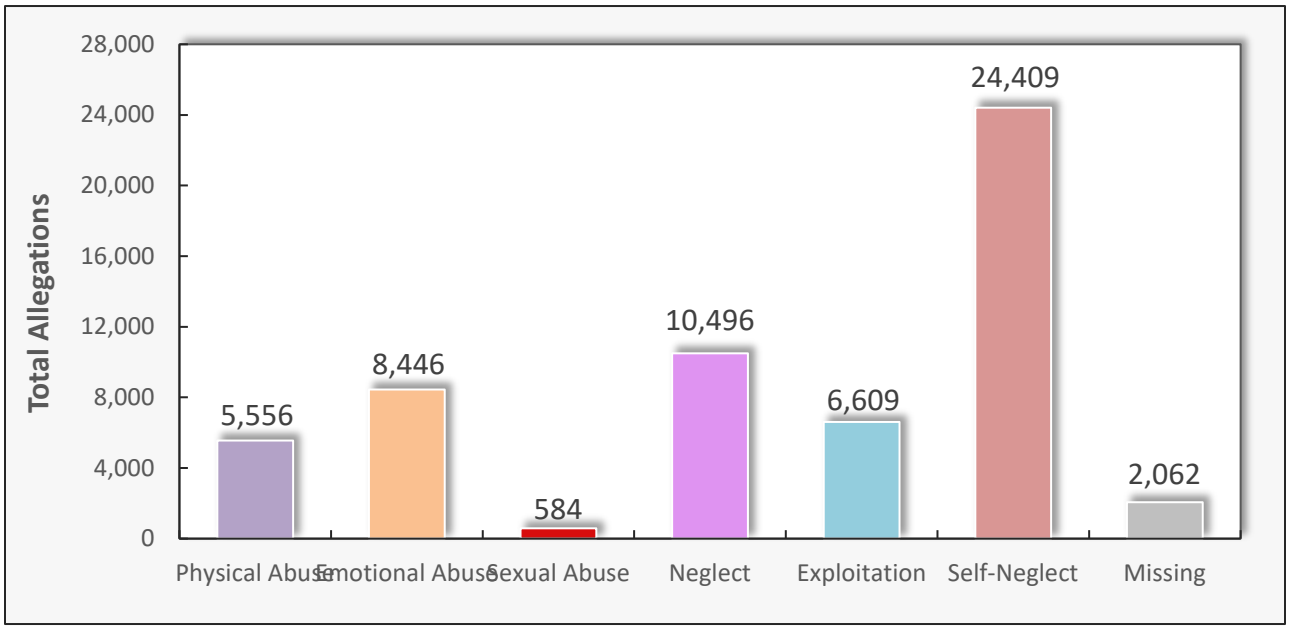
EOEA administers a statewide system that receives and investigates reports of abuse and provides needed protective services to Massachusetts adults aged 60 and older. Anyone who is concerned can file a report, at any time, by phone or using an online reporting portal, with a state-wide intake system. These reports are forwarded to 19 Protective Services (PS) agencies, each within an ASAP, to screen reports for jurisdiction, conduct investigations, and develop a service plan to alleviate the abusive situation.[14]

SERVICES PROVIDED AND PEOPLE SERVED

ASAPs received over 55,000 allegations of abuse in FY24 (see Figure 13).

[14] EOEA designates the 19 PS agencies. EOEA also provides conservator and guardianship services through four guardianship agencies and oversees a Money Management Program through the local ASAPs. The Money Management Program at each ASAP deploys trained and monitored volunteers who provide bill-paying assistance to older adults who are having difficulty managing their day-to-day finances.

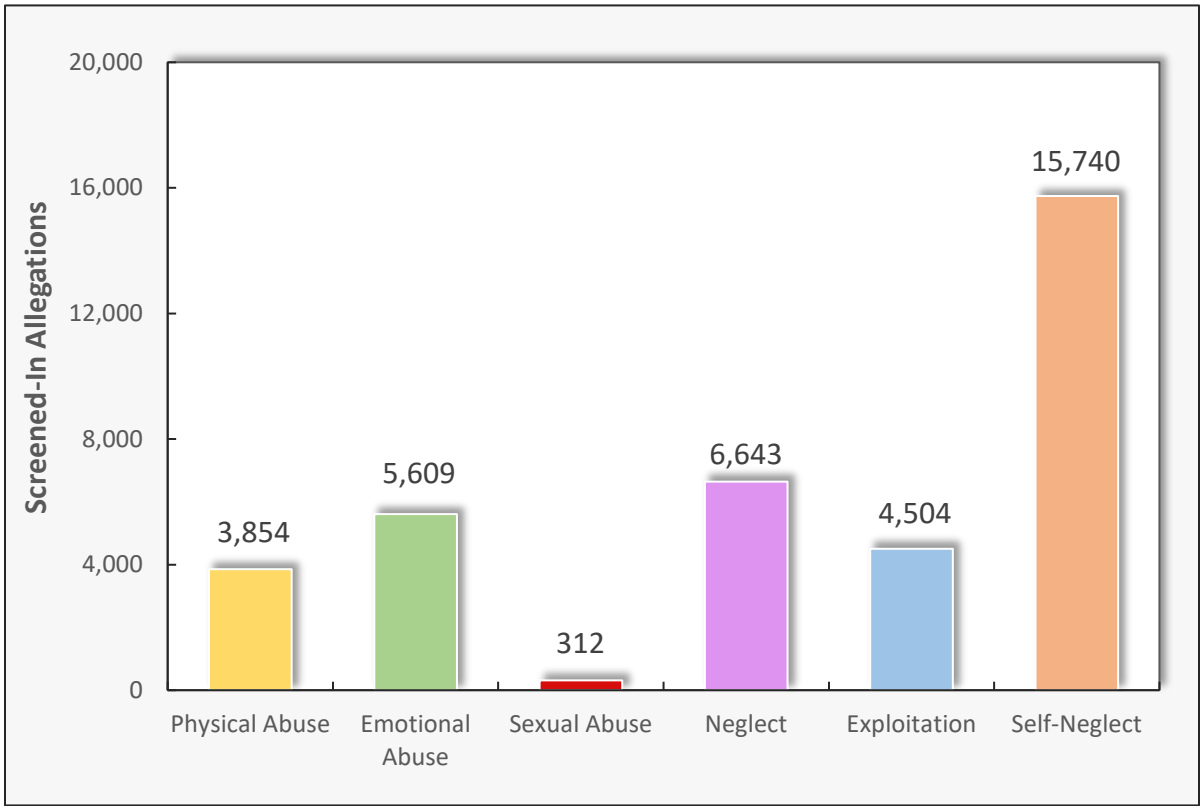
Figure 13. Number of Allegations Reported to Protective Services, by Allegation Type



Notes: For reports phoned-in to the Central Intake Unit or walk-ins, staff categorize the allegation types, and the Protective Services Agency screener might add to or refine them. For reports filed using the online reporter portal, the screener classifies the allegation type. A reporter might report multiple types of allegations for an older adult (for example, allege both neglect and exploitation); each allegation is presented in the figure. This means that the number of allegations exceeds the number of alleged victims. Sometimes multiple reports are submitted for the same allegation (for example, a child and a primary care physician are both concerned about neglect); these intakes are typically not consolidated into one intake for the reporting in this figure. (An intake is a reported allegation that has been entered in the Adult Protective Services database.) Sometimes an older adult can have multiple reports submitted for different allegations over time. When a report is screened out, some allegations might not be classified.

ASAPs initiated investigations for over 35,000 allegations in FY24 (see Figure 14).[15]

Figure 14. Number of Allegations Investigated by Protective Services, by Allegation Type

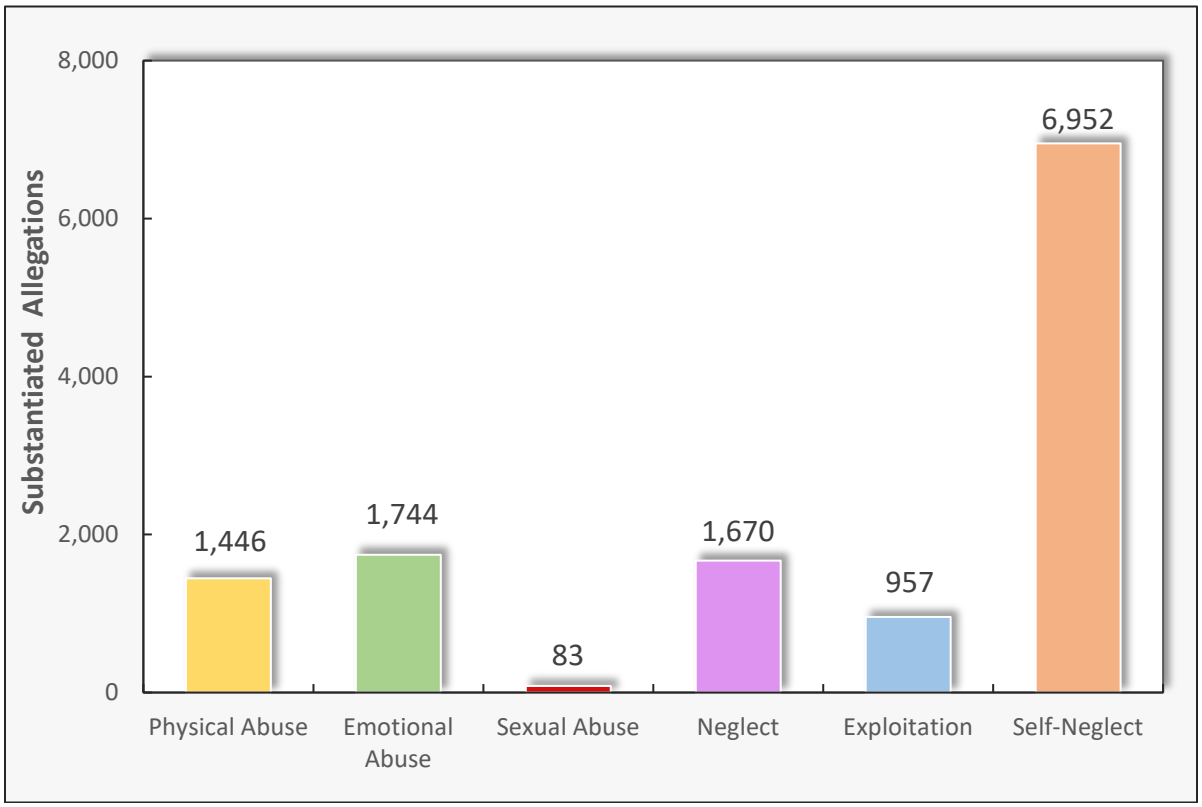


Notes: The Protective Services Agency might screen-in multiple types of allegations for an older adult (for example, allege both neglect and exploitation); each allegation is presented in the figure. This means that the number of allegations exceeds the number of alleged victims. There could be multiple Intakes with the same allegations listed. Although there can be multiple reports for the same allegation (see Figure 13), only one of the reports will be screened in with the resolution of investigation—so there can be multiple reports for the same allegation, but typically only one investigation for the same allegation.

[15] Some allegations that qualify for investigations do not lead to actual investigations (for example, allegations that are referred to the relevant district attorney).

ASAPs substantiated allegations for almost 12,000 allegations and usually provided ongoing services for the victims (see Figure 15).[16]

Figure 15. Number of Allegations Substantiated by Allegation Type



Notes: Sometimes multiple intakes exist for the same allegation or older adult; these intakes are consolidated into one investigation. A single investigation for an older adult can investigate and substantiate multiple allegations.

SHINE

Serving the Health Insurance Needs of Everyone (SHINE) is a health insurance assistance program that provides free health insurance information, counseling, and assistance to Massachusetts residents with Medicare and their caregivers. The SHINE Program is

[16] If the allegations are substantiated, there are three circumstances under which a protective services agency would not provide ongoing services: (1) the victim does not consent, (2) the victim moves out of state and the agency no longer has jurisdiction, (3) the victim dies, or (4) the agency has a compelling reason (for example, the services would harm the older adult). For the last case, the agency must obtain and document approval from EOEA prior to taking such action.

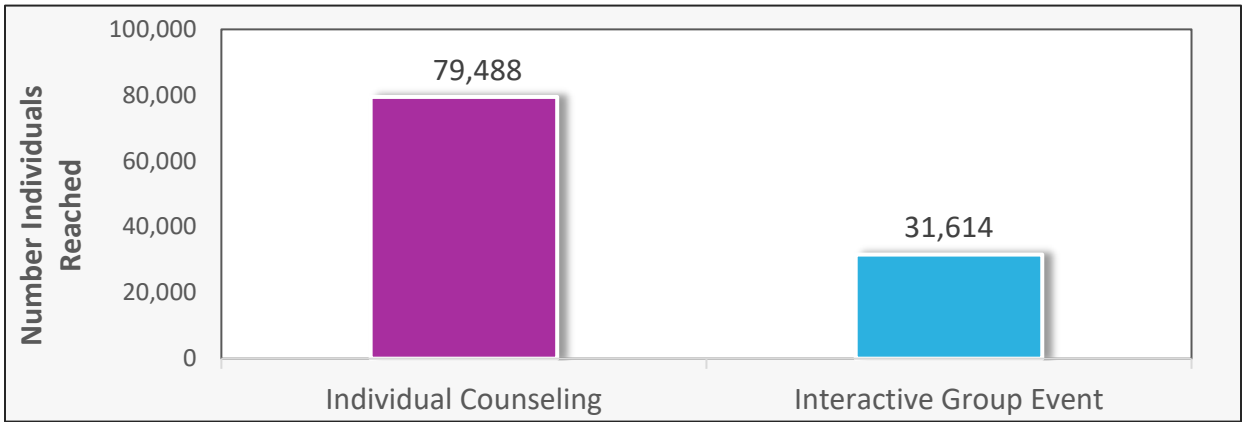
administered by EOEA in partnership with ASAPs and Area Agencies on Aging (AAAs), social service and community-based agencies, and COAs.

Fourteen programs—thirteen regional and one statewide language-based—supervise and train over 650 volunteer and in-kind health benefits counselors to provide information and assistance in many areas of health insurance, including Medicare Part A, Part B, and Part D, Medigap insurance, Medicare HMOs, retiree insurance plans, prescription drug programs, Medicaid, Medicare assistance programs (QMB, SLMB, and QI), and other programs for people with limited resources. The SHINE program helps older adults and people living with disabilities understand their Medicare and MassHealth benefits, along with other health insurance options. The program ensures that Massachusetts residents with Medicare and their caregivers have access to accurate, unbiased, and up-to-date information about their health care options.

SERVICES PROVIDED AND PEOPLE SERVED

Over 100,000 residents received assistance from SHINE (Figure 17).

Figure 16. SHINE Participants, by Counseling Type



Notes: The figure reports unique participants in individual counselling sessions and interactive group events (that is, each participant is only counted once).

PRESCRIPTION ADVANTAGE

Prescription Advantage helps Massachusetts older adults and younger residents with disabilities pay for their prescription medicines (*secondary prescription coverage).*[17] Once members spend a certain amount, Prescription Advantage covers the co-payments for the

[17] Prescription Advantage supplements prescription drug benefits by helping to pay for medications covered by Medicare Part D or other insurance.

remainder of the plan year, and the program often lowers the co-payments members pay for covered drugs and, for some members, covers the premiums for basic Medicare prescription drug plans. Prescription Advantage is available to residents: (1) who are over the age of 65, eligible for Medicare, and have a gross annual household income less than 500% of the Federal Poverty Level,[18] (2) who are aged 65 or older and not eligible for Medicare, or (3) who are under age 65, work no more than 40 hours per month, meet MassHealth's CommonHealth disability guidelines, and have a gross annual household income at or below 188% of the Federal Poverty Level.[19]

SERVICES PROVIDED AND PEOPLE SERVED
During FY2024, 6,177 unique individuals received assistance from Prescription Advantage.[20]

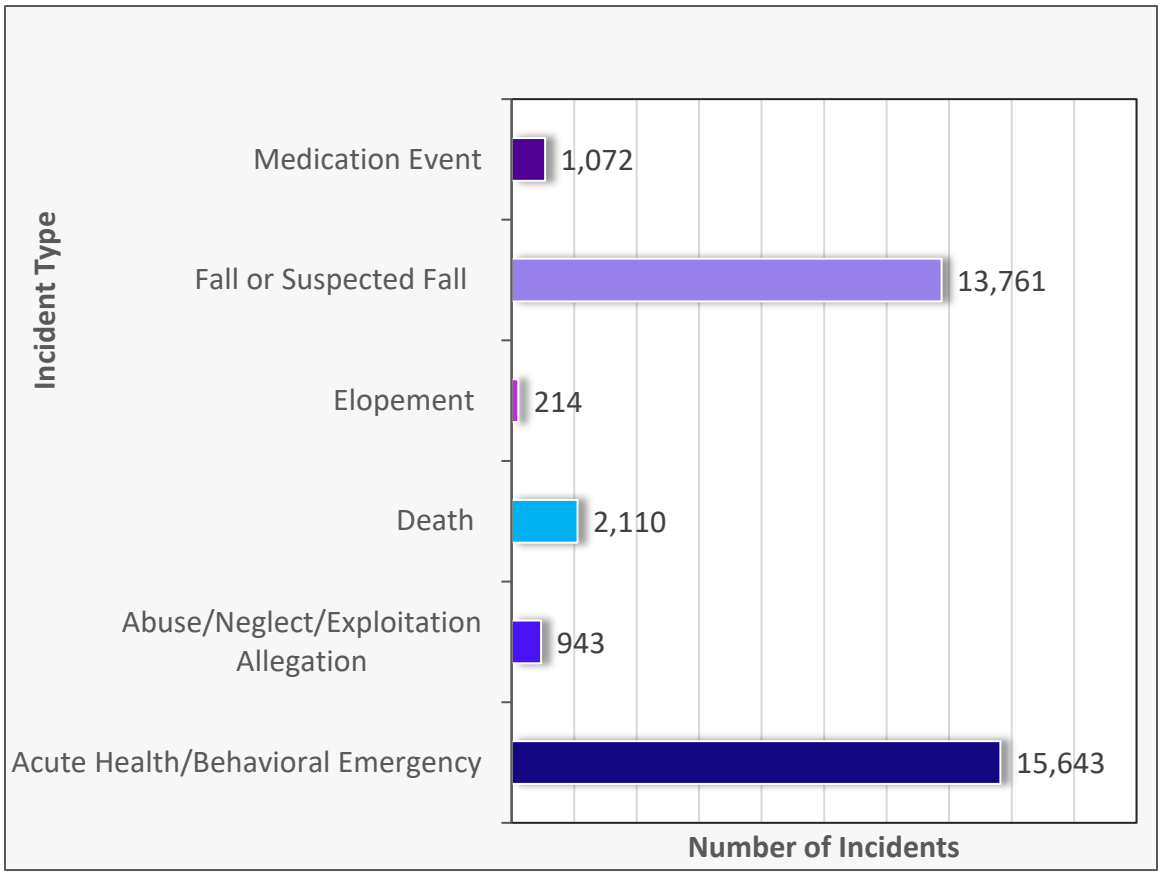
ASSISTED LIVING RESIDENCES

EOEA certifies roughly 270 Assisted Living Residences (ALR) with more than 17,000 residents across the Commonwealth.[21] Over 75% of ALR residents receive help with at least one ADL, and a similar percentage receive medication assistance. EOEA's Assisted Living Certification Program is responsible for the certification and regulatory oversight of these privately-owned communities. This includes processing and reviewing over 20,000 incident reports submitted by the ALRs in accordance with the requirements of the regulations.

SERVICES PROVIDED AND PEOPLE SERVED
Over 20,000 ALR incidents were reported to EOEA; over 80% of these incidents were falls/suspected falls or acute health/behavioral emergencies (Figure 17).

[18] In FY23, the federal poverty level was $14,580 for a one-person household.
[19] Residents cannot be MassHealth or CommonHealth members or have benefits through a Medicare Savings Program (MSP), also referred to as a MassHealth Buy-in Program.
[20] Defined as individuals who had at least once claim paid or lower copays during FY23.
[21] For more information on Massachusetts ALRs and ALR residents, see EOEA's Annual Aggregate Data Report (link).

Figure 17. Number of Assisted Living Residence Incidents Reported by Incident Type



Notes: This figure excludes incidents that were saved to the database system but not actually submitted. Deaths include unexpected deaths and other deaths. EOEA requires that ALRs submit incident reports for "unanticipated deaths" but ALRs often also submit reports for anticipated deaths (such as residents who pass away under hospice care).

OPTIONS COUNSELING

Chapter 211 of the Acts of 2006 requires the Executive Office of Elder Affairs (EOEA) to issue an annual report about the Options Counseling (OC) Program. Pursuant to the statutory language:

> *A person seeking admission to a long-term care facility paid for by MassHealth shall receive pre-admission counseling for long-term care services, which shall include an assessment of community-based service options. A person seeking care in a long-term care facility on a private pay basis shall be offered pre-admission counseling. For the purposes of this section, pre-admission counseling shall be conducted by the executive office of health and human services or the executive office of elder affairs or their subcontractors... The division shall report to the general court on an annual basis the number of individuals who received pre-admission counseling under this section and the number of diversions to the community generated by the pre-admission counseling program.*

BACKGROUND

EOEA created and piloted an OC Program in 2008 in response to the passage of Chapter 211 of the Acts of 2006. In 2010, counseling services were expanded across the state through a network of eleven (11) regional Aging and Disability Resource Consortia (ADRCs), comprised of partnerships between the Aging Service Access Points (ASAPs)/Area Agencies on Aging (AAAs) and Independent Living Centers (ILCs).[22] OC provides coverage to every city and town in the Commonwealth.

To identify people who need counselling, Options Counselors conduct outreach in organizations that provide services to older adults and people with disabilities, including hospitals, nursing facilities, assisted living residences, municipal agencies, and housing entities. Counselors can also advertise in health fairs and some private businesses where older adults and caregivers go regularly, such as pharmacies, hair salons, grocery stores, funeral service organizations, and local hair salons. Finally, counseled individuals are referred to the service by providers that

[22] OC is funded through the state budget EOEA account (line item) 9110-0600, often referred to as the Community Choices account for home care services. The law stipulates, under section 9 of chapter 118E of the Massachusetts General Laws, that funds shall be expended from this item to implement the pre-admission counseling and assessment program. The FY24 allocation for the counseling service is issued through contracts with the ADRCs based on the proportion of home care consumers and the number of nursing facility beds in each geographic region.

include discharge planners, ombudsman, and care managers who are employees of the 10 ILCs and 24 ASAPs.

FY24 RESULTS

This appendix presents information on the 4,702 counseled individuals whose cases were closed during the period of July 1, 2023 – June 30, 2024 (FY24). EOEA obtained outcome data, for 3,369 counseled individuals from counselor discussions with consumers, family, and caregivers.[23] Approximately 88.1% of the individuals who received OC were living at home or in the community at the time of counselling. The remaining 11.9% of counseled individuals were in an institutional setting (acute care hospital, rehabilitation facility, or long-term care facility/skilled nursing facility).

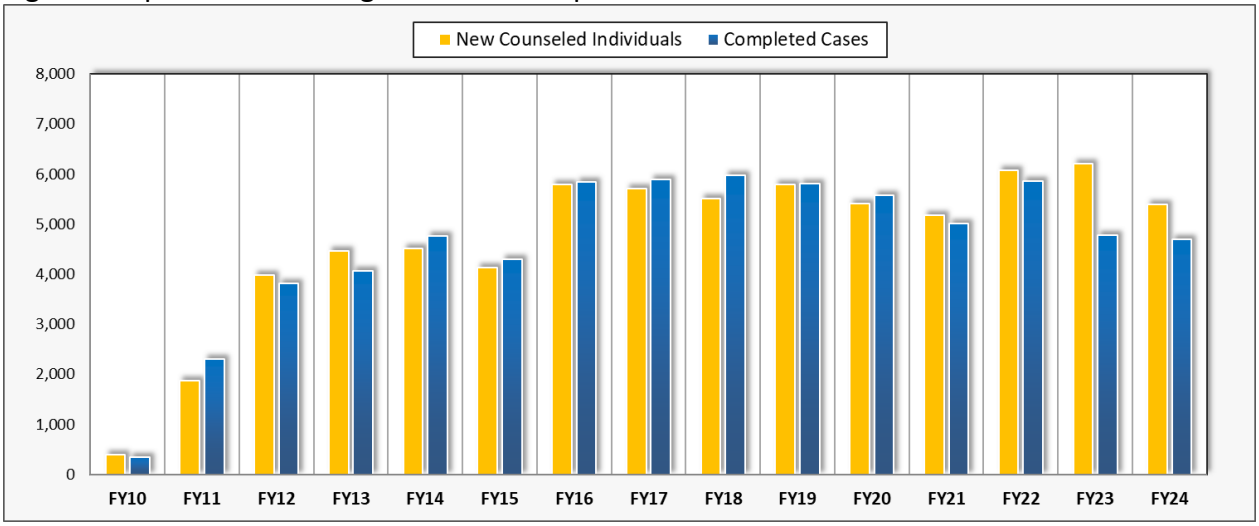
In FY24, EOEA had outcomes for 3,369 people who completed Options Counseling; at final check-in, approximately 88% of those people were living in their community.

NEW & COMPLETED CASES FY10 – FY24

Over the past eight years, roughly 5,000-6,000 people have received Options Counseling annually. Figure 1 presents the number of new Options Counseling cases and completed cases, each year, from the beginning of the program through FY24.

[23] Data on where consumers ultimately reside (labeled an *outcome* in this report) is collected during the final check-in, which happens 5-20 business days after the final counseling session. Counselors make up to three attempts to contact the consumer for the final check-in: (1) phone call, email, or in person, (2) phone call, email, or in person, and (3) final closing letter. During the check-in, counselors also collect information on the reason why the consumers chose an institutional setting, whether the individual receives formal home care services, or receives informal services from family/friends. To simplify presentation and make the report more accessible, these distinctions are not provided in this report. Check-in data is documented and maintained in the Aging & Disability Database.

Figure 1. Options Counseling: New and Completed Cases FY10 – FY24

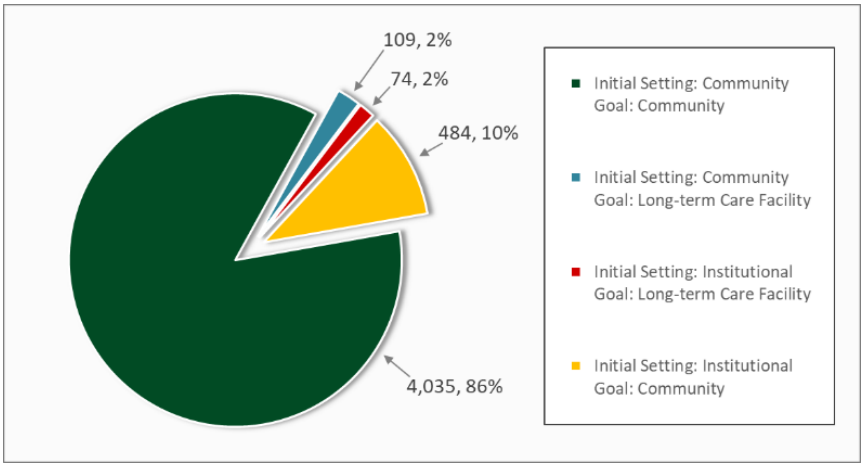


Notes: These numbers include I&R referrals, where the counseling process starts at one agency and is later referred to another. There were 376 I&R referrals in FY24. These referrals are not included in subsequent figures, as referred individuals served by multiple agencies still only have one outcome.

GOALS OF COUNSELED INDIVIDUALS

During the initial consultation, 96% of counseled individuals whose cases were closed expressed an initial desire to live at home or remain in a community setting (Figure 2). Approximately 88% of counseled consumers were living in a community setting at the time of initial counseling.

Figure 2. Number of counselled individuals, by initial setting and initial goal

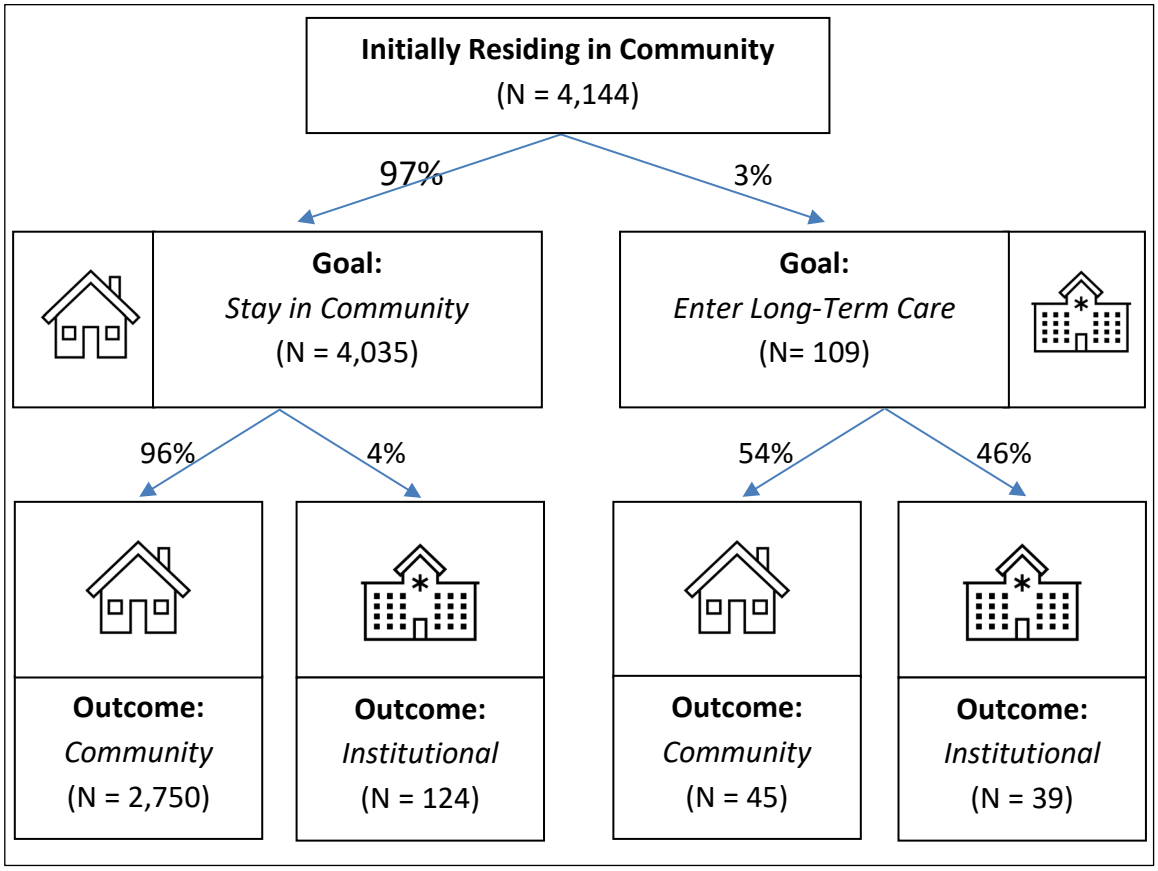


Notes: Roughly 72% of completed-case individuals had known outcomes (N = 3,369); the remaining individuals (N = 1,366) could not be contacted, declined counseling, were transitioning, or died. The numbers in this figure exclude the 376 I&R referrals in FY24.

OPTIONS COUNSELING OUTCOMES

In FY24, OC completed counseling with 109 people who were living in the community but considering residency in a nursing home. EOEA obtained outcomes for 84 of the people who completed counseling; roughly 41% were able to remain in the community (Figure 4).[24]

Figure 4. Outcomes, Counseled Individuals Initially Residing in the Community



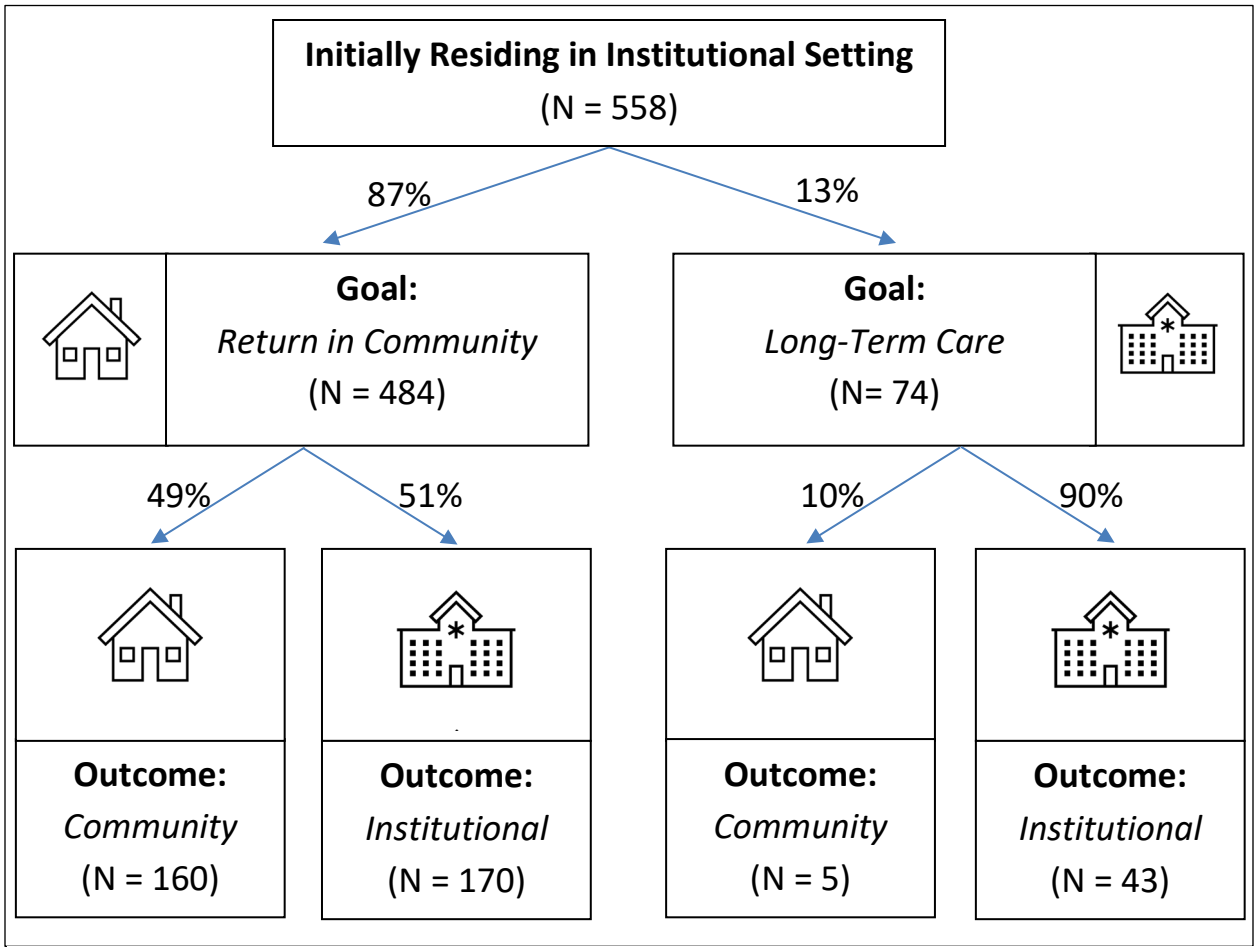
Notes: Outcomes were not available for approximately 29% of counseled individuals with an initial goal of staying in the community (EOEA was unable to contact 494 individuals, 398 individuals declined to provide outcome data, 43 individuals died, and 226 individuals did not otherwise have outcome data). Outcomes were not available for approximately 23% of counseled individuals with an initial goal of entering long-term care (EOEA was unable to contact 10 individuals, 2 individuals declined to provide outcome data, 3 individuals

[24] See the Appendix for outcomes for the subset of individuals who are living in the community and at risk of long-term care admission. These individuals are roughly 6% of all individuals who are living in a community with a goal of staying in the community.

Notes Cont.: died, and 10 individuals did not otherwise have outcome data). An institutional outcome indicates the individual was in an acute care hospital, rehabilitation facility, or long-term care facility/skilled nursing facility.

In FY24, OC completed counseling with 74 people who were residing in an institutional setting and considering residency in a nursing home. EOEA obtained outcomes for 48 of the people who completed counseling; roughly 7% of those currently in an institutional setting were able to return to the community (Figure 5).

Figure 5. Outcomes, Counseled Individuals Initially Residing in Institutional Setting



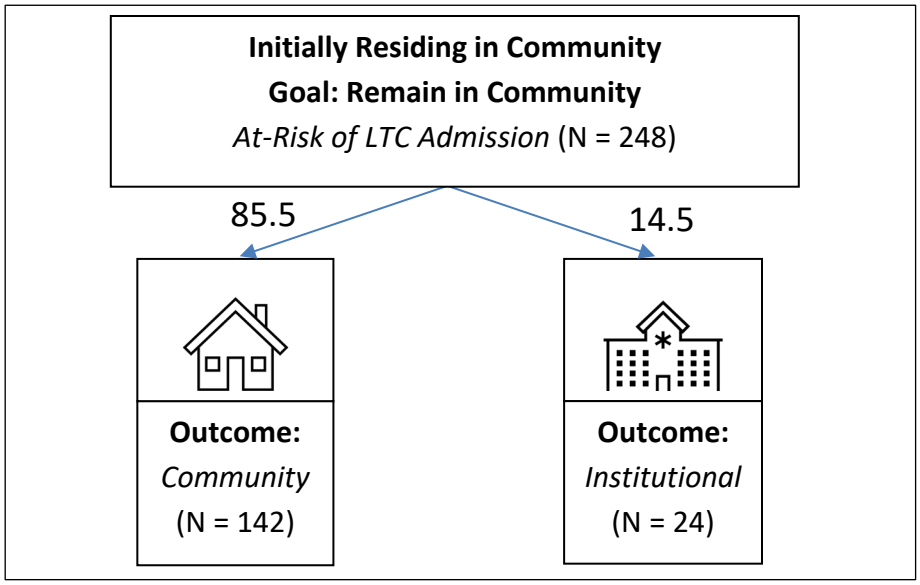
Notes. Outcomes were not available for approximately 32% of counseled individuals living in an institutional setting who had an initial goal of staying in the community (EOEA was unable to contact 43 individuals, 29 individuals declined to provide outcome data, 13 individuals died, and 24 individuals did not otherwise have outcome data). An additional 45 individuals were classified as *Transition in Progress*, which indicates that the individual is in the process of transitioning to a community setting but discharge is still pending, and the

Notes Cont.: individual is still in an institutional setting when the final check-in occurs (that is, whether the individual ultimately transfers to a community setting is unknown, but the discharge is imminent). Outcomes were not available for approximately 35% of counseled individuals living in an institutional setting who had an initial goal of staying in long-term care (EOEA was unable to contact 6 individuals, 3 individuals declined to provide outcome data, 5 individuals died, and 12 individuals did not otherwise have outcome data). An institutional outcome indicates the individual was in an acute care hospital, rehabilitation facility, or long-term care facility/skilled nursing facility.

LIVING IN COMMUNITY AND AT RISK OF LTC ADMISSION INDIVIDUALS

Approximately 6% of all counseled individuals living in the community and wanting to remain in the community were identified as being at risk of LTC admission. Of these individuals, 85.5% successfully remained at home or in another community setting (see Figure A.1).[25]

Figure A.1 Outcomes, Individuals at Risk of LTC Admission in Community with Goal to Remain



Notes: EOEA classified 248 individuals as being At Risk of LTC Admission (these individuals are a subset of the 4,035 individuals who were identified as being In the Community and had an Initial Goal of Remaining in the Community). Outcomes were not available for approximately 33% of counseled individuals with an initial goal of staying in the community (EOEA was unable to contact 32 individuals, 29 individuals declined to provide outcome data, 6 individuals died, and 15 individuals did not otherwise have outcome data). An institutional outcome indicates the individual was in an acute care hospital, rehabilitation facility, or long-term care facility/skilled nursing facility.

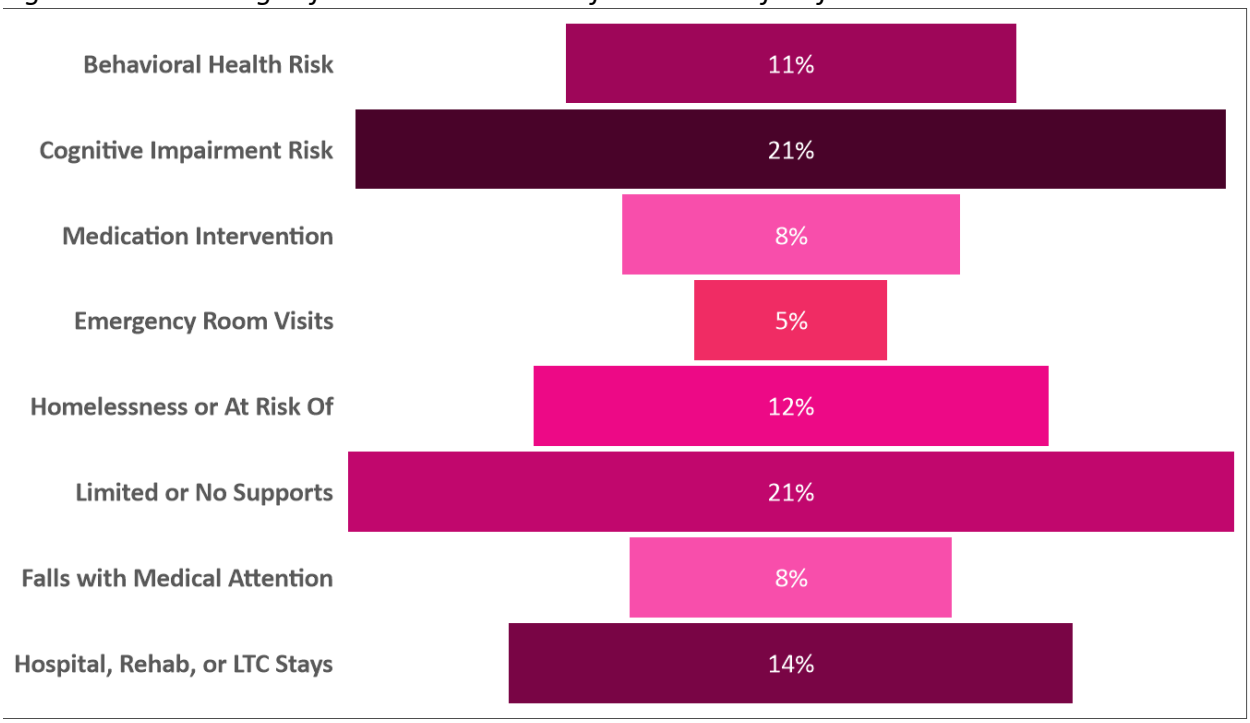
[25] The percentage, 85.5%, is based on individuals with known outcomes (denominator for calculation is 248); outcomes were not available for approximately 33% of counseled consumers. Roughly 2% of individuals in this category subset died before follow-up.

RISK FACTORS FOR LTC ADMISSION

Consumers can have one or more of the following factors that increase their risk for LTC admission (see Figure A.2). These factors are:

- Behavioral Health Needs that Pose Health/Safety Risk
- Cognitive Impairment that Poses Health/Safety Risk
- Difficulty Managing Prescriptions / Medications, Resulting in Medical Intervention
- Frequent ER Visits (2 or More Within Last 30 Days)
- Homeless or at Risk of Homelessness and Has Critical Unmet Need
- Limited or No Supports and Has Critical Unmet Need
- Recent Fall (Within Last 30 Days) Requiring Medical Attention
- Recent Hospitalization, Rehab Stay, or LTC Stay (Discharge Within Last 45 Days)

Figure A.2 Percentage of consumers with risk factors identified for LTC admission



APPENDIX: BUDGET

Table A1: Massachusetts State Budget, FY2021 – FY2024

Line Item	Name	FY2022 GAA	FY2023 GAA	FY2024 GAA	FY2025 GAA
9110-0100	Elder Affairs Administration	$2,245,094	$3,698,641	$5,051,799	$5,711,892
9110-0600	Community Choices	$253,512,831	$284,588,960	$303,085,276	$303,085,276
9110-1455	Prescription Advantage	$17,419,671	$17,771,506	$19,574,870	$19,832,247
9110-1604	Supportive Senior Housing	$7,763,422	$7,936,416	$9,492,576	$11,719,484
9110-1630	Home Care Services	$184,909,953	$200,390,552	$214,130,442	$236,882,945
9110-1633	Home Care Case Management	$64,433,467	$78,455,807	$78,456,327	$95,153,249
9110-1635	Enough Pay to Stay	$27,936,378	$40,040,717	-	-
9110-1636	Protective Services	$35,871,728	$42,764,146	$43,198,936	$47,886,211
9110-1637	Home Care Aide Training	$1,206,947	$1,206,947	$1,206,947	$1,207,262
9110-1640	Geriatric Mental Health Services	$1,200,000	$2,500,000	$2,500,000	$2,509,293
9110-1660	Congregate Housing	$2,634,232	$3,831,491	$3,931,491	$3,381,393
9110-1700	Elder Homeless Placement	$286,000	$286,000	$286,000	$286,000
9110-1900	Nutrition Services Programs	$10,483,808	$12,072,852	$12,872,860	$12,657,217
9110-9002	Grants to Councils on Aging	$18,171,651	$24,888,519	$28,200,000	$29,631,000
Total	-	**$628,075,182**	**$720,432,554**	**$721,987,524**	**$769,943,469**

Notes: The funds listed represent the General Appropriations Act (GAA) funding.
Source: https://budget.digital.mass.gov/summary/fy25/enacted/health-and-human-services/elder-affairs/

Table A2: FY2025 Federal Spending

Line Item	Name	Amount
9110-1067	FY23 Medicare Improvements for Patients and Providers (SHIPs)	$250,000
9110-1068	FY2023 Medicare Improvements for Patients and Providers (AAAs)	$200,000
9110-1069	FY2023 Medicare Improvements for Patients and Providers (ADRCS)	$105,000
9110-1073	Senior Community Service Employment Program Older Worker Employment	$860,000
9110-1074	Older Americans Act	$110,000
9110-1075	Title VII Ombudsman	$781,032
9110-1076	Title IIIB Supportive Service	$12,319,040
9110-1077	National Family Caregiver Support Program	$5,684,567
9110-1079	Title III D Preventative Health	$930,000
9110-1083	Ombudsman Program under Title VII of the OAA	$207,328
9110-1084	Supportive Services under Title III-B of the OAA	$12,204,216
9110-1085	Congregate Meals under Title III-C1 of the OAA	$6,219,847
9110-1086	Home Delivered Meals under Title III-C2 of the OAA	$9,329,771
9110-1087	Preventive Health under Title III-D of the OAA	$912,244
9110-1088	Family Caregivers under Title III-E of the OAA	$3,001,131
9110-1089	Adult Protective Services	$4,259,458
9110-1093	Public Health Workforce Within AAA FY22 ARPA	$1,700,000
9110-1094	State Health Insurance Assistance Program	$900,000
9110-1096	State Health Insurance Counseling Program Workforce Expansion Grant	$115,000
9110-1097	ADRC No Wrong Door Public Health WorkForce ARPA	$115,000
9110-1098	ARPA Long Term Care Ombudsman 23	$375,355
9110-1157	Ombudsman One Care Plan Initiative	$315,000
9110-1173	Older Americans Act	$23,221,529
9110-1174	Nutrition Services Incentive Program	$8,137,637
9110-1178	Community Service Employment Program	$1,748,857
Total		**$94,002,012**

ADRC = Aging & Disability Resource Consortia; ARPA = American Rescue Plan Act
SHIP = State Health Insurance Counseling Program

Source: https://budget.digital.mass.gov/summary/fy25/enacted/health-and-human-services/elder-affairs/