JOINT STATE GOVERNMENT COMMISSION

General Assembly of the Commonwealth of Pennsylvania

REPORT OF THE ADVISORY COMMITTEE ON LONG TERM CARE SERVICES AND SUPPORTS FOR OLDER PENNSYLVANIANS

(Revised)

AUGUST 2014

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August 21, 2014

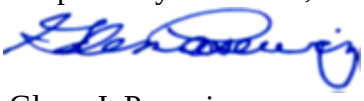
To the Members of the General Assembly of Pennsylvania:

House Resolution 255 of 2013 directed the Joint State Government Commission to form an advisory committee to study the long term care services and supports delivery system, to determine if the system is meeting the needs of independent and care-dependent older adults and their families, and to report to the House of Representatives its findings and recommendations.

Experience shows that consumers and their families are not likely to plan for long term care before a crisis hits, when urgent care is often needed. The advisory committee developed recommendations to improve the system's structure, and to reduce barriers to care, services, and payment. Better transitions from one level of care to the next, improved coordination of services, and increased cost sharing will help to expand access to services for all Pennsylvania seniors who are in need.

The full report, "Report of the Advisory Committee on Long Term Care Services and Supports for Older Pennsylvanians," is also available on our website, http://jsg.legis.state.pa.us/.

Respectfully submitted,



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INTRODUCTION

On June 27, 2013 the Pennsylvania House of Representatives adopted House Resolution 255 (HR 255), Printer's Number 2098, which directed the Joint State Government Commission (JSGC) to:

> study the Commonwealth's delivery system of long-term care services and supports for independent and care-dependent older adults, including: a review of the current infrastructure that exists for providing services and supports; consumer access to the system, including an identification of barriers that exist; and financing issues; and to report its findings and recommendations to the General Assembly.

The resolution was focused specifically on "older consumers and families," if and how Pennsylvanians are preparing for future long term care needs, whether their needs for independent and dependent care are being met and whether current public and private programs for financing of services can continue to meet their needs. Recommendations include proposed policy and legislative options to ensure that "Pennsylvania's long-term care services and supports delivery system is safe, accessible and affordable."[1]

Long term care (LTC) typically refers to the variety of services and supports that meet health care or personal care needs over an extended period of time. These services can apply to those age 60 or older, who are defined in law as "older Pennsylvanians," or those under 60 who typically have a chronic illness, cognitive or functional disability. While individuals under age 60 and those over age 60 may have similar needs for ongoing daily activities, the physical, emotional, social, cultural, financial and housing supports are often distinctly different for seniors, their support networks, and caregiver needs.

Aging in the Commonwealth, and around this country, has been the topic of an increasing number of studies and there is no denying the demographic trends that have been described as a silver tsunami of seniors that will overwhelm the system already struggling to meet rising demand for services. How can the state deliver more services to more people given budgetary constraints? How can those services be safeguard without the unintended impact of regulations on providers, making them spend more time on compliance paperwork than delivery of care? How can true consumer choice be promoted when there may not be the money to support those choices? There is no one solution and the complexity of the combined funding, delivery, and support systems will keep this issue on the front burner for families, consumers, and policy makers in the decades to come.

The current system serves vast numbers of consumers, both in facilities and with a variety of home care programs, but coordination is loose, funding is compartmentalized, and other barriers exist. Support services are also being provided to allow consumers to age in place and to increase the accessibility for older adults and their families to programs in their communities. The critical building

[1] House Resolution 255 appears in Appendix A of this report.

blocks for a comprehensive LTC system are local Area Agencies on Aging (AAAs), created to act as the focal point for planning and community services. According to the AARP, 87 percent of those age 50 and older want to receive services in their own homes. Costs must be shared, and when public dollars are expended accountability is paramount. There is also a need to develop a mechanism to ensure dollars are spent wisely and care is provided without undue regulation that adds costs to the government agencies and service providers who provide care.

Providing a level playing field between facility and home care means greater choice for consumers. Nursing home care is currently an entitlement not available to those who prefer home care options. Consumers must go through a lengthy waiver enrollment process to receive Medicaid home care funding. Sate paid benefits under the Pennsylvania Lottery are available directly to eligible seniors with no waivers required. There is also a need to balance people's ability to pay against their need in a tiered payment system to help prevent vulnerable seniors from falling between the cracks. Efforts to allow money to follow the person and for consumers to direct their own care will be improved with better intake planning, smoother transitions and more support for family caregivers. It is clear that education and awareness are unlikely to prompt a large number of people to plan for LTC, but can guide them where to go when a crisis occurs. There are no easy answers to these complex issues and even describing the issues is difficult. Many topics, including funding or regulatory reform, could easily be studies of their own.

Long term care is a delicate balance of services and supports. From independent to skilled nursing care, the key to sustainability is finding the right mix between the cost borne by consumers and finite public resources. Approaches have been piecemeal and fragmented, often characterized as chasing federal dollars which ultimately leads to creating new programs with new rules and regulations. There is a need for a strategic plan, with goals and measures, one that is focused on aging and includes leaders with the will to implement that plan. This issue has very strong and defined special interests with huge dollar implications based on policies adopted.

While many services are available and there is a level of cooperation among the various state agencies, there is no defined system that provides for cross coordination of services that allows consumers to move freely among those services. Further, payment silos compartmentalize long term care and hinder collaboration. There is a need for greater accountability to develop and coordinate the long term care system as service providers, payers, and regulators are often intermingled with new programs and regulations that change in a compartmentalized manner. This compartmentalized approach to providing services and payments reveals the need to establish a more coordinated, seamless system of services where consumers can more readily be connected to and move between programs and levels of care.

While the state is currently providing services and supports for older Pennsylvanians, and connecting millions of seniors with care through local AAA's, there are also shortfalls. Services and supports are primarily available through the Departments of Aging and Public Welfare, many of which are funded by the Pennsylvania Lottery. The sheer number of programs and options are difficult to navigate, and JSGC staff had difficulty getting detailed information and data about those programs and the consumers they serve. Nursing homes are common across the state, and comprehensive data is readily available, but home care options are few in many areas and additional family caregiver supports are needed.

Home care is an increasingly available and popular option for many aging consumers, but there is no statewide coordination of home care beyond the collection of home care agencies and consumers who choose self-directed care. Funding waivers and allowing the person to choose the setting they wish to be cared for, would expand consumer choice but system development and coordination is needed to ensure quality and accountability. Rebalancing efforts at the state level have shifted appropriate individuals from facility to home care. The level of services needs to correspondingly grow and regulatory and workforce requirements need to be balanced as well.

There is a recognition that living in community is not possible for all seniors. In some cases, where a great deal of nursing care is required, facility based care may provide the same level of care at a similar cost. Often lost in the funding shuffle are family caregivers, who will need increased support services, especially those providing unpaid care as the sole caregiver. Encouraging employers, physicians, and local governments to serve as resources to connect families with support services is key. Many companies have healthy initiatives, stress free work environments, day care services and employee resource centers, but they rarely include the family supports and outreach that recognize elder care support.

Waiting for services and income eligibility limits can decrease true consumer choice of available care options. Service providers are forced to navigate a multitude of regulations that require them to spend a significant amount of time and manpower on meeting bookkeeping and facility regulations, conducted in some cases by four state departments, which could be better spent on providing direct patient care. State agencies have seen a rapid increase in the demand for services, which will continue. With additional demand for services the agencies are constantly looking to make existing dollars stretch farther, to serve more people and provide quality, accessible services. Consumers face the responsibility to better prepare themselves for future long term care needs and the state and federal governments must keep services flexible and funding sustainable to meet the needs of a rapidly aging population with increasing vitality.

Long term care is not an investment in the future for the state's children, it does not maintain the infrastructure in roads or bridges, but it serves an important government function to help its most vulnerable citizens. That function may be as critical as the constitutional duty to protect the health, safety and welfare of all Pennsylvanians. The aged represent some of the most vulnerable of those citizens, a generation that has paid its dues and should receive a level of programs and services to its benefit. Policy makers often focus on getting the youngest citizens off to a great start in life, but the oldest citizens need the opportunity to end their days with choice, dignity, and respect. There is a certain stigma attached to long term care and end of life planning, causing most people to ignore preparation until the need for it is undeniable.

Much of the LTC policy is determined by the state, but the federal government, which shares the cost and promulgates regulations for long term care services and supports, often drives what services can be provided through funding. However, the state can have a dramatic impact through its own cost and service plans including the lottery, which affords Pennsylvania the great advantage of having a restricted fund dedicated to the benefit of older Pennsylvanians.

There are many view points on the best way to proceed with LTC in the coming years, and policy makers face difficult decisions as the complexity of the issues around almost every option can be overwhelming. There is often agreement to support efforts to provide greater choice and enable seniors

to reside in a setting of their choosing. Implementing those policies can involve system reforms with a potential to transform the way long term care is financed, delivered, and administered. Developing a more comprehensive LTC system to provide services and supports is a complex process that requires commitment from state officials and cooperation of federal authorities. System change is not easy, and while there has been philosophical growth in acceptance of living in the least restrictive environment, which is typically in Home and Community Based Services (HCBS), the most recent focus has been cost savings. Policy reforms are consistently being discussed as rising costs for consumers, businesses, and governments create an increased need for a more efficient health care delivery system; however, caution is needed to ensure that cost concerns do not overwhelm service needs.

Contents of the Report

This report contains background information outlining the status of long term care in Pennsylvania. It is organized by department to show the services provided, supports coordinated, regulations enforced and payments for those services. The recommendations of the advisory committee are contained within the Findings & Recommendations chapter, which includes several proposed statutory and regulatory changes. The recommendations propose policy and legislative changes that focus on more efficiently and effectively meeting the needs of consumers. The report is organized to reflect the major role the state plays in meeting those needs, with a chapter each on the Departments of Aging (PDA), Insurance, Military and Veterans Affairs (DMVA), Department of Public Welfare (DPW), and Health which includes basic background and program descriptions, eligibility, and enrollment information.

Every effort was made to show a 10-year trend in data by program, and while that timeline for data was not always available, there are clear trends that can be shown in the increased demand for, and spending on, various aging programs.[2] Additional data, by county, shows the number of services by facility/residences and selected support services. Other topics, like family caregivers, self-payments, and third-party payments, for certain levels of care are difficult to quantify, but less important. The need for innovation, and the availability of choice were consistent points for discussion and selected start-ups, models, and eHealth initiatives are highlighted.

The goal of this advisory committee and JSGC staff was to objectively review the issues relating to long term care, establish the current state of services and supports, and analyze the needs of the growing population of seniors. In providing suggestions of how best to meet those needs, this report recognizes that supports, facilities/residences, home care, and family caregiving will all play a role in meeting the appropriately timed needs of consumers. Some information represents the opinions expressed during meetings and tours, and others are based on staff analysis and observation of programs, departmental operations and LTC system organization.

[2] Data for this study was provided by the Pennsylvania Departments of Aging, Health, Public Welfare, Insurance and veterans Affairs, respectively. That information was supplemented with other sources, from JSGC research, to provide the most accurate and current data available.

Advisory Committee Process

Following the adoption of HR 255, the JSGC formed an advisory committee of experts to guide and assist in the review of issues relating to the long term care services and supports delivery system. This committee was comprised of 29 members from across Pennsylvania, representing a diverse and geographically balanced mix of state and local government agencies, service providers, regulators, payers of service, consumer and provider advocates, academics, family members, Area Agencies on Aging, and industry and trade associations.[3] This group reviewed and discussed topics in person, by teleconference, and via email in a thoughtful, objective review that saw many differences of opinion but ultimately consensus on comprehensive recommendations. The goal in analyzing the services and supports for older Pennsylvanians is to contribute positively to the ongoing discussion and offer constructive recommendations.

In an effort to thoroughly understand the scope and intricacies of these complicated issues, JSGC staff spoke with a diverse list of stakeholders and experts representing a wide range of services and service providers. Staff visited nursing homes, assisted living residences, personal care homes, continuing care retirement communities, adult day services, and senior centers. In addition to the Advisory Committee discussion and review, the staff conducted extensive background research, exploring many government, industry, academic, and independent studies on various long term care topics.

The advisory committee held its first meeting on September 19, 2013, and reviewed the priorities for system development and change from each member. This preliminary discussion established many thought provoking ideas to begin the review. At the September meeting it was decided to seek feedback from across the Commonwealth through four informational sessions, which were held in the southeast, west/northwest, northeast, and central regions of the state. These sessions enabled the committee members to hear directly from consumers, family caregivers, direct care workers, local facility, and home care providers as is detailed in Appendix D.

Informational sessions were held between October 2013 and February 2013. They revealed the long term care issues which were common across the state in both rural and urban areas. Throughout the sessions there was frustration amongst consumers and families about connecting to services, navigating a confusing and often complicated system, eligibility for services with inflexible income limits, a lack of standardization across various programs' paperwork, and delays in receiving access to programs when they are needed most.

The recommendations in the report offer policy ideas to improve system structure and organization to reduce barriers, and break down silos that currently characterize service delivery and payment. Better care transitions and improved coordination of service providers are also crucial, along with increased support for family caregivers. This must include better communication with consumers and families to ensure they know where to turn when a crisis hits, which is often their first exposure to long term care. Expanding access to services and supports through a tiered system that shares costs, improves quality, and increases accountability will advance more equal community, facility, and home

[3] Although an Advisory Committee member may represent a particular department, agency, association or group, such representation does not necessarily reflect endorsement of the respective constituents of all the findings and recommendations in this report.

care options to provide crucial balance to meet future needs and help prevent seniors, who need assistance but don't qualify for supports, from falling between the cracks.

Many of these aspects affect the discussion and ultimate recommendations are federal in nature and cannot be controlled by the state, but they have a dramatic impact on the Commonwealth. Regulations govern eligibility, income limitations, standards of care in facilities, waiver qualifications for in home care, hospital admission paperwork, and reimbursement rates are primarily federal issues regulated by the Centers for Medicare and Medicaid Services (CMS). The state legislature can do little to influence many of those issues. The recommendations represent a consensus of the advisory committee that was achieved after numerous discussions, revisions, and refinement. Following the information sessions JSGC staff compiled the feedback received throughout the research and review process.

Additional Topics Considered

Medicaid Managed Care

Medicaid Managed Long Term Services and Supports (MLTSS) is the program that oversees delivery of LTC services and supports through capitated Medicaid managed care programs. This approach shifts the focus from favoring a particular level of care to one that centers on the health needs of the consumer. Given Pennsylvania's high percentage of Medicaid patients, this program could expand the amount of money available to care for people by diverting them to home care, but allow those in facilities to remain. Quality assurance measures would provide continuity, and DPW would set contractual standards and perform oversight. The goals are to enhance access, improve quality, and contain costs. Managed Care Organizations (MCOs) attract enrollment through their networks, provide case management and emphasize preventative care.[4]

Pennsylvania uses a managed care program for Medical Assistance, called Health Choices, to provide behavioral and physical health care. A MLTSS program could use the same Health Choices zones (regions), and requires an enhanced Office of Managed Care Services. MCOs would provide all Medicaid services as defined by DPW, would contract directly with providers, and negotiate rates. The main benefit promoted for MCLTSS is the state paying a monthly fee (capitation payment) to an MCO, who assumes the risk for managing the full range of care, including Medicaid institutional, home and community based services, pharmaceutical, and acute care. The heavy focus would be on diversion or transition from institutional settings. In 2014, CMS projects 25 states engaging in MLTSS programs, including six of the ten states with the largest aging populations, with three others currently considering implementation. The Commonwealth has been solicited to implement Managed Long Term Care Services and Supports, and consider a pilot project in Allegheny County. The advisory committee heard these ideas and concerns but did not achieve a consensus to recommend their inclusion in the final recommendations. [5] While many states that have shifted to MLTSS approach cite cost savings, Pennsylvania has not produced a detailed study of projected program specific savings and outcomes.

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[4] PA Coalition of Medical Assistance MCOs provided an in-depth PowerPoint presentation at the February 6, 2014 Informational Session. JSGC staff also met with the Coalition on August 26, 2013, to review their proposals.

[5] PA Coalition of Medical Assistance MCO's, "Briefing Paper: A Road Map for Implementing Medicaid Managed Long-Term Services and Supports (MLTSS) in Pennsylvania," October 2013 (Revised); University of Pittsburgh,

Workforce Considerations

Long term care direct care workers call for increasing the number of staff to provide better patient care, and expressed concern that nursing home workers have a high incidence of health related injuries. They also request an increase time spent on direct patient care. (Direct care workers can include home health aides, nurse aides, personal care aides, and attendants.) LTC employs 192,000 workers in direct care and 282,000 in support staff, making it the eighth largest employment sector in Pennsylvania. A stable, professional workforce is needed to ensure high quality care to the growing senior population. Numerous studies point to a relationship between staffing levels and quality care. High rates of staff turnover can also affect resident care and can be a result of wages, work environment, and stress.

Recruitment, retention, and training were frequently mentioned at informational sessions and by administrators and staff during facility tours, and echo many of the findings from studies dating back a decade in Pennsylvania. Pennsylvania's labor force statistics show an aging workforce for long term care workers and a listing in the statewide high priority occupations. These issues are not exclusive to facilities and also impact workers in home and community based service settings.

The advisory committee considered recommendations that would increase the minimum standard for nurse aid hours, standard contracts, and require a minimum amount of a facility's Medicaid reimbursements to be spent on direct resident care, but consensus was not reached on these issues. While the committee members support more highly trained, flexible, and focused workforce, these recommendations could not be made without further analysis of spending on patient care, reimbursement formulas, and overall profit margins for the industry, which is beyond the scope of this study.

Reimbursement Formulas

There was also discussion about reviewing the paradigm of senior care. There is a need for more comprehensive care that treats the consumer and not just the disease, the need for payers to compensate providers for follow-up care that mitigates illness and makes a healthier person, and for more effective and efficient care. Initiatives were also discussed to try to change the current reimbursement formulas from those that flow to facility care to a "money follows the person initiative." The advisory committee heard and reviewed these topics but realized many of these initiatives are culture changes, attached to huge dollar amounts, and recommendations may not reflect the breadth and depth of this issue.

Reduced Instances of Hospital Observation Status

Instances of hospital admissions, as they relate to Medicare coverage for nursing home transitions and waivers, were discussed at the informational sessions. These issues are predominantly created by federal rules but have a dramatic impact on costs in Pennsylvania, not only for hospitals but for nursing homes, home and community providers, and consumers. Many older Pennsylvanians enter a hospital following an emergency room visit, and they may subsequently need rehabilitation and recovery in a nursing home, or from a home health care agency, after an acute care episode. However, Medicare, the primary health insurance coverage for adults over age 65, only covers the cost of nursing

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Institute of Politics, Policy Brief, "The Future of Medicaid Long-term Care Services in Pennsylvania: A Wake-up Call," Winter 2013.

home care after a hospital admission of at least three days. If a consumer is held for less than three days, or is in the hospital under observation status, a nursing home stay will require a consumer to pay those costs out of pocket, if they are not covered by Medicaid or private insurance. This is a burden on consumers who may need to shoulder these costs, as many third party and long term care insurance policies may not cover the immediate care.

The Patient Protection and Affordable Care Act added a section to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to Inpatient Prospective Payment System hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. This has increased pressure on hospitals to reduce readmission. Defined readmission to a hospital within 30 days of a discharge from the same or another hospital results in financial penalties to discharging hospitals. An established methodology is used to calculate the excess readmission ratio for each applicable condition, which is used, in part, to calculate the readmission payment adjustment. A hospital's excess readmission ratio is a measure of a hospital's readmission performance compared to the national average for the hospital's cohort of patients with the applicable condition. Three years of discharge data and a minimum of 25 cases are used to calculate a hospital's excess readmission ratio for each applicable condition. For FY 2014, the proposed excess readmission ratios will be based on discharges occurring during the three year period of July 1, 2009 to June 30, 2012. Given the lack of state control, these rules are not addressed in the recommendations.

Politically Sensitive Issues

Because of the ongoing nature of legislative and administration efforts on LTC, the advisory committee chose not to endorse specific legislation, the Healthy PA or Medicaid expansion initiatives, specific lottery funding enhancements or the FY 2014-15 state budget. Topics of elder abuse and long term care for those under age 60 were outside the purviews of HR 255. Every effort was made to present clear and concise analysis of programs, however, efficiencies and spending evaluations of individual programs are beyond the scope of this study. The JSGC is aware of the political implications of topics addressed in this report and made every effort, as it does with each project, to remain fair and objective while conducting its analysis of the issues. In addition to the Advisory Committee on Long Term Care Services and Supports, current advisory and study groups include the Governor's Long Term Care Commission, Supreme Court's Elder Law Task Force, and DPW's Managed Care Advisory Committee's Long Term Care Subcommittee.

Laws, Regulations, and Rulings Affecting Long Term Care

The Act Creating the Pennsylvania Department of Aging

The Pennsylvania Department of Aging was created by Act 70 of 1978, to include the Department of Aging in the Administrative Code. In addition to establishing the Department, Act 70 brought the state into greater conformity with the Older Americans Act with a mission of "advancing the well-being of Pennsylvania's older citizens." The goals included maximum coordination of federal and state programs for seniors, to avoid duplication, and to promote a more efficient delivery of services. Further, the creation and growth of programs that help seniors maintain independent lives, the continued evaluation of programs, services, and senior centers help to ensure effectiveness. This Act laid the groundwork for many aging programs and services that exist today, including AAAs, that provide an

important local link to services for seniors and their families, across the state. In addition to creating AAAs as the local advocate for the aging and as a clearinghouse for information on older citizens, the law also promoted community education, fostered statewide collaboration, established the Pennsylvania Council on Aging, developed a statewide plan on aging, receive and dispense federal and state funds, and to review all plans, policies and regulations that impact older Pennsylvanians.[6]

Pennsylvanian Older Adult Protective Services Act

Pennsylvania's Older Adult and Protective Services Act, in 1987, established the first Pennsylvania law for protecting older adults from abuse, neglect and exploitation, and to provide seniors "with services necessary to protect their health, safety and welfare."[7] This act makes the Department the primary provider of public information, allows it to set training standards for staff, implement local protective services plans, establish reporting requirements for selected cases of abuse and neglect, and require personnel at facilities to submit to criminal history checks. The Department provides services, primarily through lottery funds, to support service contracts with 52 Area Agencies on Aging around the Commonwealth.[8]

The Older Americans Act

The Older Americans Act [9] was enacted in 1965 to provide services to people age 60 and older. The law established the federal Administration on Aging, under the Department of Health and Human Services, to administer grants to states for a wide array of service programs including nutritional, preventative health, caregiver support, employment services, social services, training, case management, transportation, homemaker services, and elder abuse and protection. It offers support to each state's agency on aging and 629 Area Agencies on Aging nationwide. The focus of its $1.88 billion funding ($62 million to Pennsylvania) in FY2014 was aimed at services to promote "aging in place." States are required to provide a non-federal match of 25 percent for family caregiver support and 15 percent for other support services, including meals.[10] Funding for the program has remained flat over the last several fiscal years, but the focus on aging health and long term care support services has remained consistent.[11]

The Olmstead Decision

The Americans with Disabilities Act declared the rights of persons with disabilities to be cared for in community based settings. In Olmstead vs. L.C. the U.S. Supreme Court ruled that restrictions which could impinge upon those rights and unnecessarily segregate those persons were found

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[6] Act of June 20, 1978, P.L. 477, No. 70.

[7] Older Adults Protective Services Act, Act of November 6, 1987, P.L. 381, No. 79. The Department of Aging was added to the Administrative Code by Act 70 of 1978, Administrative Code of 1929, P.L. 177, No. 175.

[8] The most recent amendments to the Older Adults Protective Services Act were enacted in 1996, Act of December 18, 1996, P.L. 1125, No. 169.

[9] Older Americans Act of 1965, Pub.L. 89-73, 79 Stat. 218, July 14, 1965; Dept. of Health and Human Services, Administration on Aging, "Older Americans Act," http://www.aoa.gov/AoARoot/AoA_Programs/OAA/index.aspx.

[10] Wendy Fox-Grage, Kathleen Ujvari, AARP Public Policy Institute, "The Older Americans Act," May 214, http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2014/the-older-americans-act-AARP-ppi-health.pdf.

[11] National Health Policy Forum, Older Americans Act of 1965: Programs and Funding," http://www.nhpf.org/library/the-basics/Basics_OlderAmericansAct_02-23-12.pdf.

unconstitutional. This decision was groundbreaking in the elimination of unnecessary segregation of persons with disabilities and requiring their integration to a care setting that best fits their need. The decision affects home and community based services for both the aging and those under age 60 with a physical and cognitive disability, and has contributed to the increased prominence of waivers and rebalancing initiatives to serve people in a community based setting.[12]

Regulatory Provisions

Regulations governing all long term care settings and services, including long term care facilities and home health care, are impacted by federal Medicare regulations. Regulating provisions typically revolve around two issues, providing healthcare and paying for it. According to the Pennsylvania Department of Health, 90 percent of regulations the state enforces are from the federal government and revolves around payment for services through the Medicare system, along with required staffing, application requirements, benefit eligibility and reimbursement rates. The advisory committee included several recommendations addressing regulatory matters, but in most cases the regulations should address system improvements and place greater focus on direct patient care. Regulations should set a collaborative review process of coordinated change.[13]

Organization of Long Term Care Services and Supports in Pennsylvania

While each of the departments and agencies listed below provides services and supports for long-term living, most are not exclusively focused on the aging population and serve both individuals under and over the age of 60, including those on low incomes and with cognitive and functional disabilities. The Department of Aging is the only state agency focused exclusively on providing services to older Pennsylvanians, their families, and caregivers.

- Department of Aging: Provides, promotes, licenses, regulates, and pays for long term care services and supports, primarily funded through the lottery. Through contracts with Area Agencies on Aging, the Department provides information, advocacy, protection from abuse, family caregiver support, Alzheimer's outreach, home and community meals programs, Adult Disability Resource Centers, counseling, and case management. The department also administers the PACE/PACENET programs, the OPTIONS waiver and licenses adult day services, domiciliary care homes, and senior community centers.
- Department of Health: Licenses and regulates hospital, rehabilitation, and health care facilities including long term care providers such as nursing homes, home care, home health, and hospice.

[12] Olmstead v. L. C., 527 U.S. 581 (1999).

[13] Regulations covering the Dept. of Aging are in Title 6 of the Pennsylvania Code. They includes regulations on older adult daily living centers, domiciliary care homes, and family caregiver supports. State Veterans Homes are covered in Title 43 Pa. Code, Ch. 7 which details standards for eligibility, application, admission, and maintenance fees. The Dept. of Health, under Title 28 Pa. Code, Ch. 201, 203, 205, 207 and 209 address Long Term Care Nursing facilities and Ch. 601 and 611 cover Home Health and Home Care Agencies. The Dept. of Public Welfare's provisions under Title 55 Pa. Code, are by far the most extensive. LIHEAP assistance is addressed in Ch. 601, Personal Care Homes are covered in Ch. 2600 and Assisted Living in Ch. 2800. Medical Assistance covers Hospice (Ch. 1130), Nursing Facility Care (Chapter 1181), Nursing facility Services (Ch.1187), County Nursing Facilities (Ch. 1189) and Home Health Agencies (Ch. 1249).

- Department of Public Welfare: Licenses and regulates personal care homes, assisted living residences and adult day services. Pays for services and supports received by all those in facility based care, the Aging waiver and LIFE programs for home care under the Medicaid benefit system. It also administers the LIHEAP program and coordinates the nursing home transition program.
- Department of Insurance: Licenses continuing care retirement homes. Regulates rates and licenses insurance providers to market a variety of products.
- Department of Military and Veterans Affairs: Operates and funds nursing and personal care homes that serve veterans and their spouses.
- Department of Revenue: Operates the Pennsylvania Lottery and distributes lottery revenue to fund services within the Departments of Transportation, Public Welfare, and Aging. It also administers the Property Tax/Rent Rebate program.
- Department of Agriculture: Administers the Seniors Farmer Market Nutrition Program.
- Pennsylvania Housing Finance Agency: Administers programs and distributes funding to promote safe and affordable housing.
- Department of Transportation: Administers the Senior Free Transit and Shared Ride programs.

Background of Long Term Care Issues in Pennsylvania and Beyond

Long Term Care Services and Supports (LTSS) is a general term that refers to the variety of supportive services designed to help people who need help with Activities of Daily Living (ADLs), and can include assistance with eating, bathing, dressing, incontinence care, transferring from bed, chair or toilet. Services are typically not medical care, but rather assistance with everyday tasks and are not covered by Medicaid, Medicare or most health insurance plans. The exception is typically the care received after being released from a hospital and admitted directly to a skilled nursing or rehabilitation facility following an injury or illness. Other common, supportive care, known as Instrumental Activities of Daily Living (IADLs) can include housework, money management, medication preparation, meal preparation and clean-up, communicating, and shopping.[14] Seventy percent of people turning age 65 will need long term care during their lives, which will increase in likelihood as they age.

Seniors' preferences clearly show a trend toward in-home care and community services, but the reality is that not all care needs are best met in the home environment. Trends both nationally and in Pennsylvania over the last decade show nursing homes beds declining while HCBS grows. Both the federal and state budgets have failed to keep pace with rising demand and have struggled to control costs for Medicaid and Medicare. Private insurance, that consumers rely on more frequently, face rising premiums and increased copays. Opinions differ as policy makers continue to consider many different options to provide services and control costs. Some policy makers feel services should be consolidated and focused, others feel there should be multiple entry points and no wrong door to entry into the LTC system. Some feel multi-faceted departments work well, other feel functions like education, awareness, and protective services should be separated from licensing, regulating, and funding.

[14] U.S. Dept. of Health and Human Services, "Long Term Care Path Finder," http://longtermcare.gov/the-basics/what-is-long-term-care/.

Discussions by policy makers in the state and federal governments have focused on rebalancing the distribution of LTC consumers between home and facility based care. This typically pits nursing homes against HCBS in a funding battle. Both types of care will be needed in the future and should not be viewed as an either or proposition. These settings deliver different levels of individualized care; adequately funding and removing barriers will help LTC reach those in appropriate settings, given the availability of funding and appropriate policies. Given finite government resources, arbitrary rebalancing targets will hold down spending, flat funding Medicaid facility care and waiver programs will control costs to a degree, but with the population growing in the foreseeable future these will be only temporary solutions.

The time and duration of level of need will vary over time but, according to the U.S. Department of Health and Human Services, a person at age 65 faces a 70 percent chance of needing some type of long term care during their life.[15] Twenty percent will need care for longer than five years, 60 percent will need unpaid home care for a year, and 35 percent will need some sort of long term care. According to the AARP (61.6 million persons in the U.S. one in four adults) were unpaid family caregivers in 2009, the last year data are available. Fourteen percent who cared for older adults are age 65 plus themselves, the average age of a caregiver is 49 years old and they are providing an average of 20 hours of care a week.[16]

Payment for LTSS is only provided by Medicare if a physician determines there is a required skilled service or rehabilitation, but only after three days of admission to a hospital. That care can be provided in a nursing home for a maximum of 100 days, or at home if receiving a skilled home health or in-home service. The majority of long term care services are for non-skilled ADLs, which are not covered by Medicare. Medicaid pays for the largest share of services, beginning on day 101 in nursing homes, but strict income limits and state eligibility requirements apply. Consumers only reach 101 days if they need skilled services and are making progress in their care and rehabilitation. LTC expenses can cost tens of thousands of dollars annually, with Pennsylvanians median costs in 2013 ranging from $38,000 for Assisted Living, $45,000 for Home Health and $94,000 for Nursing Home Care.[17] Care is often rendered by families and can put a burden on spouses, children, who are living longer, and in some cases seniors in their own right. This can cause anxiety in time and money, can strain employment and family relationships, and disrupt their own lives as they seek to care for loved ones.

LTC Funding

Funding for LTC is a significant cost to the state and federal government. According to the Congressional Budget Office, federal spending for FY 2013 was projected at $3.455 trillion dollars.[18] Of that, Social Security totaled $751 billion or 21.7 percent of the total federal budget, Medicare $524 billion (15.2 percent), Medicaid $283 billion (8.2 percent), Administration on Aging $2 billion, interest

[15] Pennsylvania Health Care Association, "PA Long-Term Care Statistics," 2011, http://www.phca.org/research/ long-term-care-statistics.htm.

[16] U.S. Dept. of Health and Human Services, Administration on Aging, "Who Will Provide Your Care," http://longtermcare.gov/the-basics/who-will-provide-your-care/.

[17] Genworth 2013 Cost of Care Survey, 2013, pg.59, https://www.genworth.com/.../130568_032213_CostofCare _Final_nonsecure.pdf.

[18] Barry Blom, Congressional Budget Office, "How the Actual Federal Budget Results for 2013 Compared with CBO's May 2013 Estimates," November 6, 2013, http://www.cbo.gov/publication/44711.

on national debt $248 billion (7.2 percent), defense spending $653 billion (18.9 percent), education $72 billion (2.1 percent). The federal Medicare system serves 54 million beneficiaries.

Nationally, 68 percent of LTSS expenditures went to persons with developmental disabilities living in non-institutional settings. Thirty eight percent of LTSS expenditures went to older adults and persons with physical disabilities were for non-institutional services. In 2011, Pennsylvania ranked 41st among states in percentage of HCBS at 37 percent, but spent the second most among states when looking at waiver dollars.[19] CMS had 11 total non-institutional categories that it was supplying waivers to in FY2011, and only 4 for institutions. Year after year expenditures have been increasing, but non-institutional care has risen 10 percent on average with institutional settings rising only one percent.[20]

State general fund spending totals for FY 2012-13 were $28.5 billion. Of those expenditures, Education was $11 billion or 38.5 percent, Health and Welfare combined for $10.8 for 37.8 percent, Corrections, Probation and Parole $2 billion, Debt Service $1.1 billion, Judiciary $309 million, Legislature $272 million and the Executive Offices of the Governor $159 million. By itself, Medical Assistance (MA) and Long Term Living accounted for $6.49 billion or 22.8 percent.[21] Current MA spending accounts for nearly one quarter of all state spending and some projections have shown that rise could equal fifty percent of the state budget by 2025. To put that in context, total spending in FY 2000-2001 totaled $19.9 billion, with the largest coming from Education $7.21 billion for 36.2 percent, Health and Welfare $6.7 billion or 33.7 percent and Corrections $1.18. Medical Assistance and LTC totaled 3.13 billion.[22] Lottery monies contribute $1.8 billion towards services for older Pennsylvanians.

This "silver tsunami" is a global as well as a national issue that will affect all communities in the state.[23] It is undeniable; it is at the states doorstep as the baby boomers increase the need for aging services. The graying of this state has increased demand on both services and funding. At the same time, the gap between Medicaid payments for nursing homes and HCBS, and the actual cost of care continues to widen. Historically, payments from Medicare have helped offset this shortfall but federal cost containment measures have reduced Medicare payments. The rates paid by Pennsylvania's Medicaid program are far below the actual cost of care incurred by providers, creating a $25.92 shortfall per patient per day, or approximately $9,500 annually per patient. As a result of multiple Medicare rate cuts over the past several years, it no longer fully subsidizes increasing Medicaid shortfalls. Medicare costs have eaten into the ability of long-term care facilities to cover any losses accrued through a high Medicaid population. Nursing homes with lower or no Medicaid populations, generally have larger staffs than facilities with higher Medicaid populations.[24]

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[19] These waiver dollars account for spending under §1915(c) of the Social Security Act, for Home and Community-Based Services Waivers.

[20] Steve Eiken, Kate Sredl and others, CMS, Truven Health Analytics, "Medicaid Expenditures For Long Term Services and Supports in 2011," June 2013, pgs. I, 16-18.

[21] Pennsylvania Office of the Budget, "Commonwealth of Pennsylvania, 2013-14 Executive Budget," February 5, 2013, http://www.budget.state.pa.us/portal/server.pt/community/past_budgets/4571.

[22] Commonwealth of Pennsylvania, "2000-01 General Fund Enacted Budget Highlights, May 24, 2000," pgs. 19-40, http://www.portal.state.pa.us/imageserver/Budget%20docs%201969-2000/2000_01Brief.pdf.

[23] The "silver tsunami" is common a term used by many researchers and policy makers to refer to the growth of the aging population.

[24] ELJAY, LLC, "A Report in Medicaid Funding for Nursing Center Care: A Special Report on Pennsylvania," January 2014. Note: Rates vary across the state so reimbursement shortfalls for families and home care can vary accordingly.

Historical Perspective

Historically, long term care was provided by families who cared for the ill and frail in their homes as part of an extended family relationship. Life spans were markedly shorter, people did not survive to old age, so care was not rendered for long and it was not a public issue. Poor houses and community charitable institutions, such as churches, helped to care for those whose families could not care for them. The Great Depression of 1929 brought many people to the surface who could not care for themselves in old age, and could not remain in their homes but their families could not afford these added costs. The Social Security Act of 1935 helped people pay for care in newly established nursing homes. The large expansion came following the enactment of Medicare in 1965, which guaranteed access to healthcare for Americans age 65 and older. While access improved under the Great Society, nursing homes became a level of care of last resort for people who could not stay at home, and relegation there became an existence of measured care to live out your days in a facility based setting.

Elder care did not grow as a sector of the economy until the 1960's, when it became an extension of healthcare services. Nursing homes have evolved in response to competition, consumer demand and payment structures. It has only been in recent years, and the increase of HCBS, that this change shifted the culture of nursing homes to look less institutional and hospital like, and to feel more like home. Elimination of nursing stations, medication carts, regimented meals and activity schedules is designed to maintain health, enhance quality, and attract seniors to the appropriate level of care willingly and without stigma. Fostering a more homelike setting, with more interaction and relationship building makes for a more desirable long term care setting. Independent senior living, assisted living, and personal care settings offer more independence and amenities. It is this mix of needs and options that allows seniors to have more options to age in settings which safely and effectively meet their needs.

Entitlements directed care to nursing homes until the last decade, when HCBS began appearing to meet consumer demands for home based care, particularly after the Olmstead decision. Types of care compete for state, federal, and private long term care funding as rebalancing approaches, that shift people from nursing homes to HCBS, are made. Rebalancing has been a hallmark of recent federal and state service trends. Independent living options at retirement communities allow a senior to age in place, with all levels of care provided at the same location. Innovative programs like money follows the person, and self-directed care are all becoming more popular as consumers seek choice in what level of care is right for them, at what time, and in what place.

Not all care settings are reimbursed by public insurance programs. Nursing home care, and home care provided through waiver programs to nursing home eligible individuals, provide reimbursements through Medicare, Medicaid and the Veterans Affairs health systems.[25] Intermediate levels of care like assisted living, personal care, independent senior housing, and seniors still residing at home are eligible for some services and supports primarily through self-pay. Costs for care are often unfunded, depending on income and eligibility, and force consumers and families to rely on self-pay. Some third party and long term care insurance assist with costs. Income ceilings for benefits create hard cap cut-offs that leave many people in gaps where their income and assets keep them from qualifying for services, while they struggle to pay for expenses on their own. These intermediate levels of care are viable living options for seniors who do not require nursing home care; however, the stumbling block

[25] Specific LTC programs, including waiver programs, are described in more detail in the relevant chapters through the report.

many face is the current lack of any reimbursements for that care as self-pay or third-party insurers need to pick up the cost of that care, leaving it out of reach for many seniors.

Public system finance, private LTC planning, hospital admissions status, discharge planning, and service availability are all factors that drive quality and have significant impacts on personal and family costs. "The cost of long term care continues to outpace affordability for middle income families," which is a factor in all states as savings are depleted more rapidly due to rising costs for care.[26] Depleting savings and inadequate or lack of long term care insurance to fill the gap often causes consumers to turn to the public safety net of Medicaid. People with complex needs in home care or facility care need effective transitions to help avoid unnecessary hospitalizations, which drive up costs even more. Relying heavily on caregivers and a lack of supports therefore can cause them to damage their own health and well-being. Nationwide, an average of 84 percent of the median income is attributed to LTC costs, so while home care is generally more affordable than nursing facilities, many consumers cannot sustain either arrangement on their own.[27]

Improving access, ensuring quality, and providing affordability is a key to innovative LTC but even qualitative measures are competing with quantitative metrics to control costs. Billions of dollars are being spent on LTC in both the private and public sectors as Medicaid expansion, Medicare rate reforms and rebalancing efforts are considered. Efficiencies in operations and delivery, along with healthy living initiatives by government and private insurers, will only go so far to divert people from needing LTC and it is inevitable that more services will be needed to serve a growing aging demographic.[28] These issues will be of increased importance as they not only drive cost but needs and transitions of care. Allocating limited resources to serve more people than in years past will stretch government funding. Accountability and quality are key components that must be maintained with the growth of any aging services.

Conclusions

The current status of long term care services and supports in Pennsylvania are compartmentalized, limited in availability, and will need to be exceptional to meet the needs of Pennsylvanians in the not so distant future. There are many opportunities to begin shifting the culture and creating the structure to ensure continued services and improved success. The focus on finding new funding sources, including new federal funding programs, cannot distract from providing services. Additional programs and qualifications can impact seniors and their families struggling to navigate a system with many niche programs and eligibility requirements. Maintaining a strong focus on aging

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[26] S. C. Reinhard, E. Kassner, A. Houser, K. Ujvari, R. Mollica, and L. Hendrickson, AARP, The Commonwealth Fund, and The SCAN Foundation, "Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers," June 2014 http://www.longtermscorecard.org/~/link.aspx?_id=DCD2C261D26D414C971D574D577A78FE&_z=z.

[27] Id.

[28] The Pennsylvania "State Health Care Innovation Plan" was developed by the Corbett administration and released in December 2013. The plan tasked the Depts. of Aging, Insurance, Health, and Public Welfare with engaging stakeholders and driving innovation through initiatives that include payment reform, supporting providers to transform care delivery, improving and expanding eHealth technology and telemedicine, workforce development and strengthening public health programs. Many of these mirror what was heard by the advisory committee, but the innovations in healthcare do not address aging services as part of the overall plan.

long term care services and supports, on improved collaboration across levels of care, better coordination of services statewide, and improved system structure are needed to meet the increased need.

While there are good people performing good work to help to provide services and supports, the approach is too compartmentalized and a fully developed LTC system remains elusive. There are a vast array of programs at present that are designed to provide services to older adults in their communities, homes, residential facilities and nursing homes. Independent living and facility options are available throughout the state, but they do follow population trends on the demand side and are not a prevalent in rural, low-population areas. Aging is not an urban or rural issue, but many realities in rural areas heighten the difficulty of service provision. Family caregivers, independent and care dependent older adults, and middle income seniors are most likely to fall between the gaps, and may be unable to afford self-pay but do not qualify for many services.

The advisory committee for this study has contributed thoughtful recommendations to the continued policy discussion. The numerous reforms suggested by this report will help to accelerate transition to an improved system of services and supports for Pennsylvania seniors and their families. Services are available and in some areas are plentiful, but those services need a greater reach into low-population areas. Consumers need to prepare for their long term care needs with advanced planning. Payments for services need to expand eligibility to reach more people, in varying levels of care, and hard caps that define program eligibility need to be relaxed to expand access to those seniors who fall between the cracks. In the end, it may not be enough to rely on promotion and educational programs. Consumers are not likely to pre-plan for care in large numbers. A more realistic goal is to provide the tools to help consumers and their families receive timely services when they are needed the most, usually in time of crisis.

There is a need for leadership on these issues, and it will take time and focus to solve the problems of an aging population. There have been 20 years of reports and studies to identify the problems, and demographic analyses that have shown trends now upon the state. Pennsylvania has an opportunity to take the lead in providing that focus, but it will take innovation to be efficient and agile in providing more benefits to more people while continuing to serve the unique needs of seniors and preserving system accountability. It must be a resource for all seniors, regardless of income eligibility, cultural needs, language or level of care, and must break down barriers within its own system to be more accessible.

The issues in this state are far from unique as growth of older populations is outpacing the ability to fund them both nationwide and in Pennsylvania. Caregiver shortages caused by changing family structures of a aging baby boomer generation, higher divorce rates, and fewer children will have a huge impact on those family caregivers providing uncompensated care. The policy of providing care and supports needs to match the practice and requires more system development and strategic planning. Infrastructure must be in place to assure accountability and quality in HCBS delivery system that balances a system of nursing homes that is overly restrictive to one of self-directed care home care that is nearly unrestricted. There is a need to balance quantity and choice with quality and accountability. System development and strategic planning, with focused goals and objectives, will help to break down service barriers, funding silos and compartmentalized services.

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The JSGC would like to thank the advisory committee members for listening, learning, and sharing throughout this process. Each of the state agencies with a role in long term care participated, provided data, and documents that enabled this report to be a comprehensive review and analysis of available long term care services and supports in Pennsylvania. Throughout the research and information gathering stage of the report the advisory committee and JSGC staff engaged over 100 people through facility tours, individual meetings, and informational sessions. The JSGC and advisory committee members gratefully acknowledge the time and efforts of each individual who shared their feedback and contributed to this report. Each person freely shared their diverse backgrounds, perspectives, and expertise, some from very heartfelt personal experiences within their own families and their own homes. Facility operators and care givers who are on the front lines of these issues and are engaged in providing long term care on a daily basis provided valuable feedback, experienced frustrations of their own, and offered many constructive observations. This report reflects much of that feedback and themes that were observed throughout.

FINDINGS & RECOMMENDATIONS

The findings and recommendations reflect the main topics encountered during the work of the advisory committee, and many of these ideas were discussed during the informational sessions. After further discussion and deliberation, the advisory committee reached consensus to include each of the topics in this chapter. Although an advisor may represent a particular department, agency, association, or group, such representation does not reflect endorsement of the respective constituency of all the findings and recommendations contained in this report.

System Structure and Organization

1. *Redesign and enhance the long term care system in Pennsylvania*

Many programs currently exist to provide services and supports to seniors and their families, and there is an extensive network of AAAs across the state that helps to connect people with those services at the right time, in the right place. Despite this success, the Commonwealth should enhance and refocus programs, increase supports, eliminate barriers, and help increase access to seniors that might otherwise fall between the cracks of care needs and available services.

The current state of long term care in Pennsylvania are compartmentalized, limited in availability and scope will need to be exceptional to serve the needs of a rapidly aging population. Long term care in Pennsylvania is characterized by loose coordination, inconsistent communication, fragmented delivery and navigation difficulty by consumers and providers alike. There are multiple entry points for services, multiple services with differing levels of qualification and approvals, county-by-county variations, duplicative regulations, and paperwork that characterize a disjointed and confusing system. Pennsylvania should provide long term care services and supports to all eligible an older adult in need in a residence of their choice. [29]

[29] Determinations of eligibility for long term care benefits, including nursing homes, HCBS, and support services requires an individual to complete a variety of forms and applications. These programs almost always require a determination of functional and financial eligibility including medical assessments, AAA assessments, nursing facility clinical eligibility to determine skilled care needs, provider agreements, certification forms, and detailed financial histories. Transfers from one level of care to another require duplicative discharge, entry, and referral forms that contain the same information, but are not standardized and must be replicated on each specific form as required by regulation. Documentation of medical evaluations, skilled nursing care plans, and personal care support plans are required annually. They contain information within required medical records and paperwork takes staff time away from patient care without adding to their quality of care. In some cases, like AAA services, there are standardized assessments, but with so many different programs and levels of care available, each with their own unique eligibility requirements, facilities and families can face an array of paperwork for an admission to or application for one service. This paperwork can overwhelm families in the midst of crisis and in many cases come on the heels of hospital forms or insurance claims.

2. *Accountability*

Programs are difficult to assess and monitor given the large portfolio of services, numerous state agencies involved, lack of or inconsistent data collection, and compartmentalized management. Given the large number of seniors served by long term care programs, and the billions of dollars invested in the system by both the state and federal governments, increased transparency and disclosure are key parts of built-in accountability. A more balanced approach between regulatory protections and oversight within facility and home and community based services and supports are needed statewide. Systematic and disaggregated data collection is needed; clear communication between doctors, health care facilities, state and local agencies and records management may reduce costs, reduce paperwork, and accelerate resolution of eligibility assessments and claims.

3. *Eliminate barriers and break down funding silos*

Pennsylvanians are confronted by a fragmented system attempting to promote awareness, provide information, connect service providers, and navigate the payment silos. This state needs a consumer friendly approach that provides greater availability of and access to services. The primary focus should be to reduce barriers and provide a seamless system across the continuum of care, including medical care, safe and affordable housing, supportive and supervisory services. Eliminating duplicative paperwork, rules, and regulations will aid in providing meaningful support for families while helping to break the intensity that follows the acute onset of an illness or accident that result in the need for long term care. The ultimate goal is to sustain coordination of care in a consumer directed model that connects people with the right services when they are needed.

Streamlined paperwork, workflow, and more focused staff training that engages and provides the consumer with the benefit of overall knowledge will alleviate stress for those trying to navigate the system. Workflows are used to determine the who, what, and how patient care and information sharing is conducted. Creation and implementation of a centralized coordinated case management system could be linked with discharge planners. AAAs should collaborate more with current referral sources, which include hospitals, health care facilities, physician offices, or other initial points of contact to break down funding silos and provide ongoing services to seniors and families across the state. Older Pennsylvanians will need expanded access to quality services in the settings they choose, across the spectrum, to match their individual needs with the services.

4. *Develop a standardized assessment tool which can be used to for all individuals needing long term care services to determine needs and measure outcomes*

Currently, a variety of assessment tools which are used in long term care settings. Each is prescribed by a different payer and at times by the provider type. There is a standard tool used to assess clinical eligibility at the time of application for Medical Assistance (MA) benefits, or long term care services paid for through Older Americans Act and state lottery funding. It is used across the care plan life of a consumer receiving community based services through AAAs. While the level of care determination is used upon application for MA benefits of individuals receiving other long term care services, such as nursing homes, it does not represent a tool that measures clinical eligibility across the time the consumer is accessing long term care benefits. Nursing homes, adult day, home health and PACE/Life each have separate tools that are used to assess the client and develop a plan of care. These tools are totally independent of one another and it is impossible to understand and compare the needs,

how those needs are addressed, and the costs and outcomes that result from the various interventions. Thus far, efforts to design and monitor Pennsylvania's long term care system have been unsuccessful.

Older adults have the same needs no matter where the live across the Commonwealth and increased standardization will help to get consumers, consistently, to the right level of service. The PDA should strengthen its efforts to standardize the current level of care determination so there can be assurances that clinical eligibility has inter-rater reliability across AAAs and assessors.[30] The Department should also invest time and resources in the development and implementation of a tool that measures clinical eligibility across the time the consumer is accessing benefits.

5. Enhance consumer protections

Economic abuse is a growing threat to the elderly and there is a need for enhanced protections against financial fraud and pension poaching. Many seniors employ the services of financial planners, insurance agents and attorneys, the intent is not to deny them of reasonable fees, but additional safeguards are needed against unscrupulous individuals engaged in unfair and deceptive business practices who often sell unneeded products, do not provide full information, or charge unwitting seniors and veterans to fill out applications that would otherwise be free services. Consumers and veterans also need tools to direct them to legitimate sources for planning including financial/estate planning, reverse mortgages, long term care insurance options, living wills, powers of attorney, and advance medical directives, which should be encouraged and implemented in an early and timely fashion. In addition, AAAs, the PDA, veteran's service providers, and other agencies should develop public-private-partnerships to promote long term care planning and support.[31]

6. Increase the use of electronic health records across the Commonwealth

Electronic health records are important to the long term services and supports system. The state should develop an incentive program to encourage the use of eHealth medical records by long term services and supports providers to aid in seamless transitions and better coordinate patient care, needs identification, and placement. eHealth partnerships should be further developed and implemented in order to facilitate information sharing across the Commonwealth. Under the Pennsylvania eHealth Information Technology Act,[32] patients have a choice as to whether or not their information is exchanged on the eHealth partnership. Currently, most health systems exchange information only within their networks and there are many challenges with proprietary information sharing and privacy across systems and levels of care.

Specific funding for long term care providers to enhance eHealth and information sharing techniques should be considered. Long term care providers were not eligible for federal stimulus monies for electronic records in hospitals under the American Recovery and Reinvestment Act of 2009. On their own, long term care providers lack the resources to build electronic health records capacity and share information. Centers for Medicare and Medicaid Services (CMS) does mandate specific patient

[30] Inter-rater reliability in statistics is defined as the degree of agreement among raters, and is used as a refining tool for human judges to measure their variables and adjust the training they receive to promote consistency.
[31] Washington State Attorney General, "New laws will help protect veterans against Pension Poacher scams and increase economic protections for military service members," March 27, 2014, http://www.atg.wa.gov/pressrelease.aspx?id=32001.
[32] Act of July 5, 2012, P.L. 1042, No. 121.

assessments in the long term care structure, however, the format is not an accepted format for eHealth exchanges. Penalties go into effect in 2015 for those providers that have not adopted Health Information Exchange (HIE) practices.

While electronic records are becoming the norm, it is important that agencies maintain the capacity to disseminate and accept paper forms as well. Many seniors do not have the know-how to utilize electronic forms, medical conditions may prohibit such and some low population areas of the state do not have high speed internet service.

7. Expand health information exchanges

While many health care providers have access to and are using eHealth technology, some have not embraced or do not have access to the resources necessary to fully implement eHealth initiatives. Standing alone, long term care facilities sometimes struggle to participate in information sharing and creating minimum data sets (MDS), in a common electronic format, to capture information.[33] This occurs primarily because long term care and home care providers are outside of existing health networks, but there is an increasing realization that a continued connection between physicians and consumers is mutually beneficial. The information contained within an MDS can be translated into a continuity of care document, which is the key document used in hospital settings and physician practices for electronic health information exchange.

Direct secure messaging (secure email-like formatting for state and national information sharing) and other technology would enable all hospitals and physician practices to send information electronically but each provider must have it to enable bi-directional messaging. Establishing information in one place prevents loss or lack of information and improves continuity of care. EMS and pharmacies can be added to this information for further detail in patient records. Funding is typically the largest impediment for providers that do not currently use eHealth initiatives, as point-to-point program interfaces required to use this data are extremely costly. Another barrier is the lack of a provider directory of who has direct messaging capabilities. The solution to this would be creation of one interface with an exchange. Nursing homes can use a tool similar to KeyHIE Transform for continuity of care documents, do not have to build their own programs and can use a tool like this on a subscription basis (est. $500 annually) for direct secure messaging and information sharing.

8. Establish a permanent long term care oversight/advisory body

A coordinating council would facilitate inter-agency cooperation, serve as a statewide resource, enable monies to be transferred between programs, improve transparency and accountability. The goal is to serve the senior population with the most appropriate funding sources, helping to break down silos within state government, and afford each program with the potential to serve more consumers. This body should include all relevant state agencies and stakeholder groups as well as consumers, counties and veterans groups, be geographically representative, with membership appointments from the Governor and Legislative leaders. They should review proposed rules and regulations on long term care, and advise the Governor and all relevant agencies on licensure, financing, systems of support, and the

[33] Information provided by the Pennsylvania eHealth Partnership showed that as of January 2014, current HIE participation include only 21 hospitals, 172 physician practices, 28 home health locations and 70 long term care facilities.

State Plan on Aging. Its mission would need to be inclusive but specific and task oriented.[34] This body should be imbedded within the Department of Aging, but multi-agency representation would help prevent any one agency, interest group or Secretary from exerting disproportionate control.

It is important to note that this proposal is similar to the existing Intra-Governmental Council on Long-Term Care, currently within the Department of Aging's organizational chart and structured with a comparable membership and responsibilities. This body was created in 1988 and while it falls in Section 212 of the Public Welfare Code[35], it is chaired by the Secretary of Aging, who under the Rendell administration, discontinued the Council meetings in approximately 2009 and re-tasked its staff. While the Council and its benefits were included in the *2012-2016 State Plan on Aging*, the Corbett administration has not convened the Council or called meetings of this body as of July 2014.

9. *Develop a focal point for aging long term care services*

Seniors are often on fixed incomes and in order to access services they need to navigate a multitude of programs that have multiple applications, approvals and rules, and whose resources are often finitely limited. It may be challenging for seniors to identify specific programs or understand and complete applications. A state clearinghouse with rapid dissemination of information for planning preventive and long term care assistance could help avoid crisis decisions and contribute to reductions in health care spending. The state should provide streamlined information and resources with clear descriptions of available services, including payment sources, to help modernize a currently disjointed and cumbersome system with many barriers. Efficiencies could be gained by the coordination of state agencies, programs, assessments, and applications.

Although both federal and state caregiver support programs exist, many individuals are not aware of how to utilize those programs. AAAs have networks across the state and could be enhanced to embrace this clearing house concept. Counselors, caregivers, care managers and health care professionals, including physician extenders with the proper training, could help with access and information dissemination. Consumers and caregivers alike would benefit from step-by-step guides to long term care that outlines the services available and how to connect with them. Financial counseling that clarifies what happens when monies are depleted, and family counseling that helps to reinforce the responsibilities of the primary care-giver in meeting the needs of consumers are both needed. The APPRISE program offers free health insurance counseling for older Pennsylvanians, and could be a model for an information clearinghouse.

There is an opportunity to serve more seniors and provide support to their families and caregivers, but services need to have an increased focus on dedicated aging services and supports. Innovative programs and integrated services for older adults can help to enhance the good services already being provided by expanding their reach statewide. Housing, transportation, health care, case management, and care transitions are needed as the instances of in home care increase. These services will help consumers navigate the system, connect people with the supporting infrastructure and receive care in the appropriate time and setting.

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[34] The proposed Pennsylvania Long Term Care Council, contained in House Bill 252, Printer's No. 1128, could serve as a model.

[35] Section 212 of the Act of June 13, 1967, P.L. 31, No. 21 known as the Public Welfare Code. Section 212 was added by the Act of December 21, 1988, P.L. 1883, No. 185.

Long Term Care Services and Supports

10. *Expand home and community based services*

Most seniors want to be cared for at home, where delivery of services is often more cost-effective. A lack of funding for HCBS, however, and long waiting lists prevent the programs from reaching their full potential.[36] People are often faced with the choice between struggling at home or going to a nursing home they do not need, which comes at a higher cost. Consumers need greater education about and access to in-home services, especially in low population areas. Services should always be provided in the least restrictive setting that is feasible. A "Demand Pull" versus "Cost Push" approach to funding is essential to create a person centered, person driven choice model of care. In most cases, home care is the least expensive level of care, yet it is the hardest to access and most difficult to arrange. Increased or shared funding for home care will allow more services to be accessed by more people and make supports available to help defer institutional living. Allowing spend down to waiver while in home care will help increase consumer access and choice. Greater availability of funding for and more oversight of the HCBS industry is needed and careful consideration must be given to a mechanism that does not overly burden providers but establishes safeguards to eliminate fraud, abuse, and waste in the consumer directed model of HCBS.

11. *Increase availability to and affordability of transportation services*

Transportation services in many low population areas are limited or nonexistent, with services expensive to operate while providing affordable fares that promote ridership. Access to primary care and social needs is a critical factor in maintaining a senior's well-being and independence. Most frequent riders utilize the programs to reach other support services like adult day centers, senior centers, doctors' appointments or even the grocery store, but there are some transportation services that are unable to cross county lines, even if the closest program is located nearby. Programs like shared ride are available through local transportation organizations to persons 65 years of age and older, however, services need to be promoted so that consumers know about facilities and services, and can adequately reach those services. Rural transportation systems, due to the geographical and demographical differences to urban systems, need mechanisms that distribute resources able to provide transportation for the needs of its residents that are convenient and affordable. Measuring their efficiency and effectiveness against urban systems is difficult due to population densities and markets served. Performance measures and peer review ultimately place rural transportation systems at a disadvantage for meeting comprehensive transit needs of rural residents. The mechanisms for distributing resources reward systems that operate efficiently in higher density and growing areas.[37]

Fixed route systems are common in urban areas and costs are typically lower than rural areas, who only have access to shared ride transportation that almost exclusively serves the

[36] While there have been long waiting lists, with the increases in funding received in FY2013-14 and FY2014-15 these will be greatly reduced or eliminated; however, they occurred in the past and will occur in the future if funding levels do not keep pace with the growing demand for services.

[37] Amendments to Title 75, the Vehicle Code, have impacted funding for all mass transit systems around Pennsylvania, including rural systems. Those amendments included Act of July 18, 2007, P.L 169, No. 44 and Act of November 25, 2013, P.L. 974, No. 89. Note: Shared ride is not available through AAAs, though a few are shared ride providers, but AAAs, for the most part, help support the co-pay without arranging the trips.

disabled and elderly, who may have an institution to sponsor them. Shared ride receives no operating assistance, and fare structures are needed to fund the system. Fares for those with subsidies, such as seniors and persons with disabilities, are significantly higher than fixed route systems subsidized with public transportation funds. If they are unaffordable when discounted they will not be attractive to the general public and institutional sponsors at full fare. Simple economics indicate that fewer users leads to higher prices, perpetuating the problem. The result of the funding inequity between fixed route and shared ride systems burden rural residents who lack affordable transportation options for life sustaining needs.

12. Need for expanded respite care and adult day services

Development and creation of additional adult day services centers should be emphasized, with increased education about services available to the elderly and aging populations. Families caring for their loved ones at home need support to allow them to continue to provide care. The family caregiver program gives families the opportunity to care for their loved one at home with additional supports enabling them to hire respite caregivers. Insufficient resources for respite care lead to increased waiting to access services. In low population density areas, where licensed adult day services are not feasible, nursing facilities and personal care homes should be allowed to provide adult day services, for more than the current three individuals, and the cost of that care should be eligible for payment by the Aging Waiver or OPTIONS funds. DOH regulations preclude personal care homes and nursing facilities from incorporating adult day services for greater than three individuals within the care setting unless the facility is distinct.

13. Enhance AAA services and ensure oversight

AAA program care managers show great compassion and understanding toward their clients, however, the programs lack adequate funding and have waiting lists for services. Many consumers need simple services and the Aging Waiver program provides services and supports to help them stay in their own homes. AAAs are not fully paid for service coordination until a service plan is approved by DPW's Office of Long Term Living for waivers. All work put in prior to that referral is not reimbursable, the wait can be long for consumers and the service needs to be more individualized. There is a need to give people more options and help to navigate the system. AAAs are designed as the focal point to connect people with local services and supports and they need to have the resources to provide more than just information and referral. Enhanced care manager services should allow for more quality time spent on consumer education and more one-on-one time helping families and older adults understand their care options to help connect them with the services most likely to assist them. PDA should consider creating a Navigator position, or expanding the duties of the care managers services to include helping older adults and their families navigate the long term care system.[38] AAAs should be able to review any proposal to take on more responsibilities, as their resources are already stretched. An adequate funding formula is

[38] The Ombudsman within PDA provides valuable services to assist older adults and consumers of long term care to resolve issues affecting their quality of life and care. In addition to providing information on rights and options and helping to remedy problems, Ombudsman also advocate, on behalf of consumers, for quality standards in the delivery of facility based (nursing and personal care homes) and HCBS. Expanding the duties of the Ombudsman to include system navigation, or designating staff in that office as a Navigator, would enhance care coordination efforts and cross-agency collaboration. Federal Medicare guidelines for long term care ombudsman programs, require them to operate independently to avoid possible conflicts of interest.

necessary to avoid tasking AAAs with new responsibilities, which are often made without increased funding that makes them unfunded mandates. By evaluating their personnel structure and financial stability to provide current programs, their needs to enhance those offerings with new and expanded services and supports will be shown. Consistent fiscal and organizational strength across the Commonwealth is crucial to serving older adults in their time of need.

14. Expanded access to meals services

Home delivered meal programs and those provided at support services like senior centers need to be expanded, funded and provided consistently, as they are an important support service for seniors and their family caregivers. Those who have special diets like diabetic or pureed foods, and need home delivered meals are often not covered by standard programs. Services are limited in low population areas, where food banks and home delivered meals are scarce. Older adults also need increased access to emergency meals, upon discharge from an acute care setting, until AAA assessments can be done and permanent, traditional services are engaged.

15. Increase end of life care and planning

There is a need for greater end of life planning and care management, which can be provided through all local AAAs. Consumers and their families need access to information or resources to help plan end-of-life care, and the need to break the current stigma around this care, which people put off and prefer not to think about until the moment of need is upon them. There is a noticeable lack of information disseminated on end of life care, and that level of planning must be a part of long term care planning. Funding for hospice care is crucial to families at this difficult time. Federal conditions of participation require that consumers on hospice can stay on MA waivers when they are designated six-month terminal status. State policy within DPW needs clarified as Medicare typically covers hospice care for those eligible for Part A hospital insurance.

16. Integrate Veteran's and AAA services

Since the Veteran's Integrated Service Networks Region IV is nearly co-extensive with Pennsylvania, closer integration of the U.S. Department of Veteran's Affairs (VA) Non-Institutional Care (NIC) services with community LTSS would benefit veterans, their families, and both the VA and the Commonwealth. The Veteran Directed House and Community based program has been helpful in fostering relationships between the few VA medical centers and their AAAs, where the program currently exists. The program and those relationships need to be more fully developed to include the menu of VA NIC programs. This could start with a data exchange to promote coordination of benefits, particularly to identify eligible veterans on OPTIONS wait lists, where the VA could more expeditiously provide services.

17. Expand the Elder PAC and LIFE programs

The Elder PAC (Elder Partnership for All-Inclusive Care) program serves both waiver (dual) and OPTIONS (non-dual) nursing facility clinically eligible consumers. It is currently a pilot project combining HCBS through the Philadelphia AAA with medical care provided through an in-home primary care program. The Commonwealth should extend the Elder PAC model to all AAAs. Collaborating with medical providers who care for substantial numbers of frail elders

requiring HCBS services, working with a limited number of care managers who coordinate those services improves responsiveness, accountability, and outcomes. This team approach to coordinated care must be expanded to integrate services, add flexibility, reduce costs, and improve care. This focus on innovation and integrated services has the potential to realize cost savings and enhance quality.

LIFE programs (Living Independently For Elders) are also critical and should be leveraged to allow innovation. These programs are the state's version of the federal Program for All-Inclusive Care for the Elderly or PACE, a care model to provide for needs within the community whenever possible. Integrated services include preventative, primary, acute and long term health care for those who qualify. There is a need to reduce regulations to take apart the triangle of complex medical management, supporting and supervising services, and housing. Financing is needed to reinforce integrated care with non-institutional care targets. The Commonwealth should leverage the substantial resources and investment it has in LIFE programs by treating them as regulatory safe harbors, to foster innovation and use the current survey process to maintain regulatory oversight of the care provided. In the area of integrating housing with supportive services, current regulations have limited the ability of LIFE programs to minimize the share of members in institutional settings. A number of LIFE programs have innovative models, but are limited in their ability to develop and expand those options. Service collaboration coordinates transportation, physician care, specialists and home health all in one package. Additional programs are needed to streamline access, increase planning and fairness in linking programs, and save time and money for the consumer. Currently there are waiting lists for these programs, and more funding is needed to reduce those lists and expand the number of consumers who can be served.

18. *Increase access to the OPTIONS program*

The OPTIONS program serves consumers who are not eligible for Medical Assistance, and is a state program funded through the Pennsylvania Lottery. Applicants are required to have a level of care assessment to determine if they are clinically eligible, and the level of needs and supports required. Financial eligibility will also be determined and people with income over $714/month must pay 50 percent of the cost of care, based on a sliding scale. The cap exception process should be streamlined and made more predictable and the cost share imposed upon the consumer should be the same percentage of the cost as the share required of those consumers who are below the cap.

A senior in a hospital bed who is told they are to be discharged tomorrow cannot wait for the state to decide if a AAA can provide more than the current monthly maximum amount of OPTIONS services. The consumer and the AAA need an answer quickly, before the consumer and their family decides they have no choice but an otherwise unnecessary nursing home stay, just because no decision has been forthcoming. The shared cost of the services charged to the consumer should be consistent with the percentage the consumer would have paid if their care plan cost had been below $714 a month. To penalize a consumer who had been required to pay a lower cost share with a much higher, 50 percent cost share just because they are now in need of more care is

regressive, and increases the likelihood that the consumer will opt for institutional care when it could otherwise be avoided. [39]

19. Improve discharge planning and care transitions

Too little attention is paid to transitions in care. Patients who are hospitalized often say anything to be discharged from a hospital setting because they want to be cared for at home, whether services are immediately available or not. Hospital discharge planners are under significant financial pressure to discharge patients quickly. The bureaucracy involved in accessing home and community based care paid for by Medical Assistance, Older Americans Act, or state lottery funding, prevents swift access to services. As a result individuals are often discharged home without the supports to help assure that they are not re-hospitalized or go to a more restrictive and costly level of care than what is needed or preferred. Collaboration must take place between AAAs, home care providers, hospitals, and nursing homes to assure that consumers being discharged from hospitals have the best outcome and that a consumers' level of care matches their preferences and need. The level of care covered by insurance should not push or pull the decision.[40]

20. Increased family caregiver supports

With the increase of diversionary programs, designed to keep people in their homes and communities for longer periods of time, increased supports for family caregivers will be required. Family caregivers represent the largest segment of care providers in Pennsylvania and in the United States. Most of that care is uncompensated, and can range from 24-hour residency with the family member to occasional help with medical appointments, grocery shopping, or housework. The average age of a caregiver is rising, and declining birthrates make the pool of available caregivers smaller. They are susceptible to stress, depression, physical injury and can develop their own medical problems during their work. Few supports are available for caregivers, and the reach of those supports needs to be extended in terms of numbers served and programs provided.

21. More focused public education and awareness

Practical experience over time has shown while awareness is important, the reality is consumers do not pay attention to the support available until they are in a crisis. They do not plan in large numbers and likely never will. When consumers get to the point of needing services, the system must make sure services are available. The system needs to be responsive when services

[39] The cost of an individual's monthly care plan cannot exceed $714.60; however this monthly cost cap is subject to an exception process with Department approval in certain specific instances. If an exception is granted, a 50 percent cost share is applied to any service plan that exceeds the monthly cap.

[40] The Community-based Care Transitions Program (CCTP), offered through the CMS Innovation Center, provided funding to test models for improving care transitions for high risk Medicare beneficiaries. Five awards were granted to CCTP programs in Pennsylvania including: Delaware County Office of Services for the Aging, North Philadelphia Safety Net Partnership (Philadelphia Corporation for Aging), Western Pennsylvania Community Care Transition Program (Southwestern PA AAA /AAA of Westmoreland County), Allegheny County AAA; and York/Adams Care Transition Coalition (York County AAA/Adams County Office for Aging, Inc.). A number of other AAAs, not operating under a CCTP grant, are offering care transitions services or are in various stages of exploring the possibility of providing care transitions and developing a program.

are needed and allow consumers to easily work within and navigate the programs that do exist. PDA should encourage AAAs to establish public-private-partnerships with health professionals, physicians, pharmacies, clinics, health fairs, and even utility companies through their billing to further outreach efforts and produce contacts with people not easily reached. DPW through Medical Assistance should streamline their eligibility and enrollment process to enable individuals, without undue delays, to receive appropriate community based services. People may never plan in advance but giving them the knowledge of what services are available and where to go in crisis, normally at the acute onset of injury or illness, will help in their time of need.

Payment for Services

22. *Reduce waiting for long term care and support services*

Individuals and families often cannot afford supports while awaiting approval by Medicaid. The length of time it takes to qualify for HCBS varies across the state, but in many cases a three to five month wait is too long for the individual and informal supports/families to pay for services in the home. In order for a consumer to receive nursing home care they must be interviewed and determined eligible for Medicaid by the facility. To receive Waiver services with the same eligibility requirements, the process is much longer and often is a barrier to the less restrictive, more preferred level of care. Medicaid eligibility determinations need to be modernized and presumptive eligibility considered.[41] Waiting for AAA services including meals and personal care services has increased from days to months in some areas. The strategy of "at the right time, in the right setting, and at the right intensity" is difficult to achieve.[42]

The reduction in the number of caseworkers/case managers at AAAs and DPW has caused delays in serving Medicaid beneficiaries; moreover, families and nursing home providers are negatively affected as well. Waiting lists often reflect the fiscal realities within certain programs, and the lists are those eligible persons who are waiting for funds to be available before services are able to be provided. AAAs need more funding to provide services for all those in need, and eliminate current waiting lists. Medicaid eligibility is antiquated and consumers and providers have difficulty navigating a system which further delays services. Clinical practice often competes with regulations for resident's rights and treatments. The 100 percent review of service plans in Harrisburg is redundant, as plans are done by the AAAs/service coordination agencies with CMS requiring only a random selection to be reviewed. The state's review of all plans unnecessarily adds to the wait time for consumers.

23. *Eliminate hard caps for benefits*

Seniors are often not eligible for services in waiver or family caregiver programs due to slight income overage, yet cannot afford services due to the cost of medications, meals, and other

[41] The concept of presumptive eligibility is addressed in more detail in recommendation number 30. Another idea discussed was the allowance for coverage of 60 days for unlimited episodes of care for long term care. This might help consumers overcome the nursing home coverage gap without the required three consecutive days in the hospital, and would be a small cushion to help get HCBS started.

[42] Pennsylvania Department of Aging, *Pennsylvania State Plan on Aging 2012-2016*, pg. 1.

necessities while living on a fixed income. These individuals are more likely to fall between the gap of available services and supports. Inconsistency within income limits, allowable assets, spousal assets and Social Security cost-of-living adjustments are present across program qualification formulas. A tiered system, with a sliding scale, allowing partial benefits or co-pays for services could help many seniors qualify for some help to stay in their homes or a less intensive level of care, and keep them out of more expensive nursing homes. Loosening eligibility requirements to allow for partial payments could serve a large pool of eligible seniors, making personal assets, along with state and federal dollars, go further as people live longer.

24. *Reduce the gap between actual cost for care and reimbursements*

The gap between Medicaid payments for nursing homes, home care, adult day, support services, and the actual cost of care continues to widen. Historically, payments from Medicare and private pay have helped to offset this shortfall but federal cost containment measures have reduced Medicare payments, compressing staffing and affecting the main driver of quality. The rates paid by Pennsylvania's Medicaid program are far below the actual cost of care incurred by providers, especially nursing homes, creating a $25.92 shortfall per patient per day, which equates to approximately $9,500 annually per patient.[43] As a result of Medicare rate cuts over the past several years, this program no longer fully subsidizes Medicaid shortfalls.[44] Improving the case mix index, which helps to maximize the average cost per day within a facility, across payees, could help.

Medicare costs have eaten into the ability of long term care facilities to cover any losses accrued through a high Medicaid population or patient census. Private pay patients represent roughly five percent of the long term care patient population, too few to cover any additional losses to the care facility for Medicaid patients. Nursing homes with lower Medicaid percentages, or no Medicaid percentages are generally higher staffed than facilities with higher Medicaid populations, due to the loss accrued with higher Medicaid populations. A regressive payment system penalizes facilities for successful rehabilitation and improved resident health by concurrently reducing benefits. Pennsylvania currently gives an incentive to facilities with greater than 80 percent Medicaid residents; the Commonwealth also places a cap on administrative costs at 12 percent of the total facility costs.[45]

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[43] ELJAY, LLC, "A Report in Medicaid Funding for Nursing Center Care: A Special Report on Pennsylvania," January 2014. Note: Rates vary across the state so reimbursement shortfalls for facilities and home care vary. Acuity rates, Alzheimer's care and other needs factor into the case mix as well.

[44] Medicare reimburses 100 percent of skilled nursing costs over days 1 to 30 for a person who qualifies, after initial three qualifying midnights of hospital admission, while costs for days 31 to 100 are covered 80 percent but skilled needs are still required. The remaining 20 percent is covered by private pay, private insurance or Medicaid. Custodial care is not covered by Medicare, and admittance to a nursing home does not require a skilled need. The facilities determine, with CMS approval or denial, if the patient requires skilled need-allowing for Medicare coverage days 1 to 100. HMO's require one day for Medicare coverage, with some situations requiring no day of admittance, taking the patient directly from the hospital emergency room.

[45] Title 55, Pa. Code, §§1187.111, 1189.105. Note: States vary in their incentives and criteria for additional funding. New Jersey, for example, created a Nursing Home Quality of Care Improvement Fund, thus making grant money available for training, improvements to quality of care, and staff recruitment and retention.

25. Greater coordination of dual eligible beneficiaries

Medicare is entirely funded by the federal government and primarily covers acute care while Medicaid is funded jointly with states and primarily covers long term care services and supports. Greater coordination is needed for improved transitions between levels of care. Efforts to integrate Medicare and Medicaid financing and coordinate care for dual eligible beneficiaries could reduce spending and improve quality.[46] Integration of financing and improved coordination of care has proven difficult as payers and providers face different financial incentives. Aligning those incentives will reduce duplication of services, minimize the need to shift between acute and long term care facilities, and reduce instances of conflicting services.

26. Develop an incentive to encourage people to buy long term care insurance

Long term care insurance is considered one of the newest insurance products in the industry. Unlike traditional insurance, long term care insurance is designed to protect the policy holder against fees accrued from long term care services and supports. This coverage often includes personal and custodial care through a variety of care settings. Typical cost of policies depend on an applicant's age, daily maximum payout, coverage span, and optional benefits. As premium rates have risen in recent years, several incentive plans have been developed to increase the number of long term care insurance policy holders. One plan would require Medicaid programs to notify those with soon-to-lapse life insurance policies of their ability to convert these policies to long term care insurance.[47] Another proposal would provide federal and state income tax incentives for the purchase of private long term care insurance. Regardless of the incentives considered, there needs to be a greater awareness of the product options, better public education and more dissemination of information so consumers can make informed decisions about long term care planning. Improved safeguards should also be implemented to require notification to consumers of lapses or impending expiration of benefits of long term care or life insurance policies and benefits. This could be accomplished by the following amendment.

Amend § 1105 of the Act of May 17, 1921, P.L. 682, No. 284, known as the Insurance Company Law of 1921, by adding a subsection (b) (5) to read:

§ 1105. Disclosure and Performance Standards for Long-term Care Insurance.

(b) No long-term care insurance policy may:

(5) Be cancelled, terminated or reach their maximum lifetime benefit without (60) days written notice provided to the policyholder and beneficiary(s).

[46] According to the Centers for Medicare & Medicaid Services, dual eligible beneficiaries refer to persons who qualify for both Medicare coverage for acute care services, along with Medicaid, through medical assistance payments that covers Medicare premiums and cost sharing for those under certain income limits. By virtue of their eligibility, they tend to be poor and report lower health status than other beneficiaries.

[47] Life settlement conversion options are part of a proposed amendment to the Viatical Settlements Act (Act of July 4, 2002, P.L. 699, No. 107) in Senate Bill 1296 of 2014, Printer's No. 1887. More information on long term care insurance, rates and benefits are discussed in the Pennsylvania Insurance Department Chapter.

27. *Conduct a study on the feasibility of including personal care and assisted living homes under waiver*

A feasibility study should be conducted to determine if licensed personal care homes and assisted living facilities should, in appropriate instances, be allowed to continue to be the residence of persons who become nursing facility clinically eligible when, whether through private means or waiver services, the licensed personal care home residents' care needs would be fully met by the combination of licensed personal care home services and supplemental waiver services. The needs of residents would thus be met in their home (the personal care home), just as those needs would be met if the resident were located elsewhere in a community residence that is not a personal care home. This would promote the concept of "aging in place."

The study should include geographically balanced pilot/demonstration projects that encourage innovation and the potential for a change to the State Plan on Aging. A cost analysis and evaluation of the rate setting system should be included. If this model is feasible the state should consider applying to the federal government to allow Medical Assistance monies to be utilized as an in-home waiver within personal care and assisted living settings. The facility and the consumer should both have the option to agree to such an arrangement, and the adequacy of the combined service packages would be certified by the AAA funds or CMS/state waiver funds, if applicable, were involved.

28. *Modify financial eligibility rules and income limits for services*

Change the current regulation on the amount a community spouse can retain while the spouse is in a nursing home, to unearned income rather than gross income. This is important to those people in areas of the state where gas royalty income is used in determining the community spouse's income. Revise the waiver spend down regulations for royalties to calculate from net revenue, as well as social security cost of living adjustments. For example rental income regulations focus on net income, not gross; natural gas currently has no regulations with waivers focusing on gross income.

DPW should revise the regulation under Section 403 (b) of the Act of June 13, 1967, P.L. 31, No. 21, known as the Public Welfare Code. Suggested language could read as follows:

Title 55, Pa. Code.
§ 181.105. Royalty Payments. -- *The profit from royalty payments on gas, oil, timber or other mineral lease agreements received by the applicant/resident for the mineral rights, including extraction payments less the deductions in §181.136 (relating to deductions from royalty payments). Profit from royalty payments is counted as unearned income.*

Title 55, Pa. Code.
§ 181.136. Deductions from royalty payments.
(a) Expense deductions from royalty payments include:
(1) All post-production costs, deducted by the company, before net payment is made to the lessee.

Title 55, Pa. Code.
§ 181.452 (2). -- The total unearned income as specified in §§ 181.101-181.105, 181.107, 181.109 and 181.110.

29. Increase spending for high percentage Medicaid facilities

Residents and caregivers in nursing homes will receive a direct benefit from higher reimbursement levels and additional state budget dollars should consistently fund an "add-on" payment for nursing facilities that serve a higher than average percentage of Medicaid residents (75 percent). This funding will help these facilities continue to serve that demographic so that certain seniors do not have to leave their communities to receive care.

30. Permit HCBS providers to allow presumptive eligibility

Another significant barrier to swift access to less expensive HCBS is the time it takes to obtain a functional and financial eligibility determination. As noted elsewhere, the service plan approval process can take up to five months before a consumer may be approved to receive in HCBS. Yet a nursing home is able to admit a presumptively eligible Medicaid consumer immediately, even though clinical and financial eligibility has yet to be determined. Presumptive eligibility occurs when the state, based on preliminary income and asset information, presumes the consumer is eligible for Medicaid coverage of LTSS and subsequently confirms financial eligibility. When an individual is deemed ineligible for services, there must be a mechanism to disengage them from HCBS waivers but help connect them to other supports for which they may be eligible. Nursing facilities can use presumptive eligibility and are reimbursed retroactively, once the eligibility determination has been made. No such retroactivity can be made to home and community based services. Other unnecessary procedural obstacles exist when consumers transition from facilities back to the community, creating unnecessary delays and gaps in service.

Presumptive eligibility could readily be applied to the waivers, as the Commonwealth's "Community Choice" initiative successfully demonstrated; however, the process must be supported with amendments to the waivers to address the other elements that contribute to the delay in service delivery. The Commonwealth should review its various options under federal estate recovery rules to encourage participation of otherwise eligible older adults who decline enrollment due to estate recovery (e.g. disregard of real estate under a certain value). The money saved by having the individual receive HCBS instead of unnecessarily entering a nursing home limits the short-term risk. Not being able to expedite financial and clinical eligibility determinations has significantly impacted the state's ability to divert individuals from nursing homes to the community. The policy and practice for these two settings should be better aligned and address the unnecessary and costly barriers to access HCBS waivers.

Regulatory and Statutory Reforms

31. Address workforce issues

Consistent quality in standards of care rely on training and retention of high quality care providers. Promoting consistent quality of care can challenge providers who are forced to dedicate

significant staff time and resources in fulfilling regulatory requirements that detract from time spent on actual patient care. The nursing home case-mix system should be reexamined in order to ensure better access and quality of care. Staffing requirements and inadequate salaries, combined with increasing care expectations, stagnant reimbursements and funding delays from the federal government strain the industry and make it difficult to retain quality staff across all levels of long term care, including nursing homes, home care, adult day and support services. Pennsylvania has a minimum staffing requirement of 2.7 hours of direct care, per resident, per day.[48] These standards serve as minimum guidelines, and include care provided by RNs, LPNs and CNAs. Reimbursement rates can have an impact on workforce issues across the continuum of care and studies suggest a correlation between increased CNA staffing levels and improvements in quality of care and lower hospitalization rates.[49]

While recent improvements have been made, there is a need for standardized training and a universal curriculum that allows dual certifications for certain skilled facility and in-home direct care workers. Establishing a state home care aide/attendant certification would help elevate the profession, permit aides to work in various care settings and enhance quality of care. Clarification offered by the Department of Health has allowed trained employees practicing in facilities and HCBS settings, to administer medication in the same manner. DPW should be encouraged to amend its policies under 28 Pa. Code § 107.64, to allow Nursing Aides and Attendants, who have completed the Medication Administration Program, to work in HCBS settings. Currently, DPW only allows unlicensed staff at assisted living, personal care, intermediate care and MH/MR group home settings to administer medications upon completing the course. HCBS providers should be included in the list of applicable settings to be trained to administer medications.[50]

32. *Increase flexibility to allow county nursing homes to continue serving vulnerable low-income populations*

To help insure the viability of county homes the county share requirement should be eliminated. Counties seek removal of the statutory requirement to pay ten percent of the non-federal share of the cost of care of a Medicaid resident in the county nursing home, a requirement that does not apply to non-county nursing homes. For many years this annual cost, approximately $24 million, was met using intergovernmental transfer funds. Recently, the Certified Public Expenditure process has been used to relieve counties of this requirement, but this relief is not permanent. Over the last five years several county owned nursing homes have been closed or privatized due in part to unstable finances and an increased need for county subsidies to cover funding shortfalls.

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[48] Title 28, Pa. Code, §211.12.

[49] SEIU Healthcare, "Pennsylvanian's Long Term Care System: Building Careers, Enhancing Quality Resident Care;" Journal of the American Medical Directors Association, "Nurse Staffing Impact on Quality of Care in Nursing Homes: A Systematic Review of Longitudinal Studies," February 14, 2014, http://www.jamda .com/article/S1525-8610(13)00796-2/abstract.

[50] Title 28, Pa. Code § 107.64, Administration of Drugs; Title 55, Pa. Code §3800.188a, Medications Administration Training – Statement of Policy; Pennsylvania Department of Public Welfare, "Medication Administration," http://www .dpw.state.pa.us/provider/training/medicationadministration/.

Amend § 472 and correspondingly §443.1 (5) of the Act of June 13, 1967, P.L. 31, No. 21, known as the Public Welfare Code, to read:

§ 472. Other Computations Affecting Counties. -- To compute for each month the amount expended as medical assistance for public nursing home care on behalf of persons at each public medical institution operated by a county, county institution district or municipality and the amount expended in each county for aid to families with dependent children on behalf of children in foster family homes or child-caring institutions, plus the cost of administering such assistance. From such total amount the department shall deduct the amount of Federal funds properly received or to be received by the department on account of such expenditures, and shall certify the remainder increased or decreased, as the case may be, by any amount by which the sum certified for any previous month differed from the amount which should have been certified for such previous month, and by the proportionate share of any refunds of such assistance, to each appropriate county, county institution district or municipality. The amounts so certified shall become obligations of such counties, county institution districts or municipalities to be paid to the department for assistance: Provided, however, That for fiscal year 1979-80 and thereafter, the obligations of the counties shall be the amounts so certified representing aid to dependent children foster care as computed above plus one-tenth of the amount so certified above for public nursing home care: ~~And provided further, That as to public nursing home care, for fiscal year 2005-2006 and thereafter, the obligations of the counties shall be the amount so certified above, less nine-tenths of the non-Federal share of payments made by the department during the fiscal year to county homes for public nursing care at rates established in accordance with section 443.1(5).~~

Section 443.1. Medical Assistance Payments for Institutional Care. -- ~~The following medical assistance payments shall be made on behalf of eligible persons whose institutional care is prescribed by physicians:~~

~~(5) After June 30, 2004, and before June 30, 2007, payments to county and nonpublic nursing facilities enrolled in the medical assistance program as providers of nursing facility services shall be calculated and made as specified in the department's regulations in effect on July 1, 2003, except that if the Commonwealth's approved Title XIX State Plan for nursing facility services in effect for the period of July 1, 2004, through June 30, 2007, specifies a methodology for calculating county and nonpublic nursing facility payment rates that is different than the department's regulations in effect on July 1, 2003, the department shall follow the methodology in the Federally approved Title XIX State plan.~~

33. *Allow greater regulatory flexibility to encourage innovation*

Most federal and state rules and regulations were written assuming that traditional nursing homes would serve as a residential facility of last resort. Licensure rules and regulations make innovation difficult, and the rigidity of the process is counter-productive to encouraging modernization. Creative approaches like bed banking, permissive transfers of licensed beds from over served to underserved markets, staff sharing to reflect changing care models, changing care patterns, and comingling of levels of care are hampered by licensing regulations. Regulatory complexity and the layered prescriptive rules make it difficult to alter services. Pennsylvania agencies that provide long term care services should conduct a review of existing regulatory requirements in an effort to streamline, eliminate overlaps, and consolidate oversight.

CMS regulations require long term care facilities' patients to be under "physician service," not a licensed healthcare provider and the physician must physically enter the facility to review patient data. Allowing physician extenders, like certified registered nurse practitioners, advanced practice registered nurses or physician assistants to determine levels of care, issue DNR and homecare orders, or sign MA 51 (medical evaluations) forms could help overcome certain barriers.

34. *Conduct a study on the feasibility of consolidating personal care and assisted living homes licensure under the Department of Health*

The Department of Health (DOH) currently licenses nursing homes, home health, home care and hospice providers, along with a wide variety of other non-long term care health facilities. The Department of Public Welfare (DPW) currently licenses personal care and assisted living facilities. DPW should not conduct facility licensure, but should focus on management of benefits and payment for services. Therefore, personal care and assisted living facility licensure should be evaluated to determine the feasibility of transferring them to DOH. While the broader topic of restructuring licensure, service providers, and payment for services was considered across the five agencies involved in this study, smaller steps are more practical and will still provide system enhancements and efficiencies.[51]

35. *Amend the Assisted Living Law to improve statewide access*

Since the enactment of the Pennsylvania Law to regulate and license assisted living residences in 2007, there has been a small response from personal care homes to move into this new licensing category. The number of licensed assisted living residences remains small, and Pennsylvania appears under supplied to meet the growing need for this service option, particularly in rural areas of the Commonwealth. The regulations that went into effect in 2011, and the small response from providers, have demonstrated the need to revise the existing law to improve statewide access. The Rendell Administration projected that over 200 of the 1,352 licensed personal care homes in 2011 would license as assisted living residences within the first year but as of 2013, only 34 are licensed. Priorities to amending the sections of the Public Welfare Code dealing with assisted living residences include: high annual fees compared to personal care homes ($300 + $75 per bed for assisted living vs. $35 total for personal care); definitions make the services that may be provided confusing; the language and approach to opting out of services makes tapering services to meet the individualized needs of residents difficult; resident living unit configurations make it challenging for existing facilities to meet requirements; new resident living unit construction requirements, including unit square footage, are cost prohibitive; and the training requirements for caregivers, prior to any service delivery, make it difficult to attract, retain, and introduce a new workforce.[52]

[51] The Governor's Innovation Office helped facilitate a license simplification of Adult Daily Living Centers in 2013, allowing those serving both adults over 60 (Aging) and those under 60 (DPW) to be licensed by only DPW.

[52] The Act of July 25, 2007, P.L. 402, No. 56 amended the Public Welfare Code (Act of June 3, 1967, P.L. 31, No. 21) to establish licensing of assisted living residences within the Commonwealth. 55 PA Code, §2800 regulating assisted living residences was adopted on July 16, 2010 and went into effect on January 18, 2011.

36. Streamline the Medical Assistance appeals hearings process

Obtaining continuances of Medical Assistance appeal hearings with DPW's Bureau of Hearings and Appeals should be eased while long term care providers are pursuing other legal avenues related to the case. This extended process puts a financial burden on the providers who are waiting for payment to be released, and adds legal fees that off-set payment for services, if it is ever received in whole or part. This could be accomplished with the following proposed amendment:

Amend 67 Pa. C.S., § 1102(e)(2) to add subsection (ix) stating:

§ 1102. Hearings before the bureau.
(e) Adjudication. --
(2) (ix) *The bureau shall grant a reasonable continuance request of an administrative hearing if an appellant is engaged in a separate legal proceeding in relation to the administrative appeal that may impact the outcome of the administrative appeal hearing.*

Obtaining continuances of Medical Assistance appeal hearings with DPW's Bureau of Hearings and Appeals should be eased when long term care providers request the issuance of a subpoena.

Amend 67 Pa. C.S., § 1104 as follows:

§ 1104. Subpoenas. -- Consistent with section 1102(e)(2)(v) (relating to hearings before the bureau), the bureau may issue subpoenas compelling the attendance of witnesses, records and papers. *Upon motion, the bureau shall grant reasonable requests for a continuance of the administrative hearing to the extent necessary to allow for a response to the subpoena*. The bureau may enforce its subpoenas in Commonwealth Court. Commonwealth Court, after a hearing, may make an adjudication of contempt or may issue another appropriate order.

37. Change Medicaid rules around long term care support services make them consistent with nursing homes

Currently, waiver spend down is allowed in nursing homes but not allowed in HCBS. The current long term care system has built in entitlement for nursing home coverage under Medicare and Medicaid, but not for HCBS, which often makes the most expensive care the easiest for consumers to access. Regulations for long term care services should have standardized income limits to permit eligibility for spend-down,[53] in HCBS under waiver, to increase consumer choice and eligibility for services. The maximum income for Medicaid HCBS waiver, adult day, and other support programs should match that required for nursing homes. This concept is consistent with the monthly allowance a nursing home resident can retain, although the nursing home resident's monthly allowance is far less because all things such as room, board, and utilities are included in the care the nursing home provides. To access Aging Waiver services an individual must have income at or below 300 percent of the Social Security federal benefit rate, which is $2,163/month for 2014. Any income in excess of the minimum

[53] Spend down refers to the amount a person is obligated to pay towards the cost of long term care while residing in a facility or with a community spouse whose income exceeds the allowance. They spend down to Medicaid eligibility.

monthly waiver needs allowance must be used to contribute towards the cost of care. Establishing income eligibility for home-based care at the same level used for nursing home care would allow higher income consumers to equally access and contribute toward the cost of HCBS, just as they could for facility based care.[54]

There are disparities in determining Medicaid financial eligibility for nursing facility clinically eligible individuals as compared to those choosing HCBS. These disparities actually make it harder for some individuals who qualify for long term services to choose home care, but they can qualify for the more expensive, facility based care but not for the less expensive, more preferred home care.[55] There are several areas for the Commonwealth to leverage the substantial LTSS resources it possesses to more efficiently achieve the health outcomes and life trajectories that integrated care can provide.[56]

[54] Pennsylvania Department of Aging, "Paying for Senior Care," http://www.payingforseniorcare.com/mecaid-waivers/pa-department-of-aging-waiver.html.

[55] Pennsylvania Health Law Project, "Home and Community Based Services (HCBS) Waiver Programs: A Manual for Consumers and Advocates in Southwestern PA," May 2009.

[56] Estate recovery is governed by Section 1412 of the Public Welfare Code (Act of June 13, 1967, P.L. 31, No. 21). Repayment from probate estates happens after the death of a Medicaid recipient, age 55 or older, who received long term care services. Federal law requires states to recover the amount spent to cover nursing home, HCBS, hospital, and prescription drug services.

DEMOGRAPHICS OF THE AGING POPULATION

The 2010 United States Census shows the nation's population over the last decade is larger, older, and more racially and ethnically diverse than ever before. The Older American's Act and Pennsylvania Older Adult Protective Services Act[57] both define "older adults" as those 60 plus; however, since most Census data is presented in two age groups, categorized as 65 plus and 85 plus, the data presented in this chapter follows that precedent. The focus on population numbers is designed as a basic tool to exhibit how the demographics across the globe, within the United States, and Pennsylvania have changed over the last seventy years. Looking back to the 1950 Census and other points in between, it is possible to demonstrate the changes over the last seventy years, how the changes compare to the current population numbers and what projections are forecast through 2050.

As the number of older adults rises, so will the demand for long term care services, supports and preventative services. This demand for services will grow steadily as the populations across the globe age. Data shows a marked increase in both total aging population, of those 65 plus, over the last sixty years and projections show that trend continuing, in fact aging faster, over the next 40 years. The largest spike is in the 85 plus age bracket and with those oldest seniors living longer, coupled with a declining fertility rate and family size, the world will see the aging population outweigh the youngest population for the first time in history. These patterns are consistent across the world stage, throughout the United States and Pennsylvania. As the world ages, every community and most families will be affected in some way by the aging population and by these shifting demographics. While the demand for services may be different in urban and rural areas, quality service options will be needed across all regions of Pennsylvania.

As the population ages, it will have wide-ranging impacts both socially and economically. Families will be strained by the time and cost to provide some form of care to a loved one who is aging at home. Policies and programs will need to be expanded to meet increasing demand on the pension and healthcare systems, and healthcare providers will need to continue serving a population that is living longer. Providers of long term care will be faced with meeting the demands of a more diverse population, with varying medical, cognitive, functional, social, spiritual and cultural needs. Most importantly, as people live longer, they will concurrently need to live longer in retirement.

While long term care service needs may vary, seniors are increasingly likely to need some kind of support as they age past 65, and the longer they live the more likely they will experience a chronic condition or illness that will become dependent on some level of help. Whether it be full 24/7 skilled nursing facility care, professional home care services, short-term therapy or limited in-home assistance, seniors will challenge the workforce available to meet those needs. Preventative and support services, including help with activities of daily living, transportation or meals will also help to keep seniors in

[57] The Older Americans Act of 1965 (Pub. L. 89-73); Older Adults Protective Services Act, Act of June 19, 1997, P.L. 160, No. 13.

their homes longer, and help to maintain a sense of independence. The needs for all services, including supports for family care givers, will grow as fast as the population ages.

While planning for longer retirement is starting earlier, most people feel they will not have enough money to sustain their lifespan. The vast majority of seniors do not pre-plan for long term care, few buy long term care insurance, putting a strain on the system that needs to have services available to meet the needs of families and consumers in time of crisis. In one session, a panelist remarked that "more people pre-plan their funeral than plan for their long term care needs in retirement." Despite the many educational initiatives, it is unlikely that large numbers of seniors aging into long term care needs will begin planning, and the best interaction is those which give people the tools to connect with the right services when the time of crisis hits. By focusing on new and innovative outreach methods like physicians, pharmacies and employers, along with existing long term care supports like senior centers and transportation services, seniors and their families will be given more support and better tools to connect with the right services at the right time.

The World Population

According to the National Institute on Aging's report on Global Health, the world is facing a situation unlike any other point in its history. "We will soon have more older people than children and more people at extreme old age than ever before."[58] Falling fertility rates coupled with increases in life expectance will lead to the continued and accelerated aging. With that increase will come the need for governments to deal with increased health and economic burdens of older persons, some of whom can remain independent and others, including an increase in those suffering from Alzheimer's, dementia and stroke patients will need constant care even with basic activities of daily living. "The sheer number of people entering older ages will challenge national infrastructures, particularly health systems."[59] Family demographics are also changing and with people having fewer children, older citizens will have less family members to care for them.

Over the last sixty years the United States has consistently ranked in the top five in world population. The U.S. currently ranks third behind China and India in total population and is third in total population age 65 and over, just as it did in 1950. The US falls out of the top ten in oldest median age, where its 37.4 is nearly a decade behind Japan's 45.9, Germany's 45.5 and Italy's 44.3.[60] According to the United Nations, median age is an important indicator of population aging. There are 6.8 billion people across the globe; seniors comprise 534 million, which currently occupies the smallest age group in both raw numbers and percentage. However, trends show that the world's population is aging, and the overall percentage of that segment of the population will double from 8 percent to 16 percent, by 2050.[61] Seniors are the fastest growing age group, and "demographers warn that the biggest demographic shift is yet to come." Declining birth rates and life-extending medical advances have

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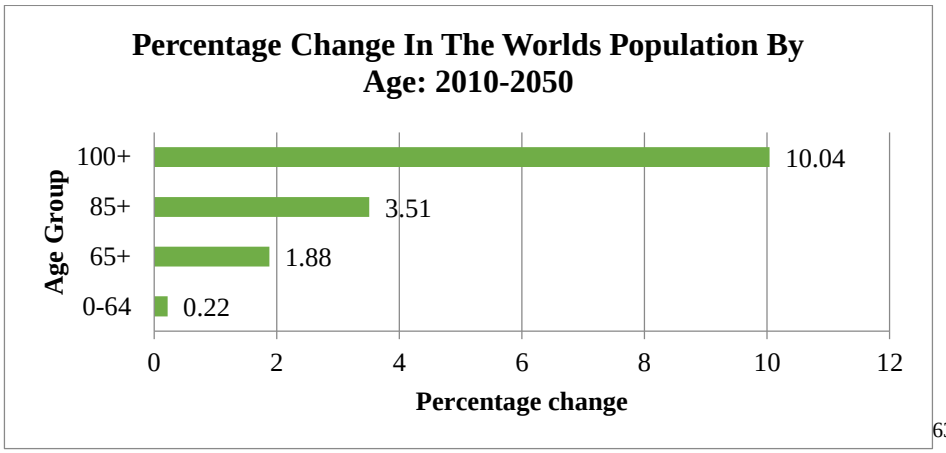
[58] National Institute on Aging, National Institutes of Health, U.S. Department of Health and Human Services, "Global Health and Aging," October 2011, pg. 1, http://www.who.int/ageing/publications/global_health.pdf.
[59] Id., pg. 5.
[60] United Nations, Department of Economic and Social Affairs, Populations Division, World Population Prospects: The 2012 Revision, "Key Findings and Advanced Tables," 2013, pgs. 19, 27-31, http://esa.un.org/unpd/wpp/Documentation/pdf/WPP2012_%20KEY%20FINDINGS.pdf.
[61] Population Reference Bureau, "2010 World Population Data Sheet," 2010, pg. 2, http://www.prb.org/pdf10/10wpds_eng.pdf.

combined to increase the so called "graying" of the world, which is projected to continue in the decades to come.[62]



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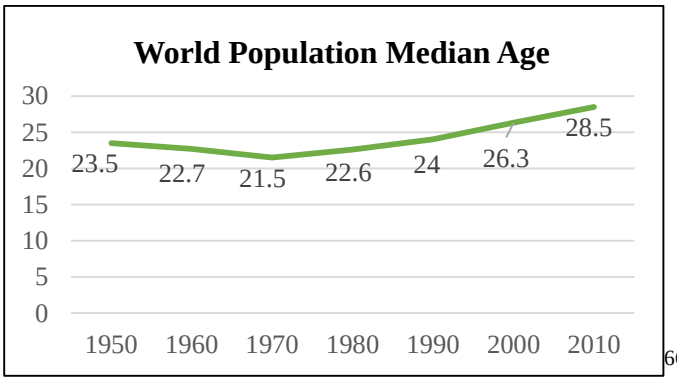
Europe today has the oldest population, and reports indicate "by midcentury most world regions will resemble Europe, which in 2005 became the first major world region where the population 65 and older outnumbered those younger than 15."[64] Western and Southern Europe are the regions which currently have the most seniors, averaging nearly 18 percent of their total population. Germany and Italy lead the way with 20 percent. Globally, Japan has the oldest population with 22.6 percent of its citizens age 65 and over. While heretofore developed countries of the world have shown little growth as they undergo aging, the developing nations of the world have remained young while growing. Yet, in 2010 that paradigm is starting to shift in areas like Latin America and Africa. They have consistently had large young populations of those under age 15, but the Census Bureau reports, "even there, the balance will have shifted toward the older group [by 2050]."[65]



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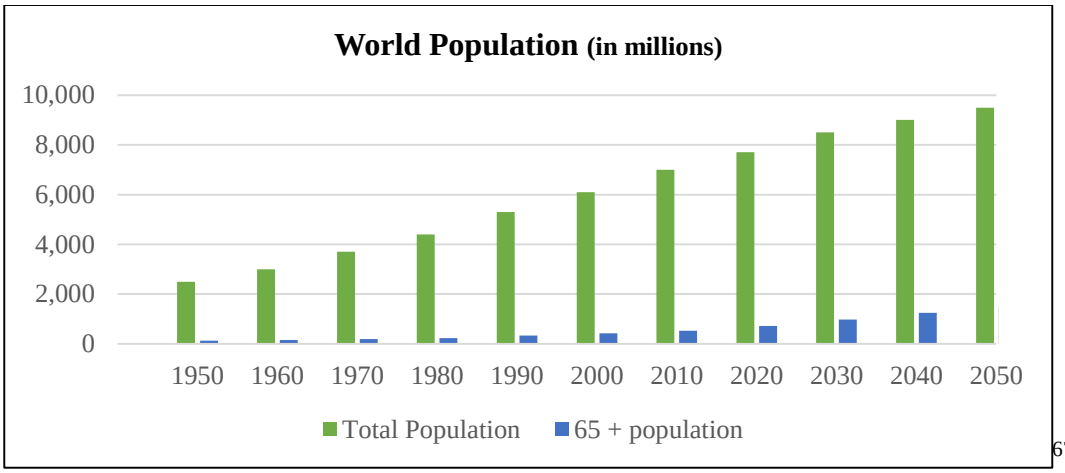
[62] Associated Press, "World's 65 and older to triple by 2050," NBCNews.com, June 23, 2009, http://www.nbcnews.com/id/31507341/ns/health-aging/t/worlds-older-triple/. While estimates vary, some project the population of those age 65 and older could reach as many as 2 billion worldwide by 2050, http://www.unfpa.org/pds/trends.htm.
[63] National Institute on Aging, National Institutes of Health, U.S. Department of Health and Human Services, "Global Health and Aging," October 2011, pg. 8, http://www.who.int/ageing/publications/global_health.pdf.
[64] Robert Bernstein, U.S. Census Bureau, "US Census Bureau News-International Data Base," PR Newswire.com, June 27, 2012, http://www.prnewswire.com/news-releases/160537115.html.
[65] Robert Bernstein, "US Census Bureau News-International Data Base," June 27, 2012.
[66] United Nations, Department of Economic and Social Affairs, Populations Division, World Population Prospects: The 2012 Revision, "Median Age of Population," 2013, http://esa.un.org/unpd/wpp/Excel-Data/population.htm.



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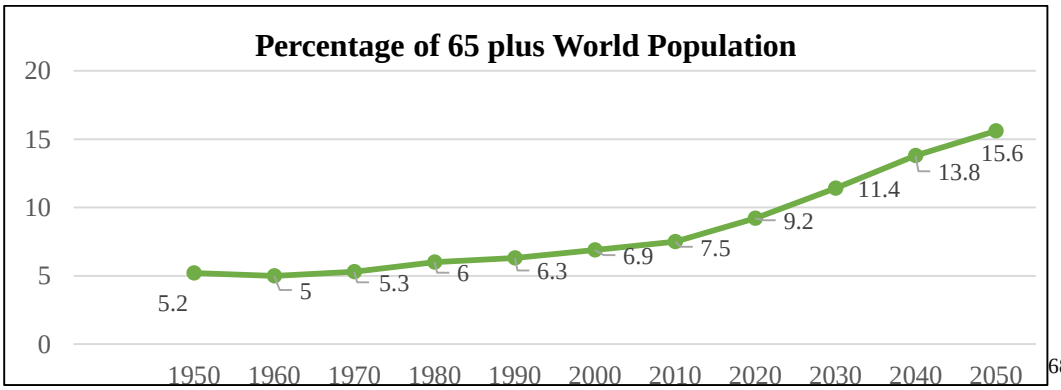

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The projected population shift around the world is clearly shown by reviewing the percentage distribution of age groups. Both the 0-14 and 15-59 age groups are projected to fall while the 60 plus and 80 plus age groups are projected to double. For the first time in history, the 60 plus age group will pass those in the 0-14 age bracket.[69] This is especially concerning as the people in the main working age group, from ages 25 to 59, is expected to peak in 2013 and begin a decline thereafter. This is important to note as the population ages faster than the workforce will grow, spending on entitlement programs like Social Security and Medicare will rise sharply in both cost of number of beneficiaries.[70]

Another display of the declining workforce examines the elderly support ratio. This ratio, "calculated as the number of working-age people ages 15 to 64 divided by the number of persons 65 or older," was studied world-wide. It is designed to show the numbers of those working-ages who are available to support older or retired persons. While the ratio is declining globally, it varies from country

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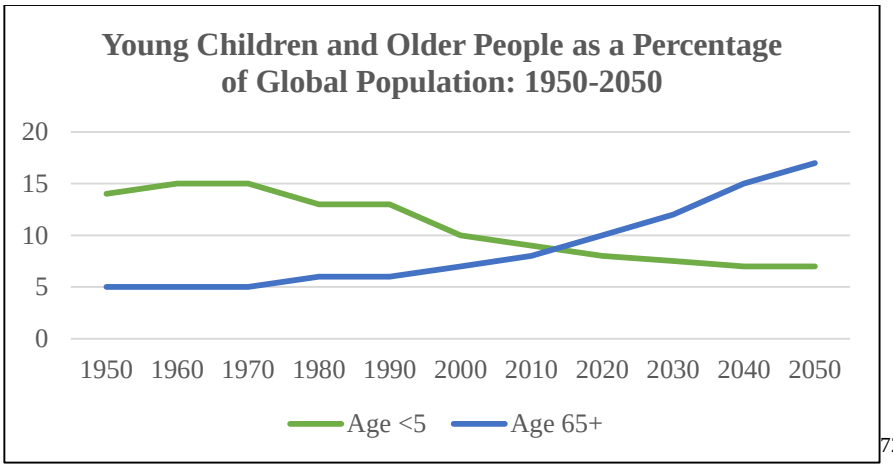
[67] United Nations, Department of Economic and Social Affairs, Populations Division, *World Population Prospects: The 2012 Revision*, "Total Population-Both Sexes," 2013, http://esa.un.org/unpd/wpp/Excel-Data/population.htm.
[68] United Nations, Department of Economic and Social Affairs, Populations Division, *World Population Prospects: The 2012 Revision*, "Population by Age Groups-Both Sexes," 2013, http://esa.un.org/unpd/wpp/Excel-Data/population.htm.
[69] United Nations, Department of Economic and Social Affairs, Populations Division, World Population Prospects: The 2012 Revision, "Key Findings and Advanced Tables," 2013, pg. 23, http://esa.un.org/unpd/wpp/ Documentation /pdf/WPP2012_%20KEY%20FINDINGS.pdf.
[70] Population Reference Bureau, "2010 World Population Data Sheet," 2010, pg. 5, http://www.prb.org/pdf10/ 10wpds _eng.pdf.

to country, with developing nations in Africa averaging 15 and over to 1. The United States falls in the lower end of the 5 to 9.9 to 1 bracket, and the lowest ratios of less than five in Germany, Italy and Japan. This is another important indicator in the factors of "below replacement" fertility rates as beneficiaries outpace the workforce.[71]



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Longer survivals coupled with declining fertility are the main factors that generate a larger aging population. China, the world's leader in population is also the leader in lowest fertility rate at 0.94 average children per woman. It is followed by many Eastern European countries that all have fertility rates under 1.5. The nations of Africa are the leaders in largest birthrate, with an average of 7.58 children per woman. The world average is 2.53, which has fallen from 3.85 in 1980 and is expected to reach 2.24 in 2050.[73] As birthrates decline life expectancy is on the rise, and is projected to increase from 68.7 today to 75.9 by 2050. Highest life expectancy is in Japan whose citizens live to an average age of 82.7, while African counties, led by Sierra Leone, live to an age of 44. Countries where the fertility rate remains high will remain relatively young.[74]

As the population ages and more people survive to older age, this prolonged life comes at a higher cost. The 85 plus age group is the most likely to need long term care, but the risk factors including cognitive function, infection and chronic disease prevention, diabetes, obesity, cancer, tobacco use, alcohol consumption, physical inactivity, hypertension and heart disease are being addressed with lifestyles at an earlier age. Early detection and management of health issues is important to help control upward pressure on overall health spending as people survive to older ages, making the burden of care increasingly expensive.[75] "Acute care and institutional long-term care services are widely available, the

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[71] Id.

[72] National Institute on Aging, National Institutes of Health, U.S. Department of Health and Human Services, "Global Health and Aging," October 2011, pg. 2, http://www.who.int/ageing/publications/global_health.pdf; Carl Haub, Population Reference Bureau, "World Population Aging: Clocks Illustrate Growth in Population Under Age 5 and Over Age 65," January 2011, http://www.prb.org/Publications/Articles/2011/agingpopulationclocks.aspx.

[73] United Nations, Department of Economic and Social Affairs, Populations Division, World Population Prospects: The 2012 Revision, "Key Findings and Advanced Tables," 2013, pgs. 32-36, http://esa.un.org/unpd/wpp/Documentation/pdf/WPP2012_%20KEY%20FINDINGS.pdf.

[74] Id., pgs. 5, 38.

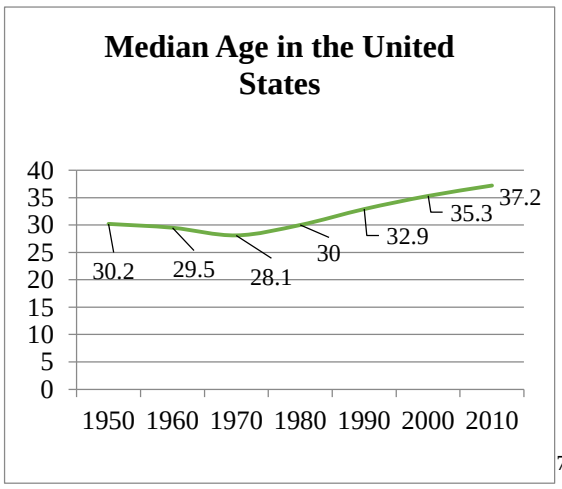
[75] National Institute on Aging, National Institutes of Health, US Department of Health and Human Services, "Global Health and Aging," October 2011, pgs. 12-19, http://www.who.int/ageing/publications/global_health.pdf.

use of medical care services by adults rises with age, and per capita expenditures on health care are relatively high among older age groups."[76]

While the work of this advisory committee focused on long term care services and supports for the senior population in Pennsylvania, the same principles identified in the recommendations on collaboration and innovation are being address around the globe. One example is AARP's work at the United Nations on the NGO Committee on Ageing. The goal of AARP's office of International Affairs is to foster global collaboration, partner with world decision makers and governments and be a catalyst to "favorably shape the social and economic implications of aging worldwide." By identifying trends, sharing best ideas and practices their program works to help people live longer, more productive and healthier lives with financial security. Key issues are financial security, retirement income, livable communities, older workforce, healthy seniors and long term care.[77]

The United States' Population Growth and Trends

More people in the United States were age 65 years and older than in any previous census report. In the decade between 2000 and 2010, the population growth was led by the 45-64 age bracket at 31.5 percent, followed by the 65 plus bracket at 15.1 percent, while the growth of the 18 to 44 age range grew only six tenths of one percent followed by the under 18 segment at 2.6 percent. The total US population grew at a rate of 9.7 percent. As a society, the United States population is at its oldest point in the last 50 years. The median age of the population in the United States has grown from 30.2 in 1950 to 37.2 in 2010. [78]



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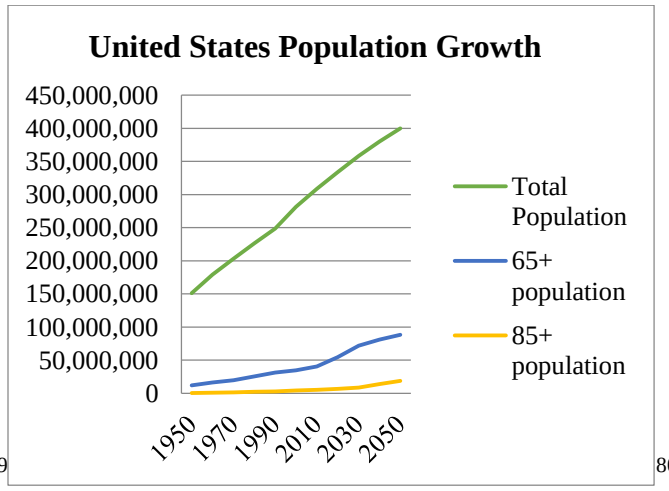

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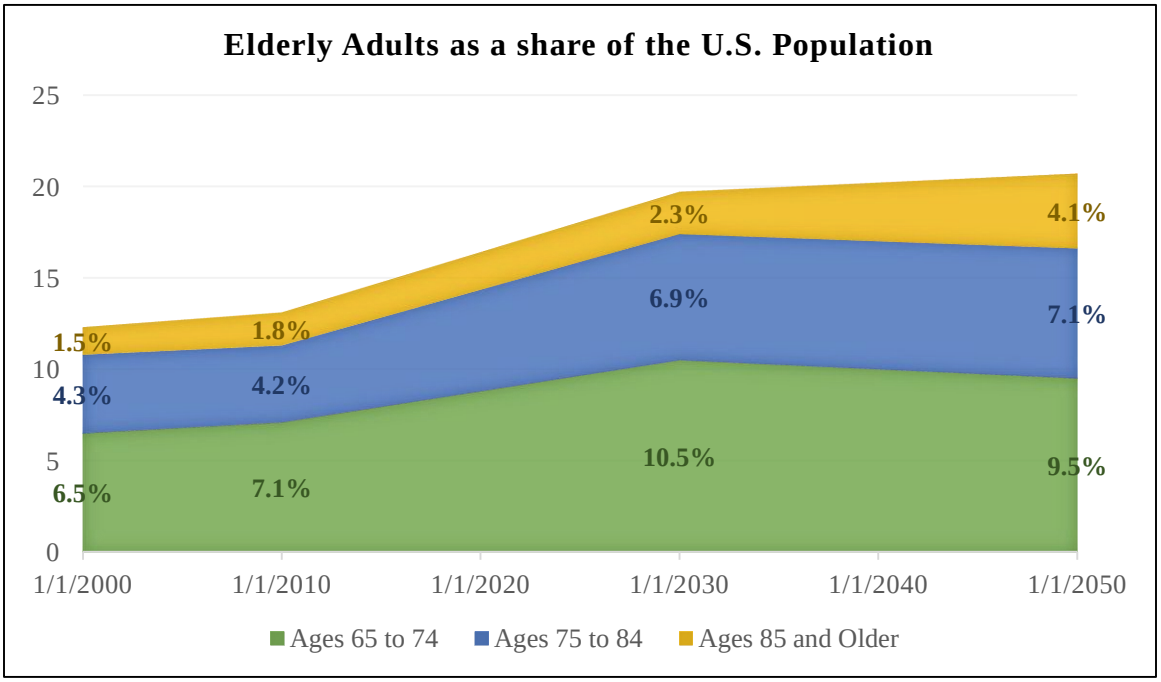
[76] National Institute on Aging, National Institutes of Health, US Department of Health and Human Services, "Global Health and Aging," October 2011, pg. 18, http://www.who.int/ageing/publications/global_health.pdf.
[77] AARP, "AARP and the United Nations,"2008.
[78] Lindsay Howden and Julie Meyer, U.S. Census Bureau, *2010 Census Briefs*, "Age and Sex Composition: 2010," May 2011, pg. 7, http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf; U.S. Census, "General Characteristics: Pennsylvania," 1950, pg. 38-72, http://www2.census.gov/prod2/decennial/documents/23760756 v2p38ch2.pdf.
[79] Population, Age and Demographic data compiled from U.S. Census data, 1950-2012.
[80] Id.

The age groups that are projected to show the greatest change in percentage distribution of the population are the 0-14 and 15-59 age ranges. The percentages are expected to fall in both of those younger, working age brackets while the age 60 plus population is expected to increase ten percent to 27 percent of the total population. Those age 80 plus are projected to double from 3.7 to 7.9 percent. Fertility rates rose from 1.77 children per woman in 1980 to 2.06 in the current census and are expected to remain relatively flat until 2050. Life expectancy has and should continue to rise, from 77.1 years of age in 2000 to 83.5 in 2050, and the gap between men and women is closing.[81] California has the largest number of people aged 65 and older, while Florida has the highest percentage of the population in that age range.[82]

An estimated 50 percent of the oldest old age population segment, those over age 85, will need some type of personal assistance with everyday activities including bathing, meal preparation and in-home mobility.[83] Between 2011 and 2029, 10,000 baby boomers will turn age 65 every single day, and with the increasing life expectancy the likelihood of those individuals needing services or supports will have a ripple effect across society.[84] The oldest of the boomers turned 65 in 2011 and the share of elderly adults is expected to grow rapidly, through 2050.[85]



[81] United Nations, Department of Economic and Social Affairs, Populations Division, World Population Prospects: The 2012 Revision, "Key Findings and Advanced Tables," 2013, pgs. 26, 35, 42, http://esa.un.org/unpd/wpp/Documentation/pdf/WPP2012_%20KEY%20FINDINGS.pdf.

[82] Lindsay Howden and Julie Meyer, U.S. Census Bureau, *2010 Census Briefs*, "Age and Sex Composition: 2010," May 2011, pg. 7, http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf.

[83] Linnae Hutchison, Catherine Hawes and Lisa Williams, *Rural Healthy People*, "Access to Quality Health Services In Rural Areas-Long-Term Care: A Literature Review," 2010, pg. 3, http://www.srph.tamhsc.edu/centers/rhp2010/Volume_3/Vol3Ch1LR.pdf.

[84] Baby boomers are defined as those born between 1946 and 1964, when more than 75 million babies were born in the United States.

[85] Congress of the United States, Congressional Budget Office, "Rising Demand for Long-Term Services and Supports for Elderly People," June 2013, pg. 7, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44363-LTC.pdf.

The country in 1950 was experiencing a very difference pace of life, in the midst of the post-World War II boom. Employment was high with an expanding economy, the population was growing due to the baby-boom, and the population was mobile and younger. Sixty-years later the U.S. economy is still struggling to return to form following the 2008-09 Great Recession, population growth has slowed while the older population of those age 65 and up has grown at the fastest rate. There was no national form of health care available in the 1950's as Medicare was not created until 1965, and more people, including more women were entering the workforce than ever before. Homeownership was expanding, and people were moving away from rural areas to spur urban and suburban growth. Many elderly people lived with or in close proximity to family members in 1950, but in 2010 about 44 percent of Americans over age 65 live alone.[86]

The 2010 census showed 308.896 million people living in the United States comprised of 13 percent from the 65 plus age group and 1.8 percent from 85 and over. In 1950, the population was half of that, standing at 151.325 million, with 8.1 percent in the 65 plus age group and four-tenths of one percent living at 85 plus. At that time it was very rare to know anyone that lived to be 90. Today, more children will grow up knowing their grandparents and great grandparents, but the odds of having multiple generations alive at the same time increases the odds that they will live separately. People increasingly prefer to be in their own homes longer. [87] This semi-independence will require in-home care, and will have a big impact on those families who will serve as part and full-time caregivers. Families are the backbone of the long term care system, providing an average of 20 hours of care a week, and with their unpaid service having economic value of an estimated $350 billion a year.[88] "The global trend toward having less children assures that there will be less potential care and support for older people from their families in the future," putting even more pressure on these family caregivers.[89]

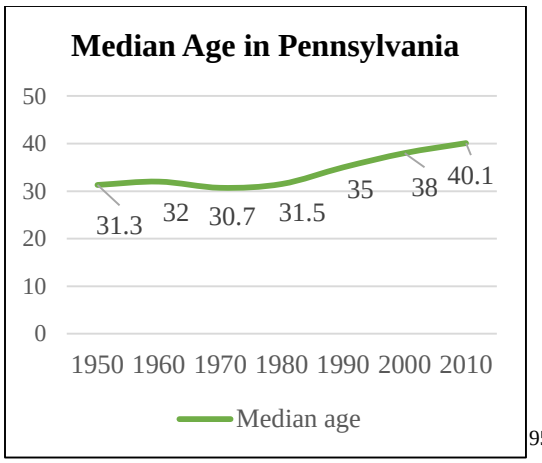
The Older Population in the United States, 2010[90]

Most Populous U.S. States, 2010							Percentage Change 2000-2010		
State	Total Population	65 plus	Percent	85 plus	Percent	Median Age	Total Population	65 plus	85 plus
California	37,253,956	4,246,514	11.4	600,968	1.6	35.2	10	18.1	41.2
Florida	18,801,310	3,259,602	17.3	434,125	2.3	40.7	17.6	16.1	31
New York	19,378,102	2,617,943	13.5	390,874	2	38	2.1	6.9	25.5
Texas	25,145,561	2,601,886	10.3	305,179	1.2	33.6	20.6	25.5	28.3
Pennsylvania	12,702,379	1,959,307	15.4	305,676	2.4	40.1	3.4	2.1	28.7
Ohio	11,536,504	1,622,015	14.1	230,429	2	38.8	1.6	7.6	30.3
Illinois	12,830,632	1,609,213	12.5	234,912	1.8	36.6	3.3	7.3	22.3
Michigan	9,883,640	1,361,530	13.8	191,881	1.9	38.9	-0.6	11.7	34.7
North Carolina	9,535,483	1,234,079	12.9	147,461	1.5	39	18.5	27.3	39.8
New Jersey	8,791,894	1,185,993	13.5	179,611	2	37.4	4.5	6.5	32.1

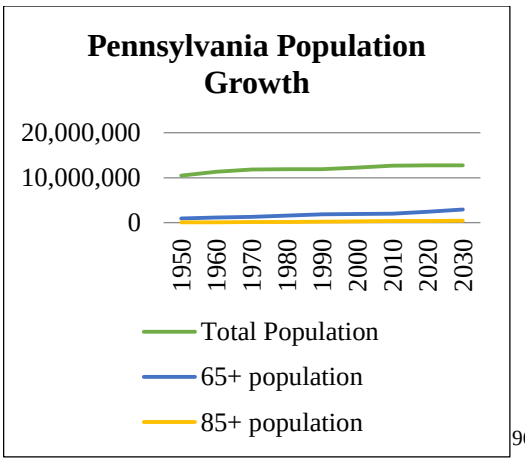
[86] The SCAN Foundation, "Demographic & Economic Characteristics of Aging Americans," February 2012, http://www.thescanfoundation.org/demographic-economic-characteristics-aging-population.
[87] National Institute on Aging, National Institutes of Health, U.S. Department of Health and Human Services, "Global Health and Aging," October 2011, pgs. 23, http://www.who.int/ageing/publications/global_health.pdf.
[88] Francesca Colombo, PBS News Hour, "How Growth of Elderly Population in U.S. Compares with Other Countries," May 24, 2013, http://www.pbs.org/newshour/rundown/2013/05/how-growth-of-elderly-population-in-us-compares-with-other-countries.html.
[89] National Institute on Aging, National Institutes of Health, U.S. Department of Health and Human Services, "Global Health and Aging," October 2011, pgs. 23, http://www.who.int/ageing/publications/global_health.pdf.
[90] Lindsay Howden and Julie Meyer, U.S. Census Bureau, *2010 Census Briefs*, "Age and Sex Composition: 2010," May 2011, pg. 7, http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf.

Population groups are expected to continue their growth and aging trends, for at least the next 20 years. The United States population is projected to grow to include 16.4 percentage of the 65 plus ages by 2020 and 20.1 percent by 2030. The age 85 and older population is expected to rise to 1.97 percent of the population by 2020 and 3.8 percentage by 2030.[91] While some projections track older Americans to as far as 2050, there are many factors that can influence those data and without accurate Pennsylvania growth projections, make accurate comparisons difficult. One interesting high-water mark of the aging population is the number of centenarians which, in 2010 numbered 53,364. Within thirty years that number is projected to grow by a factor of ten.[92]

The type and size of households is changing, the average size of a family is decreasing with more non-traditional families, blended families, ethnically diverse families and multi-generational families cohabitating. As the average size of families falls, so does the average number of people residing in each household is 2.58, down from 2.9 in 1950. These dynamics can affect the economic resources available per household, some to take into account when considering 4.4 percent of U.S. households are multi-generational and 24.9 percent of households contain an individual who is 65 years or older. Those numbers are also growing and aging, just like the population as a whole, and are up from 3.7 percent of multigenerational households and 23 percent of households containing someone age 65 plus in 2000.[93] The City of Pittsburgh lead the nation in cities of 100,000 or more, across the U.S., in the percentage of one-person households with someone age 65 and older at 29 percent.[94]



[95]



[96]

[91] U.S. Census Bureau, "Projections of the Population by Selected Age Groups and Sex for the United States: 2015 to 2060," December 2012, http://www.census.gov/population/projections/data/national/2012/summarytables.html.
[92] Julie Meyer, U.S. Census Bureau, "Centenarians: 2010," December 2012, http://www.census.gov/prod/cen2010/reports/c2010sr-03.pdf; About.com Senior Living, "Fun Facts About the Senior Population: Demographics," http://seniorliving.about.com/od/lawpolitics/a/senior_pop_demo.htm.
[93] Daphne Lofquist, Terry Lugaila, Martin O'Connell and Sarah Feliz, U.S. Census Bureau, 2010 Census Briefs, "Households and Families: 2010, pgs. 1, 15-17, http://www.census.gov/prod/cen2010/briefs/c2010br-14.pdf.
[94] Id., pgs. 11.
[95] Population, Age and Demographic data compiled from U.S. Census and Pennsylvania State Data Center data, 1950-2012.
[96] Id.

Pennsylvania's Population Growth and Trends

Communities in Pennsylvania are no different than those in other states, they are getting older, and with the landmark of the first baby-boomer turning 65 in 2011 that trend is likely to continue. In 1950, Pennsylvania's population age 65 plus was 8.4 percent and age 85 plus was four-tenths of one percent. The total state population at the time was 10.5 million, including 886,825 who were 65 plus and 39,323 who are 85 plus. The median age of the population in Pennsylvania grew from 31.3 in 1950 to 40.1 in 2010.

Pennsylvania's population growth between 2000 and 2010 lagged that of the U.S. in all segments of the population. PA's percentage of overall population growth was 3.4 percent, ranking it 42nd over the last decade. The 2.1 percent growth of the 65 plus was 49th, ahead of only Rhode Island and the District of Columbia. However, the 85 plus population grew at a 28.7 percent rate which ranked 25th overall.[97] The 19 and under category saw a decline in growth of three-tenths of one percent, the 20 to 44 age range also showed a decline in growth of six-tenths of one percent., The 45-64 age bracket growth was 25.5 percent. While its overall growth is comparatively slow, the total population segment represented by older Pennsylvania's is quite large. The more significant numbers lie in the total number of seniors that reside in the state, and represent a segment of the population who will most likely need some degree of long term care services as the age.

In raw numbers, Pennsylvania's total population is 12.702 million, which ranks it sixth most populous amongst the states in the union. The population age 65 and over is 1.959 million and the state ranks fourth in total 65 plus population at 15.4 percent. Those age 85 and older number 305,676 and the state also ranks fourth in 85 plus population at 2.4 percent.[98] The state is above the United States averages in both categories, which stand at 13 percent for those 65 plus and 1.8 percent for those 85 plus, respectively. Pennsylvania's population is at its oldest point in since 1950, with a median age growth over that time from 31.3 years of age to 40.1, ranking it sixth amongst the states, above the nationwide average of 37.2.[99] Pennsylvania is also above the median age in the United States, 40.1 compared to 37.2 years of age, ranking it sixth.[100] The state is also reported to have the second oldest average age in the nation behind Florida. [101]

The trend of an aging population is expected to continue in Pennsylvania over the next 20 years. Many organizations and agencies have weighed in with projections, including the PA Department of Aging, AARP, Leading Age PA, the Pennsylvania Health Care Association, PA State Data Center and Independent Fiscal Office. They all agree that the numbers will increase for both ages 65 plus and those age 85 plus. It is estimated that 70 percent of the people turning 65 will require some sort of long term

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[97] Carrie Werner, U.S. Census Bureau, *2010 Census Briefs*, "The Older Population: 2010," November 2011, pg.9 http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf.
[98] See Chart, "The Older Population in the United States, 2010."
[99] Lindsay Howden and Julie Meyer, U.S. Census Bureau, *2010 Census Briefs*, "Age and Sex Composition: 2010," May 2011, pg. 7, http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf; US Census, "General Characteristics: Pennsylvania," 1950, pg. 38-72, http://www2.census.gov/prod2/decennial/documents/23760756v2p38ch2.pdf.
[100] Lindsay Howden and Julie Meyer, U.S. Census Bureau, *2010 Census Briefs*, "Age and Sex Composition: 2010," May 2011, pg. 7, http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf.
[101] Pennsylvania Independent Fiscal Office Analysis, "Pennsylvania's Economic and Budget Outlook, FY 2013-14 to FY 2018-19," November 14, 2013, pg. 6-7, http://www.ifo.state.pa.us/download.cfm?file=/resources/PDF/Five-Year-Outlook-Nov-2013-Presentation.pdf.

care assistance during their lifetime, and the average care they receive will be for an average of three years.[102] The age 85 plus group is a very important component of the mix, even as the smallest raw number of the population, they are the most likely and intensive users of nursing home care.

The population of Pennsylvanians age 65 and over is projected to equal between one-in-five by 2020 and one-in-four by 2030, while the population age 85 and over is expected to grow as well, growing to 2.8 percent in 2020 then to 3.3 percent by 2030, a growth rate for seniors that continues to outpace that of the United States.[103] The Commonwealth will continue to age at a greater rate than that of the United States as a whole, and will continue to have a comparatively larger proportion and total number of seniors over the next twenty years. According to the State Data Center, further Pennsylvania projections are not available at this time. However, even the short term growth over the next twenty years will place increasing demands on long term care system, both in terms of available services, skilled care personnel, insurance providers, healthcare systems, public budgets and family finances.

Pennsylvania is also growing more diverse, as African American, Asian and Hispanics, the most prominent minority groups in the Commonwealth, have grown over the last several decades. The foreign born population has also grown significantly.[104] The needs of these groups will challenge the traditional care settings, who are often unprepared to meet their needs. For example, Asian cultures, lumped together in a Census document, actually have very different cultures, religions and dialects. Chinese, Japanese, Koreans, Vietnamese and Pilipino populations are all present in Pennsylvania and grew 85.8 percent from 2000 to 2010.[105]

The background and ethnicity of the United States is predominantly European but is changing rapidly with immigration among Asian and Latin American countries on the rise. While the United States has seen tremendous growth in foreign born populations, the majority of people identify their ancestry as German, Irish and Italian. These populations can have very subtle yet important traditions, including religious beliefs, diet and social customs that cause them to look for like-minded settings when seeking long term care. Pennsylvania Germans are predominant in central and south central Pennsylvania. They are hardworking, have strong family bonds, can be ruggedly independent in providing for their families yet very giving in helping their neighbors and communities.[106] In Asian cultures, independent behaviors that deviate from the family are discouraged and lack a directness of communication where gesture and body language are just as important as the spoken word.[107]

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[102] Pennsylvania Health Care Association, "PA Long-Term Care Statistics," 2011, http://www.phca.org/research/long-term-care-statistics.htm.

[103] Pennsylvania Dept. of Aging, "Pennsylvania Demographics: Population Trends and Highlights," http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616669&mode=2.

[104] Migration Policy Institute, "Pennsylvania: Social & Demographic Characteristics," 2013, http://migrationinformation.org/datahub/state.cfm?ID=PA; U.S. Census Bureau, "Decennial Census of Housing and Population," 1980, http://www.census.gov/prod/www/decennial.html#y1980popv1pa.

[105] Elizabeth Hoeffel, Sonya Rastogi, Myoung Ouk Kim and Hasan Shahid, "The Asian Population: 2010," March 2012, http://www.census.gov/prod/cen2010/briefs/c2010br-11.pdf.

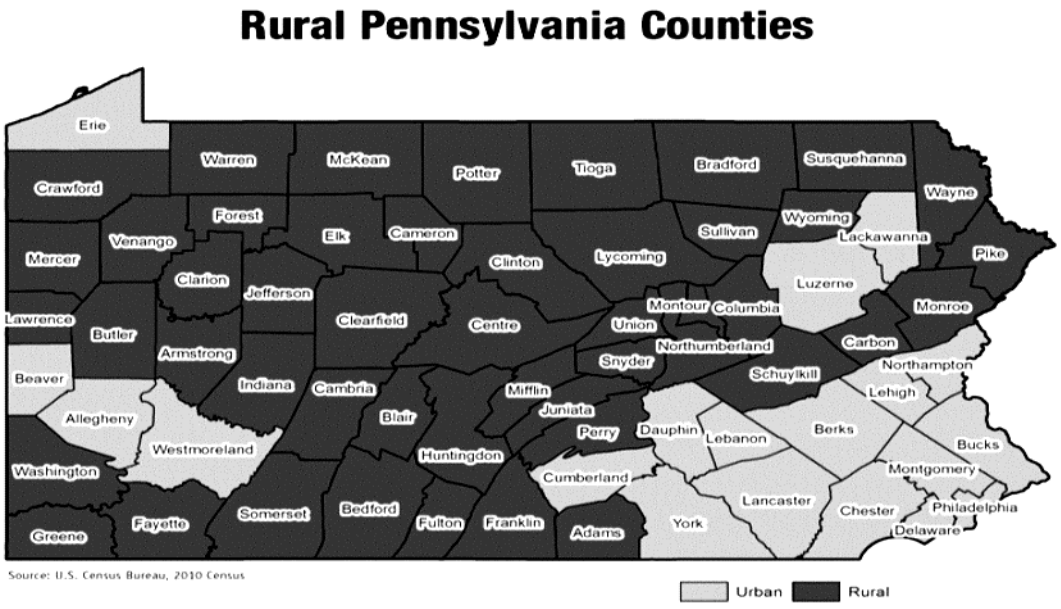
[106] U.S. Census, Selected Social Characteristics in the United States, 2007-2011 American community Survey 5-year estimates, http://factfinder2.census.gov/bkmk/table/1.0/en/ACS/12_5YR/DP02/0400000US42%7C0100000US; U.S. Census, "General Social and Economic Characteristics: Pennsylvania, 1980, http://www2.census.gov/prod2/decennial/documents/1980/1980censusofpopu80140un_bw.pdf.

[107] Marcia Carteret, "Cultural Values of Asian Patients and Families," Dimensions of Culture, 2011, http://www.dimensionsofculture.com/2010/10/cultural-values-of-asian-patients-and-families/.

Culturally sensitive services will be needed to serve those populations that may have language barriers, different customs and traditions, have unique religious needs or customs, or perhaps have stigmas attached to their groups who feel socially isolated as they age. Pennsylvania has a large Hispanic, Asian and Indian population in selected areas. Through its informational sessions the advisory committee heard from the Lesbian, Gay, Bisexual & Transgender Elder Initiative, as well as Penn Asian Senior Services, two grassroots organizations that serve older adults who suffer from language, cultural or social disadvantages that create barriers to their service needs. More information about these initiatives is found in the LTC Initiatives of Note chapter.

Services in Urban and Rural Areas

In addition to Pennsylvania's ethnic and cultural diversity, there is also a prominent urban/rural divide between the major population centers of the Commonwealth in Pittsburgh and Philadelphia, and the central, northwestern and northern tier counties within the state. Rural areas of the Commonwealth are older and less diverse than urban counties. Their growth rate of two percent is much slower than the average of both Pennsylvania (3.4 percent) and the United States (9.7 percent), respectively. Trends show that growth rate shifting to the eastern part of the Commonwealth, with an increase of seven percent, compared to a decline of one percent in the western counties.[108] Pennsylvania's urban population is 78.66 percent ranking it 20th in the nation, while its rural population is 21.34 percent, ranking it as the thirtieth most rural state.[109]



[108] The Center for Rural Pennsylvania, "Rural Pennsylvania and the 2010 Census, September 2011, pgs. 2, 8, http://www.rural.palegislature.us/documents/factsheets/Rural_PA_and_2010_Census.pdf; U.S. Census, "2010 Census Urban and Rural Classification and Urban Area Criteria," http://www.census.gov/geo/reference/ua/urban-rural-2010.html.

[109] U.S. Census Bureau, "2010 Census Urban and Rural Classification and Urban Area Criteria, http://www.census.gov/geo/reference/ua/urban-rural-2010.html.

The rural elderly face unique challenges in accessing a range of long term care services. Economies are different, the availability of services and health care vary, and the distance from small bedroom communities to those services increases in rural areas. Rural elderly have options for long term care services, including nursing homes, assisted living, hospice and in-home care services, but they often face unique challenges in accessing those services. Cost for services in rural areas is less than in urban areas, but amenities are also smaller, more sparsely located, offer a narrower range of services, and focus primarily on post-acute care.[110]

An analysis of metropolitan and micropolitan statistical areas by the U.S. Census Bureau shows the vast majority of the population, approximately 94 percent of the population (84 and 10 percent, respectively), compared to 6 percent for those outside these core based statistical areas. Almost 30 percent of the United States population was living in 42 metro areas with populations between one and five million residents, with the five most populous areas being New York, Los Angeles, Chicago, Dallas-Fort-Worth and Philadelphia. Over 55 percent of the land area fell outside of metro and micropolitan statistical areas.[111] In Pennsylvania, the population of the five southeastern counties (Philadelphia, Delaware, Chester, Montgomery and Bucks) plus Allegheny, comprised 5,232,342 or 41 percent of the state population but only 6.5 percent of the total land area.[112]

In rural areas, spouses, children and friends are the largest providers of long term care. There is a greater reliance on family caregivers due to the availability of providers, which is often driven by reimbursements systems that underlie the provider system. The resulting focus on numbers, brought on by a reliance on state and federal reimbursement, greatly reduce the market incentives in low population areas. There is also a preference to rely on informal family caregivers as rural residents often only seek a higher level of assistance when the informal system fails to meet their needs.[113]

The data trends show that Pennsylvania is becoming increasingly urbanized, however, 72 percent of the counties and 62 percent of the state's municipalities are still considered rural. Rural land area encompasses 75 percent of all Pennsylvania yet only 27 percent of the population is rural. [114] In 1900, 45.3 percent of Pennsylvania's lived in rural areas, and numbers have consistently but gradually fallen, following the national trend.[115] The average family and household sizes size in rural areas is also slightly lower than Pennsylvania's average, which trails the U.S. average in both categories. The

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[110] Linnae Hutchison, Catherine Hawes and Lisa Williams, *Rural Healthy People*, "Access to Quality Health Services In Rural Areas-Long-Term Care: A Literature Review," 2010, pg. 1, 7, 20, http://www.srph.tamhsc.edu/centers/rhp2010/Volume_3/Vol3Ch1LR.pdf.

[111] Metropolitan and micropolitian statistical areas are delineated by the U.S. Office of Management and Budget and are comprised of whole counties or county equivalents. Collectively, they are known as core based statistical areas. U. S. Census Bureau, "Patterns of Metropolitan and Micropolitian Population Change: 200-2010," *2010 Census Special Reports*, September 2012, pgs. 5-8, http://www.census.gov/prod/cen2010/reports/c2010sr-01.pdf.

[112] Demographic data on the United States and Pennsylvania taken from the following sources: U.S Census Bureau and PA State Data Center data sheets for 2010 census; Omni index, "Pennsylvania Land are in square miles, 2010 by County," http://www.indexmundi.com/facts/united-states/quick-facts/pennsylvania/land-area#map.

[113] Linnae Hutchison, Catherine Hawes and Lisa Williams, *Rural Healthy People*, "Access to Quality Health Services In Rural Areas-Long-Term Care: A Literature Review," 2010, pg. 14-15, http://www.srph.tamhsc.edu/centers/rhp2010/Volume_3/Vol3Ch1LR.pdf.

[114] Pennsylvania has a total land area of 44,743 square miles, with an average population density of 284 persons per square mile. Any county, municipality or school district is considered rural when its population density is less than 284.

[115] U.S. Census Bureau, "Urban and Rural Population: 1900 to 1990," October 1995, http://www.census.gov/population/www/censusdata/files/urpop0090.txt.

percentage of the 65 plus population living in rural areas was 16.3, above the overall average of 15.4 percent, and the median age of rural Pennsylvania was 44.1 years of age, above the Commonwealth's 40.1 years.[116] More people, proportionally, may be looking for services in rural areas, but the availability of those services will be more limited and people will need to drive farther to find services like nursing facilities, adult day, respite care and senior centers.

Unfortunately, when people choose to live in a rural setting they often do so knowing that it not always a convenient lifestyle. Services from public sewer and water to trash collection are not required to be provided, local zoning laws do not impact or restrict many business and homeowners, taxes can be lower because services are not provided, and many towns lack large amenities like shopping, schools and restaurants generally referred to as "civilization." Substantial drives may be required to purchase groceries, attend church, visit the doctor or pharmacy and even further still to a hospital. Access to services can limit choice to services, supports and care options, which often places an increased burden on seniors trying to remain independent and families providing caregiver support. Towns in rural counties are still broken by large tracts of farmland, and when people migrate or retire to rural areas for a slower pace of life, they get further away from many services and long term care does not often factor into their decision.

While the total number of households rose over the last decade, the average household and family size fell slightly. This reflects the decreasing fertility rates and increased aging. Households with individuals under 18 years of age fell while households with individuals age 65 years and over rose, as did the number of householders living alone.[117] Both Pennsylvania and the United State Median Household Incomes have risen gradually over the last 20 years, but not substantially. Household income in the Commonwealth rose gradually over the last twenty years, and now stands at $48,314, placing it 26th overall and just under the national average. The income has lagged inflation by five percent. [118] As the population ages and more people need long term care, or serve as uncompensated caregivers, the potential to strain family budgets will grow. While the state growth rate will be exponential, these needs have the potential to grow disproportionately in rural areas where access to primary care and social needs in the community is more difficult to provide in a convenient and affordable way.

The Needs of Older Adults

Needs of seniors around the nation are very diverse, and Pennsylvania is no different. People can expect to spend many years in retirement today but that has not caused them to increase preparations through increased saving, investment or long term care insurance. Escalating costs of pensions and retirees healthcare costs are concerning. Many systems, including Pennsylvania's are already strained and given the shrinking size of the workforce as a percentage of the total population will only heighten

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[116] Pennsylvania State Data Center, Research Brief, "Pennsylvania's Urban and Rural Population," October 11, 2012, http://pasdc.hbg.psu.edu/sdc/pasdc_files/researchbriefs/Urban_Rural_SF1_RB.pdf.

[117] American Fact Finder, "Profile of General Housing Characteristics: 2000," http://factfinder2.census.gov/faces/help/jsf/pages/metadata.xhtml?lang=en&type=table&id=table.en.DEC_00_DP_DPDP1#main_content; American Fact Finder, "Profile of General Housing Characteristics: 2010," http://factfinder2.census.gov/faces/help/jsf/pages/metadata.xhtml?lang=en&type=table&id=table.en.DEC_10_DP_DPDP1#main_content.

[118] U.S. Census Bureau, "Median Household Income by State: 1984-2012," http://www.census.gov/hhes/www/income/data/historical/household/

that level of burden.[119] The 2009 report from the Organization for Economic Cooperation and Development showed the expected years of retirement for men. The OECD average is 18.1 years and the US is just under that at 17.6.[120] The aging population needs better planning, more information, expanded age friendly housing options, sufficient insurance coverage and a support network that meets their diverse needs.

Elderly Pennsylvanians, wherever they reside, need access to different levels of care, they need knowledge of what services are available to serve their needs, and they need communication between the services and the consumer.[121] Many barriers exist. Seniors will need income throughout retirement to pay for living expenses for medical expenditures that will not be covered by public insurance and will be paid out of pocket. Medicare is not designed to cover long term care expenses or support services, and provides part of the cost for skilled nursing facility and home health benefits after post-acute hospital stays.[122]

The average senior will need long term care for an average of 3 years, which will be met at home informally by family care givers or paid in-home care. Nursing homes, assisted living, and personal care homes will provide the remainder in a setting outside the home. In 2005, the average level of care was provided 2/3 in home and 1/3 in facilities, and that number has continued to drift apart. Payment was 55 percent was paid for by public financing and 45 percent was out of pocket.[123] An older adult who is frail, has a physical disability or cognitive impairment may not be able to live independently. Others who can remain at home will likely need help, either formally or informally, with activities of daily living which can include personal care, homemaker services, food, clothing, safe and affordable housing, financial management, and assistance with organizing or dispensing medications in addition to their health care needs.

Studies show trends are improving and more people are planning ahead and saving for retirement. Most do not analyze the long term care aspects of retirement, and many people are focused on maintaining a monthly income to maintain their living standards. Baby boomers are more educated, better informed and generally healthier than preceding generations. As the needs for assistance and instances of chronic conditions increase with age, their retirement income and investments often fall with time. The median income for a senior age 65 and older was $25,757, roughly half of the median household income on average at $53,046.[124] The most common sources of retirement income are Social Security, which is utilized by 86 percent of retirees age 65 and older, public or private pensions from former employment, income from other assets held and current employment, which one third of seniors are now utilizing in retirement for additional income.[125]

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[119] Id. pg. 21.
[120] National Institute on Aging, National Institutes of Health, U.S. Department of Health and Human Services, "Global Health and Aging," October 2011, pg. 21, http://www.who.int/ageing/publications/global_health.pdf.
[121] Linnae Hutchison, Catherine Hawes and Lisa Williams, *Rural Healthy People*, "Access to Quality Health Services In Rural Areas-Long-Term Care: A Literature Review," 2010, pg. 15, http://www.srph.tamhsc.edu/centers/rhp2010/Volume_3/Vol3Ch1LR.pdf.
[122] Peter Kemper, Harriet L. Komisar, Lisa Alecxih, "Long Term Care Over an Uncertain Future: What Can Current Retirees Expect?," Inquiry, volume 42, Winter 2005-2006.
[123] Id.
[124] U.S. Census, "State and County Quick Facts," http://quickfacts.census.gov/qfd/states/00000.html.
[125] Emily Brandon, "The 4 Most Important Sources of Retirement Income," *US News & World Report*, March 22, 2012, http://money.usnews.com/money/blogs/planning-to-retire/2012/03/22/the-4-most-important-sources-of-retirement-income.

Selected Source of Income as Reported by American's Age 65 and Older in 2010[126]	
Income Source	**Percent of Individuals reporting Income Source**
Earnings from Current Employment	34%
Retirement Income	48%
Social Security	92%
Supplemental Security	6%
Cash Public Assistance	2%

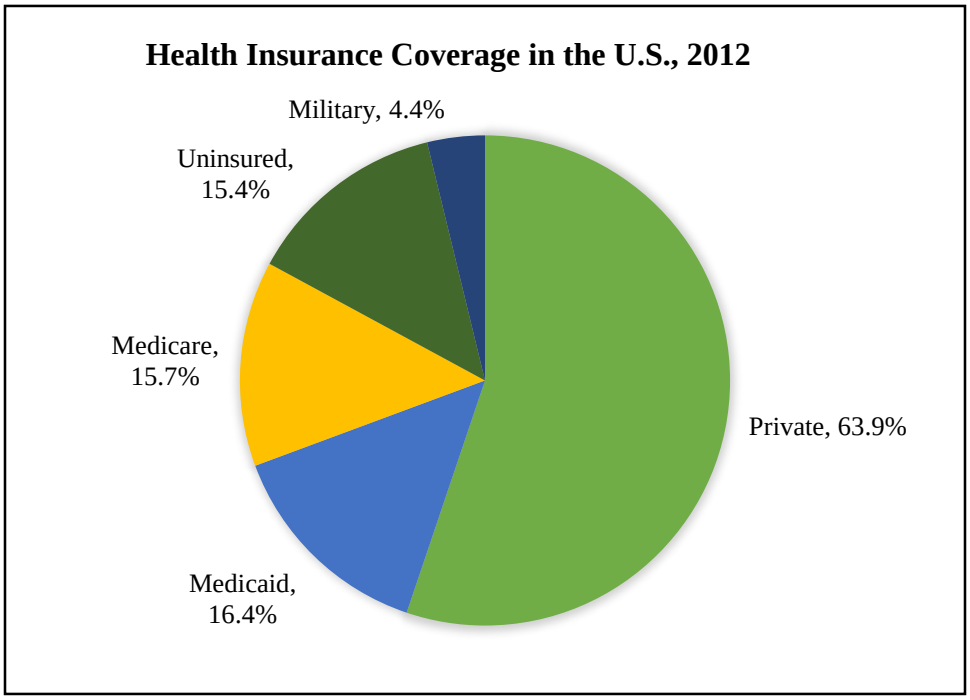
The percentage of the population with health insurance in 2010 was divided between Private, Medicare, Medicaid, Military and the uninsured, with many people having more than one form of coverage. Eighty-five percent of the population was covered by insurance across the United States, with the vast majority being served in the Private Healthcare Market including both employment based and direct purchase. Since 1999 the most dramatic increase is the growth in Medicaid coverage, up 6.5 percent, as total insurance coverage has declined slightly down 2 percent and private insurance has fallen 10 percent.[127]

Supplemental insurances and required co-pays are costs that need to be factored into retirement expenses. Unexpected changes can impact that income and costs. Both state and federal policy makers will be weighing decisions on various programs to more closely balance income and expenses, preserve programs and prioritize investments to serve both current and future beneficiaries. Reductions in Social Security benefits, rise in Medicare premiums and co-pays, cuts in annual pension increases for military retirees are in the news every time there are federal budget discussions as overall financial stability of programs are called into question and have shifted additional costs onto beneficiaries in recent years. State resources to provide services to all seniors are becoming more stressed as demand grows at a time when state revenues have been unstable. Medicare payments to providers are often misaligned with costs, and consumers can often face the same reality.[128] A popular saying reads that there are only two things in life that are guaranteed, taxes and death, but some people have added rises in healthcare premiums to that list. These are all factors that need to be considered when planning for retirement.

[126] The SCAN Foundation, "Demographic & Economic Characteristics of Aging Americans," February 2012, http://www.thescanfoundation.org/demographic-economic-characteristics-aging-population.

[127] U.S. Census Bureau, Health Insurance Coverage Status and Type of Coverage – All persons by Sex, Race and Hispanic Origin: 1999 to 2012, http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html.

[128] Mary Agnes Carey, "Five Ways The President's Budget Would Change Medicare," April 15, 2013, http://www.kaiserhealthnews.org/Stories/2013/April/15/medicare-and-obama-budget.aspx; Medicare Payment Advisory Commission, "Report to Congress – March 2012," http://www.medpac.gov/documents/Mar12_Entire Report.pdf.



In general, all persons 65 years of age or older who have been legal residents of the United States for at least 5 years are eligible for Medicare. People with disabilities under 65 may also be eligible if they receive Social Security Disability Insurance (SSDI) benefits. Specific medical conditions may also help people become eligible to enroll in Medicare. Some beneficiaries are dual-eligible. This means they qualify for both Medicare and Medicaid. In some states for those making below a certain income, Medicaid will pay the beneficiaries' Part B premium for them (most beneficiaries have worked long enough and have no Part A premium), as well as some of their out of pocket medical and hospital expenses.

With a shrinking labor force and a smaller pool of caregivers, the growing pools of people who will be seeking services and supports as they age makes it likely that consumers will need to shoulder more costs themselves. Finite public resources may produce a growing gap of seniors, between those who can afford to shoulder the costs and those who rely exclusively on Medical Assistance. Relaxing the cuts offs to phase in a system of shared responsibilities from paying may extend both public and private resources.

The trends of older Americans show they are more likely to live alone, and in 2010 some 44 percent did. These trends mean the aging population is increasingly a part of the labor force past age 65, they are less likely to move as they age, and 44 percent lived alone in 2010.[129] Planners are slowly beginning to realize that aging in everyone's issue, and will touch communities and counties large and small. While there are best practices and standards for making communities more elderly friendly and more livable, they are the exception and not the rule.

[129] The SCAN Foundation, "Demographic & Economic Characteristics of Aging Americans," February 2012, http://www.thescanfoundation.org/demographic-economic-characteristics-aging-population.

Increased elder friendly housing and communities, migration, divorce, remarriage, blended and step family relationships and economic security are factors that determine the needs of older adults as they reach age 65. Senior friendly living is a relatively new concept, but many developers have marketed townhouse residential developments to seniors and empty nesters. Including outdoor maintenance and upkeep as part of a homeowners association, or including senior friendly features in architecture, in ranch homes is attractive to this growing segment. Recreation, integrated transportation, and walking can help provide services and promote activity, which is a draw of mixed housing options of Continuing Care Retirement Communities that allow people to age in place.

Suburban neighborhoods provide easy access for these communities while urban living can be more challenging, and typically require vertical buildings with elevators. Municipal zoning laws can prove a challenge, but the ideal setting for senior living is within walkable distance to services, or with convenient transportation access thereto to help support unfunded costs of senior living. This community is a break from the traditional homes and neighborhoods of the 1950's that were built as child friendly environments, and do not transition well to age-friendly environments. Seniors most often want to downsize within their communities with easy access to medical networks, social hubs and family and friends they have established throughout their lives.[130]

Many of the oldest in the population lose their ability to live independently due to frailty or chronic conditions. The changes of needing some form of long term care grow with age, especially in the 85 plus group, and chances are they may require some form of long term care, including long hospitalization, rehabilitation or therapy, assisted living or nursing home care. The 21st century has seen an increased focus on public health and wellness programs that will help to keep older people healthy longer, delaying or avoiding disability and allowing for greater independence.[131]

Contrary to the recession of 1950, the economic recession 2008 hurt many people in the baby boomer generation, striking their savings and investments at the cusp of retirement eligibility. A 2009 AARP survey showed many adults were cutting back on spending in an attempt to save more money for retirement.[132] The U.S. Department of Labor defines baby boomers as those born from 1946 to 1964, and generation-Xers as those born 1965-1979. A 2011 survey of retirement confidence shows that more boomers have saved for retirement, but the overall total amounts are low across the generations. Baby boomers also lack confidence that they will have enough money to cover retirement.[133]

Eighty-two percent of Americans age 50 and older say they are very likely to continue doing some work to pay for their retirement, while 47 percent are likely to delay retirement. Thirty-nine percent of the working population that has reached age 50 reported having less than $100,000 saved for

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[130] Eric C.Y. Fang, "The Case for Age-Friendly Suburbs," *Planetizen*, April 5, 2013, http://www.planetizen.com/node/61712.

[131] National Institute on Aging, National Institutes of Health, U.S. Department of Health and Human Services, "Global Health and Aging," October 2011, pg. 23, http://www.who.int/ageing/publications/global_health.pdf.

[132] AARP Bulletin Survey on Retirement Savings: Executive Summary, April 2009, pg. 3, http://assets.aarp.org/rgcenter/econ/bulletin_retiresavings.pdf.

[133] Denise Appleby, "How retirement Attitudes Of Baby-Boomers And Gen-Xers Differ," February 14, 2012, http://finance.yahoo.com/news/retirement-attitudes-baby-boomers-gen-213628006.html.

retirement outside of traditional pensions or their home values. "Financial need, health and the need for benefits were cited as the most important factors in the retirement decision."[134]

A study of basic retirement expenses, including food, housing, discretionary spending, plus medical and uninsured healthcare costs showed that 44.3 percent of baby boomers born between 1948 and 1954 were projected to lack adequate retirement income. Many employees in those early baby boomer cohort will suffer from retirement saving shortfalls from employment based retirement plans. Eligibility for defined contribution plans at the workplace has a significant positive impact. Lower income households were found to be much more likely to fall into the at risk category at 87 percent, while the risk drops to 13 percent for those considered upper income households.[135]

Most national retirement income assessments assume retirement at age 65, and look at retirement plans, financial market performance, and employee behavior when calculating retirement risk assessment. How long retirement money will cover expenses decreases rapidly after 10 years, which is almost half of the average length of retirement in the U.S.[136] When people live 20 plus years in retirement, nearly all households will be within 25 percent of exhausting their total pre-retirement savings. Additional pre-retirement savings will be needed, or post-retirement income will need to be generated, which signals people staying in the job pool longer or needing to find additional employment to supplement their retirement. There is also an increasing recognition that "very few retirees actually have long term care insurance."[137]

Many financial planners advise individuals who are calculating retirement of the "need to replace 70 percent or more of their pre-retirement income in order to maintain their current lifestyle." American's are increasingly uncomfortable with their ability to live comfortably in retirement, and 60 percent of workers have saved less than $25,000 for their retirement. Similarly, 30 percent of retirees and 34 percent of current workers feel they are "not at all" confident in having enough money to pay for long term care expenses in retirement.[138] "For many, long-term care often represents the single largest lifetime expenditure for care services." While assisted living and lower levels of informal care are attractive alternatives consumers must utilize their own resources to pay for such services, with many seniors unable to afford any level of care.[139]

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[134] Eric Young, "AP-NORC survey: Working longer—older Americans' attitudes on work and retirement," October 14, 2013, http://www.eurekalert.org/pub_releases/2013-10/natu-asw101413.php.

[135] Jack VanDerhei, PhD., Employee Benefit Research Institute, *Notes*, "Retirement Income Adequacy for Boomers and Gen Xers: Evidence from the 2012 EBRI Retirement Security Projection Model," May 2012, pgs. 1, 3, 6, http://www.ebri.org/pdf/notespdf/EBRI_Notes_05_May-12.RSPM-ER.Cvg1.pdf

[136] *The Economist*, "The French spend longer than most in retirement," September 9, 2010, http://www.economist.com/node/17008998.

[137] Jack VanDerhei and Craig Copeland, Employee Benefit Research Institute, *Issue Brief*, "The EBRI Readiness Rating: Retirement Income Preparation and Future Prospects," July 2010, pgs. 1, 9, 22, http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-2010_No344_RRR-RSPM.pdf.

[138] Ruth Helman, Matthew Greenwald & Associates; and Craig Copeland and Jack VanDerhei, Employee Benefit Research Institute, *Issue Brief*, "The 2012 Retirement Confidence Survey: Job Insecurity, Debt Weigh on Retirement Confidence, Savings," March 2012, pgs. 9, 11, http://www.ebri.org/pdf/surveys/rcs/2012/EBRI_IB_03-2012_No369_RCS.pdf.

[139] Linnae Hutchison, Catherine Hawes and Lisa Williams, *Rural Healthy People*, "Access to Quality Health Services In Rural Areas-Long-Term Care: A Literature Review," 2010, pg. 15, 17, http://www.srph.tamhsc.edu/centers/rhp2010/Volume_3/Vol3Ch1LR.pdf.

In 2010 the median income was $31,408 compared to the $62, 485 for the highest wage earners age 45 to 54. Household income drops sharply for those age 65 and older and while those in their peak earning years have the greatest ability to save as they plan for retirement and long term care needs. Median income for all households under age 65 declined over the last decade, most notably to correspond with the great recession that saw disposable income and investment fall. The poverty rate has also grown in recent years for those under the age of 65, but for the oldest age group of Americans their percentages have consistently fallen since the 1950's and they represent the lowest poverty rate at nine percent. Health insurance coverage is also at its highest level amongst those 65 years and older, with 98 percent coverage in 2010 through a mix of employment based, direct purchase, military, Medicare and Medicaid.[140]

While Pennsylvania is not unique, it has begun to face challenges that will impact current and future retirees; its unfunded pension obligations. In addition to the defined benefit plans of the State Employees and Public School Employees Retirement Systems, there are 3,300 public pension systems across the state, even more than the 2,563 municipalities within its borders. That number represents almost one-quarter of all public pension plans across the country. There are different classes of county and municipal pension systems within local government for uniformed and non-uniformed municipal workers, police officers and firefighters, and each varies in size, assets, and liabilities.[141]

Local government pensions are underfunded by $2 billion, with at least 52 plans severely distressed, 234 moderately distressed and 663 minimally distressed.[142] Pennsylvania's shortfall between its two systems has grown from $33 billion in 2009 to $47 billion today, and is expected to grow to $65 billion in the next five years. While benefits for current retirees are unlikely to be impacted, raising contributions or reducing benefits of current employees could have dramatic positive or negative impacts yet unknown, just as shifts to defined contribution plans could affect available retirement income.[143]

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[140] Carmen DeNavas Walt, Bernadette Proctor and Jessica Smith, U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2010," September 2011, pgs. 6, 9, 16-17, 85, http://www.census.gov/prod/2011pubs/p60-239.pdf.

[141] Ben Finley, philly.com, "Underfunded pensions a growing problem across Pa.," July 6, 2013, http://articles.philly.com/2013-07-06/news/40393936_1_pension-costs-pension-fund-public-pension-plans.

[142] Pennsylvania Department of the Auditor General, "Auditor General Jack Wagner Calls for Consolidation of Pennsylvania's 3,200 Municipal Pension Plans, September 19, 2012, http://www.auditorgen.state.pa.us/Department/Press/WagnerCallsforConsolidationPA3200MunlPenPlans.html.

[143] Pennsylvania Office of the Budget, "Pennsylvania Pension System Reform," February 5, 2013, http://www.budget.state.pa.us/portal/server.pt/community/pension_reform/21394; Thomas Healey, Carl Hess, Kevin Nicholson, Harvard Kennedy School, "Unfunded Public Pensions in the United States," 2012, http://www.hks.harvard.edu/var/ezp_site/storage/fckeditor/file/pdfs/centers-programs/centers/mrcbg/publications/fwp/MRCBG_FWP_2012_08-Healey_Underfunded.pdf.

DEPARTMENT OF AGING

Background and History[144]

The Pennsylvania Department of Aging (PDA) was established in 1978 to advance the well-being of Pennsylvanians older citizens and to coordinate federal and state aging programs and to maximize the independence and involvement of Pennsylvanians as they age.[145] Their mission is a dual role, to enhance the quality of life for older Pennsylvanians by empowering diverse families, communities and consumers; and to protect older people from abuse, neglect, abandonment and exploitation. State law defines an older citizen as someone who is age 60 or older, while many lottery programs are targeted to seniors age 65 and up. Individual programs and services available across many state agencies have their own specific criteria including age, functional or cognitive impairment, along with income qualifications.

Organized into various offices that provide protective and supportive services, the Bureau of Aging Services promotes prompt service delivery programs. This office is responsible for management of the Older Americans Act for the federal government, and administration of caregiver support, transportation, OPTIONS, HCBS including information and referral, case management, personal care services, environmental modifications, medical supplies and equipment, adaptive devices, emergency response systems, veterans directed HCBS, domiciliary care homes, senior housing, aging in place, and nutritional services including meals on wheels. The office also serves as the state liaison between federal Administration on Aging and the local service provider Area Agencies on Aging. The Bureau of Quality Assurance performs quality management and monitoring of aging programs to ensure compliance with federal and state regulations, and to protect the health safety and welfare of consumers.

The PDA, with a current complement of 100 employees, is one of the smallest Cabinet level agencies in the state. In fact, it is smaller than many bureaus and offices within other state agencies that are involved in providing LTSS. It is responsible for consolidation of services available for older residents of Pennsylvania. Through direct oversight, the Department provides statewide services using Area Agencies on Aging (AAAs). Services provided through these AAAs include home and community based services, nutrition, transportation, employment, domiciliary care, information and referral case management, and protective services, and a long term care assessment. The foundation of the Department is to prevent the need for more intensive government aid, and protect consumers from abuse, neglect, and exploitation. Pennsylvania's aging network services nearly 1 million consumers annually, comprised of both state and community based organizations, agencies, and service groups,[146] The Department is also the lead agency responsible for the coordination and implementation of federal and state programs for older consumers.[147]

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[144] General information on the Department of Aging was taken from the Pennsylvania Manual, FY2014-15 presentation at the Appropriations Committee hearings, and the Department's website, http://www.aging.state.pa.us.
[145] Act of June 20, 1978, P.L. 477, No. 70.
[146] Pennsylvania Dept. of Aging, "2012-2016 State Plan on Aging."
[147] 71 P.S. §§581-3(a)(1)-(29).

The Department of Aging once partnered with the Office of Long Term Living, in a dual role, as the lead agency. In fact, it was billed for a time as the Department of Aging and Long Term Living. In 2008 the agencies were joined in an effort to provide better integrated services, and a broader strategy on long term living, to the aging population. This office was developed under the Rendell administration as an effort to better serve the aging population but the match was less than ideal. OLTL is responsible for the fiscal, policy and program operations of the long term living system for both the elderly and adults over 18 with disabilities. The partnership was phased out by the Corbett Administration and the separation was finalized in January 2014. The Office of Long Term Living is currently an office in the Department of Public Welfare.

The Department's Budget totaled $658 million dollars in FY2012-2013, of which 75 percent came from the Pennsylvania Lottery. Lottery monies were used to support general government operations of the PDA, PENNCARE programs, caregiver support, pre-admission assessments, Alzheimer's outreach and the PACE programs. Federal funding through the Older Americans Act makes up 20 percent with the remaining five percent coming from a combination of Tobacco Settlement and other minor augmentations. No state general fund monies are expended on the PDA. Funding for the Department of Aging has fluctuated over the past decade, and has fallen since FY2003-04. Lottery funds are down slightly, was in tobacco settlement funds that used to contribute over $80 million and are now down to $25 million.[148]

The Intra-Governmental Council on Long-Term Care is an appointed group of administration and legislative advisors. These individuals study the long term care system and make recommendations to the Governor for ways to improve the funding and operational aspects of the long term care system to benefit consumers and their families. The council is comprised of three members of the governor's cabinet, four members of the general assembly and representatives of long-term care service sectors and consumers appointed by the governor. This body was created in 1988 and while it falls in Section 212 of the Public Welfare Code,[149] it is chaired by the Secretary of Aging, who under the Rendell administration, discontinued the Council meetings in approximately 2009, re-tasked its staff and it has not reconvened. Between 1990 and 2006 the council was very active and conducted research, published multiple reports, formed work groups around specific issues.[150]

Another important role for the department is to develop the State Plan on Aging, which is a requirement of the Older Americans Act. This document is the PDA's strategic plan, and comprehensive approach to provide direction, carry out commitments and promote collaboration in serving the needs of older Pennsylvanians. The document is drafted on a four year cycle, and is typically written with the feedback from AAAs, consumers, caregivers and other stakeholders through public hearings. The hallmark of the 2012-2016 State Plan is to provide access to seniors at the right time, in the right setting, and at the right intensity. Empowering older adults with choice in care settings, expanding innovative efforts and enhancing existing services will all be needed to meet future need. Many of the topics discussed in the state plan were reflected in the HR 255 informational sessions, but the state plan's

[148] Governor's Executive Budget, FY 2005-2006 & FY 2013-2014.
[149] Section 212 of the Act of June 13, 1967, P.L. 31, No. 21 known as the Public Welfare Code. Section 212 was added by the Act of December 21, 1988, P.L. 1883, No. 185.
[150] Pennsylvania Dept. of Aging, "Intra-Governmental Council on Long-Term Care," http://www.portal.state.pa.us/portal/server.pt/community/councils/17889/intra-governmental_council_on_long-term_care/616018.

numerous mentions of disability services further illustrates the dynamic in Pennsylvania of serving older adults separately under the lottery.[151]

Aging Services and Support Programs

The Department of Aging, alongside Census data, collects enrollment and service information pertaining to consumers served by the aging network. In FY 2012-13, Census information from 2010 states Pennsylvania had 2,829,203 individuals age 60 or over.[152] Of this population of 60+ individuals, 6.6 percent or 187,838 individuals were served by the aging network.[153] In FY 2012-13, 2010 Census information states there were 625,207 individuals living within the Commonwealth age 80 and older.[154] Of this population, 14.6 percent or 91,233 individuals were served by the aging network.[155] Aging data provided to the JSGC ranged from the third quarter of FY2011-12 to the second quarter of FY2013-14, making it difficult to present trends for most data elements. The difficult in providing data was due to a change in the PDA system that did not accurately capture unique users within programs but has been recently updated to do so.

Community Services Provided to Older Pennsylvanians		
Community Services[156]	**Total Served**	
	2011-12	**2012-13**
Pre Admission Assessment		
Assessments/ recertification's	105,725	110,415
Referrals to nursing homes	39,140	40,590
Referrals to community services	45,660	44,020
Individuals Receiving Assistance		
Personal Assistance Services	1,470	1,575
Attendant Care Services	2,090	2,300
Personal Care Services	13,125	11,480
Home Support Services	6,595	5,610
Congregate Meals	132,630	116,465
Home Delivered Meals	36,425	33,160
Protective Services	17,790	16,940
Families Receiving Caregiver Support	7,120	7,200
PACE/PACENET pharmaceutical assistance (monthly average)	304,130	317,300
APPRISE	90,202	109,540

[151] Pennsylvania Department of Aging, "2012-2016 State Plan on Aging," http://www.portal.state.pa.us/portal/server.pt/community/department_of_aging_home_new/19366/hide_plan_on_aging_2012/1070778.
[152] Pennsylvania Dept. of Aging Enrollment and Service Report, Consumer Data from SAMS, Census Data from Penn State Data Center, 1st Quarter FY 2011-12 through 4th Quarter FY 2012-13.
[153] Id.
[154] Id.
[155] Id.
[156]Data provided to JSGC from the Dept. of Aging on April 21, 2014. The data ranged from the third quarter of FY 2011-12 to the second quarter of FY 2013-14, making it difficult to present trends for most data elements. The difficulty in providing data was due to a change in the PDA system that did not accurately capture unique users within programs at that time. Program Measures listed in the FY 2011-12 and FY 2012-13 Executive Budgets, as well as the "2012-16 State Plan on Aging," show minor differences with the numbers provided.

Block grant allocations in FY2011-12 and FY 2012-13 were level funded at $280 million. Wait lists for services grew during that time from 6,080 to 7,394. In FY 2013-14 funding was increased by $20 million to $300 million total, which allowed wait lists to drop to 3,049. Increases in the FY 2014-15 budget will further reduce or eliminate the wait for services and supports, however, wait lists will occur in the future if funding levels do not keep pace with the demand for services.[157]

Many programs have seen their funding decrease over the last ten years. Efforts have been made to restore those funds and reduce wait list for services that have developed as a result of increasing demand. In FY 2011-12, nearly 3,700 consumers were waiting for domiciliary care, family caregiver supports and OPTIONS. Those lists grew in FY 2012-13, rising to over 5,000 individuals. The greatest need was for the Options program, which accounted for 94 percent of the total need. Those numbers have improved in the first half of FY 2013-14 with the number of people waiting for access to the OPTIONS program cut in half, while those waiting for domiciliary care and family caregiver supports have remained stable. During the informational sessions the need for additional funding to reduce the waiting lists for these programs was discussed at length.[158]

Area Agencies on Aging[159]

Area Agencies on Aging (AAAs) are the local representatives of the Pennsylvania Department of Aging and a major component of the aging services network. There are 52 AAAs within the state providing locally attainable information and assistance on issues affecting older individuals, their families and caregivers, and their service providers. Of the 52 AAAs in the state, 19 are private, non-profit entities with their own independent governing board. The other 33 AAAs are public units, and can be single or multi-county agencies. AAAs are the front door to the Department; they serve as the navigators of the maze we call Long Term Care. Each year, an estimated 500,000 individuals reach out to AAAs for information, advice, and assistance on topics pertaining LTC.[160]

An important role for AAAs are the assessments required for appropriate consumer care. AAA are responsible for conducting nursing home level of care assessments for those consumers within the Commonwealth seeking LTC services. The needs assessment looks to see how much assistance is required on a daily basis for the consumer to complete their daily routine. Activities of daily living (ADLs) are considered in this assessment process; ADLs include such tasks as bathing, dressing, grooming, eating, and general movement around the household. Level of care can also depend on medical conditions related to an illness, disability, or chronic condition thus requiring additional treatment or extended care. During FY 2012-13, an estimated 112,000 assessments were performed.[161]

The Department allocates state and federal funds in the form of block grants to all 52 AAAs based on allocation formula. Factors included in this financial allocation include: individuals 60 years of age and older, persons 75 years of age and older, minority individuals 60 years of age and older, citizens living in rural areas of age 60 or older, and senior's age 60 and older living at or below 100%

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[157] Information provided to JSGC by the Pennsylvania Dept. of Aging on April 21, 2014.
[158] Data provided by the Pennsylvania Dept. of Aging.
[159] Pennsylvania Dept. of Aging, "Governor's Executive Budget, Fiscal Year 2014-15," Prepared for Appropriations Committee Hearings, 2014.
[160] House Aging and Older Adult Informational Hearing, "Lottery Services and Support through Area Agencies on Aging," M. Crystal Lowe, January 22, 2013.
[161] Id.

of poverty. Each factor is weighted accordingly in the Departments allocation formula. In addition, the AAAs provided funding and assist in programing for more than 600 senior centers within the state.[162]

Ombudsman[163]

The Ombudsman program is designed to enforce, protect, and enhance the health, safety, rights, and welfare of older individuals receiving long term services and supports. This program works around complaints made by, or on behalf of older individual, and includes investigations and information seeking on behalf of the aggrieved individual. Ombudsman also advocate for seniors on major issues include changes in the law pertaining to aging individuals, regulations, and policies affecting the Commonwealth. Ombudsman services are designed to operate though AAAs, which provide services free of charge on a confidential level with services available to all 2,700 long term care facilities within the state. The Ombudsman provides valuable services to assist older adults and consumers of long term care to resolve issues affecting their quality of life and care; however, it is important to note that federal guidelines for long term care ombudsman programs are required to operate independently to avoid possible conflicts of interest.[164]

OPTIONS Services

Originally called the Long Term Care Assessments and Management Program, it was established in the 1980s and evolved into what is today known as OPTIONS. The structure consisted of a centralized assessment unit, a care management unit, and a regional management agency that was the local connection to the PDA, who was the payer. This program provides management and oversight of care planning and assistance to consumers and their families being served by HCBS. It also provides home delivered meals, personal care, home health, respite, consumer reimbursement, counseling, home support, medical equipment/supplies, adaptive devices, personal emergency response systems, adult daily living services, and environmental modifications. This program is provided to Pennsylvanians age 60 and older who are otherwise not eligible for Medicaid long term care services, due to functionality or financial eligibility. The goal is to provide consumers with the choice to remain in the most appropriate setting and to function at the optimal level. This program is available to consumers on a cost sharing basis and availability may vary by AAA. In FY 2012-13, 22,000 individuals statewide were served by the options program.[165]

Entry into the program requires a level of care assessments by the AAA to determine eligibility and appropriateness. Medicaid eligibility assessments, nursing home clinical eligibility, functional and cognitive assessments are all performed or reviewed. There is no required financial eligibility but a co-payment may be required, based on a sliding scale. The need for and provisions of services is determined

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[162] Pennsylvania Dept. of Aging, "2012-2016 State Plan on Aging." Note: The allocation formula for AAAs, as approved by the federal Admin. on Aging, is weighted on five factors including the following demographic information: poverty level (25 perecent), rural population (.25), population over age 75 (.20), minority population (.20), and population over age 60 (.10). A hold harmless clause requires each AAAs block grant to act equal to the previous years allocation.

[163] Id.

[164] Medicaid.gov, "State Long-Term Care Ombudsman Programs," http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/LTC-Ombudsman-Programs.html.

[165] Pennsylvania Dept. of Aging, "Options Program," http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616683&mode=2.

and a care manager, in conjunction with the consumer, matches the needs with the appropriate services. OPTIONs is a program that helps to prevent seniors from falling between the cracks of service need and financial eligibility, and its effectiveness in preventing unnecessary facility diversion promotes independence, allows choice, and saves dollars for both the state and consumer.[166]

Aging and Disability Resources

The Aging and Disability Resource Centers, or the PA Link, is responsible for promoting services and program collaborations that create person-centered, community based approach to provide independence with dignity. Its services focus on the elderly and individuals with physical, cognitive, developmental or intellectual disabilities, of any age, through a "no-wrong door" approach. This approach allows consumers to access LTSS information from a variety of community human service agencies, including on-site locations, a comprehensive website, and a consumer hotline where they can also obtain referrals. The Link seeks to integrate information and referrals for older Pennsylvanians and those with disabilities by partnering with AAAs, Independent Living centers and Independent Enrollment Brokers.[167]

The Link is a nationwide effort to provide an array of services and supports to older adults and adults age 18 to 59 with disabilities, and is a federally funded program, with no state match, that brings in approximately $5 million to Pennsylvania annually. Every Link consists of a core partner group of collaborative partners, including each of the state's AAAs, Centers for Independent Living and County Assistance Offices and other local community partners. Available in all 67 counties, the goal is to connect consumers to local services through any Link partner and to help consumers remain in or transition back to the community.[168]

Pennsylvania Lottery Funded Programs

Programs receiving monies from the Pennsylvania Lottery Fund include the Property Tax/Rent Rebate, PACE, PENNCARE, Free Transit and Shared Ride, Alzheimer's Outreach, Pre-Admission Assessments, Long Term Living Services and Family Caregiver Supports. Costs for general governmental operations and administration are provided for in the Department of Aging.[169] In addition to PDA's operations, the lottery funds PENNCARE, PACE, Caregiver Support and other programs that are listed below, and are administered through the Department of Aging. Other lottery funding that supports programs within the Departments of Revenue and Transportation are covered in the chapter on Additional Long Term Care Services.

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[166] Information provided to JSGC by Kelly O'Donnell, Director, PDA, Office of Operations and Management, February 6, 2014.

[167] Commonwealth of Pennsylvania, Departments of Aging and Public Welfare, "Balancing Incentive Program Application," April 18, 2014, pg. 12.

[168] Pennsylvania Dept. of Aging, "2012-2016 State Plan on Aging," pg. 13, http://www.portal.state.pa.us/portal /server.pt/community/department_of_aging_home_new/19366/hide_plan_on_aging_2012/1070778; Pennsylvania Dept. of Aging, "PA Link to Aging and Disability Resources," http://www.portal.state.pa.us/portal/server.pt/ community/pa_link_to_aging_and_disability_resources/20788.

[169] North American Association of State and Provincial Lotteries, "Cumulative Lottery Contributions to Beneficiaries," June 30, 2009, http://www.naspl.org/UploadedFiles/files/new_cumulative_lottery_contributions_to_ beneficiaries.pdf.

Prescription Drug Assistance

Pharmaceutical Assistance Contract for the Elderly (PACE), PACE Need Enhancement Tier (PACENET) and PACE Plus are prescription drug programs that provide purchase assistance to older Pennsylvanians. Eligibility criteria includes all those age 65 and older who are state residents for at least 90 days, and cannot be enrolled in DPW's Medicaid prescription benefit.[170] The Department of Aging administers the programs, and contracts with a vendor who conducts the day to day operations of the program including processing applications of enrollees, reimbursing providers, and conducting safeguards and efficiency controls. Monitoring and evaluation of providers and cardholders, reviewing medication utilization profiles and dispensing practices are administrative responsibilities of the Department and help identify trends while securitizing expenditures.[171]

PACE was established in 1983 with the purpose of assisting qualified Pennsylvania residents, age 65 years and older, to pay for prescription medications. It was modified on four occasions, reauthorized twice and expanded by increasing income eligibility. Current eligibility incomes for PACE are $14,500 or less for single persons and $17,700 or less for married couples. Copayments for drug costs include $6 for generic and $9 for name brand. In 2012, enrollment for the program was 124,770 who utilized a payout of $79.18 million from the fund, with the majority of the users being single (92 percent). Usage decreased 4.1 percent from the previous year. Date certain moratoriums were enacted in 2006 and 2010 to allow seniors to maintain their enrollment despite disqualifying Social Security incomes through cost of living increases.[172]

PACENET was established in 1996 to expand the impact of pharmaceutical assistance to those with slightly higher income limits, in recognition of the increases in Social Security that were making many Pennsylvanians ineligible for PACE benefits. The program was expanded in 2001 with the help of the tobacco settlement monies and in 2003 initiated a deductible for the program. PACENET limits for enrollment are $23,500 for single and $31,500 for married couples. Copayments of $40 each month were required before benefits kick in, and include costs of $8 for generics and $15 for name brand drugs. Program enrollment was 201,370 in 2012 and expenditures totaled $122.15 million. Dynamics were much different for the average user with 37 percent married couples using the benefit. Usage increased 5.5 percent from the previous year.[173]

PACE Plus covers the premiums for Medicare Part D benefits for PACE cardholders. Medicare Part D was initiated in 2006 and corresponding amendments to state law require PACENET cardholders who choose to forgo Part D coverage to pay a monthly bench mark premium, which in 2013 was $36.57 to the program.

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[170] Pennsylvania Dept. of Aging, "PACE, PACENET, and PACE Plus Medicare," http://www.aging.state.pa.us/portal/server.pt/community/pace_and_affordable_medications/17942.

[171] Pennsylvania Dept. of Aging, "Pharmaceutical Assistance Contract for the Elderly: Annual Report to the Pennsylvania General Assembly," January 1 – December 31, 2012," http://www.aging.state.pa.us/portal/server.pt/community/pace_and_affordable_medications/17942.

[172] Id.

[173] Id.

PENNCARE

The PENNCARE appropriation formally only covered the statewide system of in home long term care services. Throughout the years, funds have grown enabling seniors to utilize personalized services allowing seniors to stay in their homes longer. In 1994-95, PENNCARE appropriations incorporated all community based and in-home services activities of the Department of Aging. Beginning in 1996-97, all of the PENNCARE appropriation was incorporated into one block grant contract to the AAAs. PENNCARE funded programs include OPTIONS in-home services, Attendant Care for both Act 150 and Waiver, Elder Abuse Education and Prevention, Ombudsman Activities, Enhanced Apprise, Nursing Home Transition, Single Point of Entry, Reduction of Waiting list for OPTIONS, and additional programs.[174]

Senior Centers

Senior centers are available on a county basis for those individuals age 60 and over. In addition to providing a nutrition meal, centers offer social activities, a range of informative programs, creative arts, exercise, volunteer opportunities, community services and other special events which are unique to individual centers. A total of 54,254 consumers were served by over 600 Senior Centers in the second quarter of FY 2013-14.[175] A statewide average of 57,358 consumers were served between third quarter FY 2011-12 and the second quarter of FY 2013-14. The majority of senior center consumers are between ages 70 and 89 with 38 percent of consumers between 70-79, and 30 percent of consumers between ages 80-89. There is at least one Senior Center serving every county in the state.[176]

Home Delivered Meals[177]

The Home Delivered Meal Program (HDM) is responsible for providing meals to those eligible older individuals living within the Commonwealth who are unable to prepare or provide their own meals and considered at nutritional risk. This includes those individuals who cannot rely on their family members or other sources of nutritional assistance. Any individual or their spouse age 60 and older is eligible for this program, and is not charged for this program. Those individuals participating in this program must, and do receive at least one meal a day, five days a week. Nutritional guidelines must be met, with AAA menus reviewed for United States Department of Health and Human Services (HHS) and state menu guideline adherence. The statewide average of 1,141,409 home delivered meals were served between third quarter FY 11-12 through second quarter FY 13-14. Programs exist in every county around the state.[178]

Congregate Meals

Congregate Meals are provided to eligible seniors in a group setting at either senior centers or adult daily living centers. Eligible persons must be age 60 or older, but can include a spouse of any age.

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[174] Pennsylvania Dept. of Aging, "Governor's Executive Budget, Fiscal Year 2014-15," Prepared for Appropriations Committee Hearings, 2014, pgs. 7, 27.
[175] Pennsylvania Dept. of Aging, "Senior Center Demographics Report."
[176] Id.
[177] Pennsylvania Dept. of Aging, "Governor's Executive Budget, Fiscal Year 2014-15," Prepared for Appropriations Committee Hearings, 2014.
[178] Data provided by Dept. of Aging, calculation (average) performed by JSGC.

There are no fees charged for congregate meals but donations are accepted. Services are provided through the AA at least once a day and five or more days a week. Menus are reviewed and approved by a dieticians to ensure that DHHS reimbursements and state menu guidelines are met. The statewide average of 883,759 congregate meals were served in all settings between third quarter FY 11-12 through second quarter FY 13-14. Not all senior centers are congregated meal sites, as the mix of funding and demand create different local needs at individual locations.[179]

Adult Day Services[180]

Adult Day Services are utilized across the Commonwealth as well as the country. These services provide a multitude of programs and options for those individuals living within their residence and affiliated nursing homes, senior centers, assisted living communities, or rehabilitation facilities. These services provide a well-planned program based style of living in which the consumer gains social, recreational, nutrition, and congregate resources. Services for consumers as well as family members are available through Adult Day Services. With the number of baby boomers continuing to reach age 60 and older, the number of individuals requiring long term services and supports is ever-present. In 2013 there were 160 Adult Day Centers serving 47 counties around the state, with a licensed capacity of 8,856. This is a service that seems to operate on the economies of scale with many rural counties across the state, especially in the northern tier of Pennsylvania, not served by Adult Day.

Domiciliary Care[181]

The Domiciliary Care or "Dom Care" program was created as part of Act 70 of June 1978. Dom Care is certified by the AAA and consists of 3 beds or less for residents who are adults age 18 or older, who cannot live independently, and generally are low in income. Providers open up their homes to individuals who need supervision, are either physically disabled, have demonstrated difficulties in social or personal situations that are usually associated with mental disability, or frail elderly persons who want the support and encouragement in a family like setting. While not available at all AAAs, where it is available local AAAs determine if a consumer is appropriate for Dom Care. Dom Care Services are required for older persons with Dom Care Homes and providers. Coordination of suitable living arrangements is conducted by the AAA by locating and evaluating available homes and appropriate home for the consumer's needs.

To initiate service, Dom Care residents enter into a contract to pay the home provider on a monthly basis for the duration of the service period. The Department of Aging is responsible for calculating monthly payments the resident will pay the provider, and applies to all Dom Care consumers within the commonwealth. Typical rate increases occur every January; as of January 1, 2014, Dom Care payments for an individual is $970, and $1708 for an SSI couple who resides together in a Dom Care home.[182]

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[179] Id.
[180] Data provided to JSGC by the Pennsylvania Dept. of Aging on January 7, 2014.
[181] Id.
[182] Id.

Domiciliary Care Homes Data[183]			
2014	**Number of Homes**	**Capacity**	**Occupied**
	582	1572	1094

APPRISE

APPRISE is a free health insurance counseling program designed to help older Pennsylvanians with Medicare. Counselors are specially trained staff and volunteers who can answer your questions about Medicare and provide you with objective, easy-to-understand information about Medicare, Medicare Supplemental Insurance, Medicaid, and long term care insurance. APPRISE Counselors can help you to understand your Medicare benefits by explaining what services are covered under Medicare Parts A, B, D, and Medicare Summary Notice, understand benefits under LTC policies, and navigate other information pertaining to health insurance. In 2012, an estimated 60,000 consumers were education or assisted with health insurance related questions.[184]

Pennsylvania Caregiver Support Program[185]

The Pennsylvania Caregiver Support Program provides benefits to the primary caregivers of care recipients. The goal of this program is to provide assistance in the form of respite and counseling to assist the caregiver. The National Family Caregiver Support Program, through the federal Administration on Aging, provides grants to states, based on their share of the population over age 70, to fund a range of supports that assist family and informal caregivers. In conjunction with states, coordinated supports include respite care, access to information on available services, counseling and support groups, and caregiver training.[186]

In addition, caregivers apply through their local AAA; the AAA will assess the needs of the caregivers as well as other needs in determining whether the Caregiver Support program is applicable. To be eligible for this program, an individual must be the primary caregiver for a person age 60 or older, or an adult with chronic dementia. Primary Caregivers may receive up to $500 per month in reimbursements for approved out of pocket expenses, ranging from respite care to household toiletries. If qualified, the program allows for up to $2000 in pre-approved reimbursements to modify the home or purchase assistive devices for the consumer. The local AAA can provide more insight into this program.

[183] Domiciliary Care Home data provided by Pennsylvania Dept. of Aging, January 2014. Includes traditional ADC serving adults age 60 and over, plus LIFE centers.
[184] House Aging and Older Adult Informational Hearing, "Lottery Services and Support through Area Agencies on Aging," M. Crystal Lowe, January 22, 2013.
[185] Pennsylvania Dept. of Aging, "Pennsylvania Caregiver Support Program," http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616680&mode=2.
[186] Dept. of Health and Human Services, Administration on Aging, "National Family Caregiver Support Program," http://www.aoa.gov/aoa_programs/hcltc/caregiver/index.aspx.

Care Program Enrollment Activity Statewide[187] During Period 7/1/2013 to 12/31/2013 as of 4/4/2014		
Care Program	**Total Enrollment**	**Count of AAAs with Consumers Enrolled**
Care Transition	133	23
Domiciliary Care	1,038	41
Family Caregiver Support Program	6,095	475
Non-Care Managed Services	440,244	54
Options	24,874	126
Protective Services	10,586	53

Count of Consumers by Age Group by Care Program[188] For the Period 7/1/2013 to 12/31/13 as of 4/4/2014					
Care Program	**Under 60**	**60 to 65**	**65+**	**Invalid DOB**	**Total**
Care Transition	6	8	117	1	132
Domiciliary Care	579	137	322	0	1,038
Family Caregiver Support Program	256	210	5,796	13	12,071
Non-Care Managed Services	36,363	34,457	355,936	9,779	436,534
Options	39	1,235	23,400	18	24,692
Protective Services	441	838	8,716	187	10,182

Count of Consumers by Number of ADL Deficiencies by Care Program[189] For the Period 7/1/2013 to 12/31/13 as of 4/4/2014								
Care Program	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**Total**
Care Transition	4	4	3	8	9	11	23	132
Domiciliary Care	365	166	141	122	139	409	1,327	2,705
Family Caregiver Support Program	111	28	45	957	541	1,938	3,187	6,077
Non-Care Managed Services	30,305	6,304	7,605	9,816	17,581	49,353	94,276	436,534
Options	662	599	1018	1,832	4,109	8,674	7,567	24,728
Protective Services	765	261	306	350	464	1,477	3,449	10,182

Conclusions

Pennsylvania's system of providing services and supports to the aging population is unique in many ways. Its large and diverse population, with a growing number of older adults, will face challenges in the coming years. One great advantage is the dedicated Pennsylvania Lottery, which provides benefits exclusively for older Pennsylvanians. Intermingling lottery monies with supports to serve adults with

[187] Information provided to JSGC by the Dept. of Aging, April 4, 2014. Note: Multiple care programs in the "Care Program Enrollment Activity" table were combined, as were the count of AAAs with consumers enrolled, to simplify the chart. Data was provided by the Dept. of Aging with calculations performed by JSGC.
[188] Id.
[189] Id.

disabilities who are under age 60 is a concern as those funds must remain dedicated to serving older Pennsylvanians. There is clearly a need for a separate Department of Aging, which is focused on the delivery of high quality, cost effective services, is responsive to seniors and flexible to their changing needs.[190]

Opportunities exist to refine and refocus, enhance awareness and improve system coordination with the existing aging services network. AAAs are a strength and need to leverage those local services and supports to provide more resources to seniors in a comprehensive, integrated and statewide system. There are polices and a state plan that provides focus to serving older adults and both DPW and PDA officials have stated the separation of PDA and OLTL with the latter moving back to DPW, was a positive policy and practical move. That move should allow PDA to focus on serving aging consumers, but that policy does not match the practice. Intermingling services and supports between the over and under age 60 populations is still a concern. While separating from OLTL, the PDA has retained leadership of the LINK program that serves those under 60 in a no wrong door approach, partnered with DPW to submit the Balancing Incentive Program application to enhance waivers through the no wrong door approach, and are now requiring those served through OPTIONS to engage aging services through county assistance agencies rather than AAAs.

The OPTIONS program is a great example of helping to expand services to seniors outside of MA and prevent individuals from falling between the gaps of service need and financial eligibility. This shared cost program is a model and should be expanded. There is also a dedicated caregiver support program that helps alleviate the burden on caregivers, who are often unpaid family members. There will be an increased need for these caregivers, and more focus is needed on family caregiver supports and increased statewide access to some programs. There are good people performing good work to help prevent abuse, fight neglect and provide services, but improved awareness and outreach will help connect people with services and help them know where to turn in a time of crisis. Strengthening AAAs and increasing their resources will allow more local aging services and supports to reach those in need.

The state, including PDA, needs to guard against an overriding focus on costs. While there is a need to remain cost effective, demand is often not pulling the service to create a streamlined aging system but arbitrary rebalancing is cost pushing people, primarily those served through MA, into waiver services for budgetary reasons. Chasing federal dollars and creating new niche programs present continually changing program options that serve a limited number of individuals under special rules but cause confusion, dilute effectiveness and create difficulty among seniors in navigating a system in search of services. Improved infrastructure and oversight is need to assure accountability and quality in HCBS delivery system. By enhancing the long term care system and focusing on development and innovations that break down barriers, funding silos and compartmentalized services, will provide more confidence and certainty to older adults who often face an uncertain future.

[190] Paraphrase of the concepts within the Pennsylvania Dept. of Aging, "2012-2016 State Plan on Aging." Note: During the separating of PDA and OLTL, the program moved to DPW. The majority of care transitions are not paid through PDA, but is a large initiative funded care transitions through Medicare.

DEPARTMENT OF HEALTH

Background and History[191]

The Pennsylvania Department of Health (DOH) was created in 1905 and has the power and duty to protect the health of all residents of the Commonwealth.[192] The DOH has the authority to enforce all laws relevant to the prevention of illness, disease and injury, suppression of disease and safeguarding of the public health. Working collaboratively with public agencies, private partners, local governments and in community organizations throughout the state it promotes and helps to establish and coordinate wellness, prevention, preparedness and retention of providers who maintain those critical services. These core functions match the DOH's mission "to promote healthy lifestyles, prevent injury and disease, and assure the safe delivery of quality health care for all Pennsylvanians."

Those partnerships help the department monitor health status, protect public health, improve quality, access and accountability within the healthcare system. Licensing and regulating health care facilities, through the office of the Deputy Secretary for Quality Assurance, is the DOH link to long term care. Licenses are issued to a variety of health care facilities including hospitals, drug and alcohol treatment centers, ambulatory surgical centers, intermediate care facilities, rural health clinics, outpatient rehabilitation facilities, psychiatric residential treatment facilities, birth centers, and health maintenance organizations. The licenses for professionals practicing at those facilities, including doctors, nurses, social workers, physical and occupational therapists, and nursing home administrators are issued by the Pennsylvania Department of State's Bureau of Professional and Occupational Affairs.

Quality assurance in the delivery of quality health care is assured through licensing, and verifying compliance with state and federal safety and health standards as mandated by law, including construction. Prior to construction and renovation, a facilities plan drawings are reviewed to ensure conformance with a safe, functional environment for patient care. The Division of Safety Inspections conducts Life Safety Code Occupancy Inspections, through both mailed review and on-site inspections.

The Bureau of Facility Licensure and Certification conducts regular, on-site inspections and surveys to assure health, safety, fire, sanitation and quality care requirements are being met. These inspections identify any deficiencies under state licensure or eligibility for federal Medicare and Medicaid program reimbursements. State licensure is a requirement for federal certification. Nursing homes are governed primarily by federal regulations, through Federal Oversight/Support Surveys, the complexity of which is outlined in more detail below. The state, in conducting their surveys, must force facilities to comply with these regulations or the state itself could be penalized financially, by the federal government, for non-compliance.

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[191] General information on the Department of Health was taken from the Pennsylvania Manual, FY2014-15 Request for Health Resources presented at the Appropriations Committee hearings, and the Department's website http://www.health.state.pa.us.

[192] The Department was created by the Act of April 27, 1905, P.L. 312, No. 218, and was modified and added to the Administrative Code of 1929.

Frequency of State Facility Inspection, by Facility Type[193]	
Acute Care Hospitals	**Surveyed and licensed on a three-year cycle**
Ambulatory Surgical Facilities	Inspected Annually
Birth Centers	Inspected Annually
End Stage Renal Disease Facilities	One-third of facilities are surveyed annually
Home Care Agencies	Inspected on a 12 to 36 month schedule based on compliance history and federal requirements
Hospice Agencies	Inspected Biennially
Nursing Homes	Inspected Annually
Pediatric Care Centers	Inspected Annually

The Bureau of Community Program Licensure and Certification, Division of Home Health, regulates home health and hospice agencies to ensure federal and state compliance with regulations and eligibility for federal Medicare and Medicaid program reimbursements. Elsewhere in the DOH the Bureau of Health Statistics and Research collects and analyzes health data to plan, administer and evaluate programs to improve the health of Pennsylvanians, and disseminates that information to providers and other stakeholders. The Bureau manages statistics related to core functions of the agency including vital statistics, behavioral risk and injury statistics, communicable diseases, cancer, health equity and school statistics. They also produce detailed reports on hospitals, nursing homes and ambulatory surgery centers and organize the information from annual surveys into detailed reports. The Department also operates and maintains the federally mandated Nurse Aide Registry which contains information on more than 229,000 nurse aides in Pennsylvania.[194]

In 2013-14 the Department of Health received a budget of $803 million dollars, of which 74 percent is from federal monies for conducting inspections. The Bureaus also collect fees from each licensee. Spending on quality assurance is $38 million, including $19 million in state appropriations plus monies dedicated to both Medicare and Medicaid agency certifications. The state funds for Quality Assurance have remained relatively stable since FY 2006-07, while the state's share of overall Department funding has fallen 31 percent, federal dollars have receded and the number of employees has fallen to the current DOH complement of 1,323 employees. Agencies across the state are being asked to do more with less, and the Bureau of Quality Assurance is one example. As its budget has fallen, the number of agencies to be licensed and inspected has risen[195].

[193] FY 2014-15 Governor's Executive Budget page E24.8.
[194] Id.
[195] FY 2014-15 Request for Health Resources presented at the Appropriations Committee hearings & FY 2006-07 Governor's Executive Budgets.

Facility and Agency Licensure

Nursing Homes

Nursing Homes are long term care facilities that provide residential personal care, which can include skilled nursing services, meals, medication management, supervision, social and recreational activities, medical care and assistance with, in most cases, a large number of activities of daily living. In some cases this care includes specialized Alzheimer's or dementia units with added security features and specialized care. Short term stays are typically covered by Medicare while stays of 100 days or longer are covered by Medicaid, but in some cases individuals may need to pay privately for their stay.

Facilities are inspected annually for state licensure compliance and every 15 months for federal certification of Medicare and Medicaid programs, or more frequently for those with compliance issues. DOH is responsible to review all allegations of suspected abuse within facilities, and reviews all complaints received, primarily through its hotline or online. Investigations can include on-site, unannounced complaint investigations. If the DOH fails to comply with survey protocols mandated by the federal government it could result in a financial penalty against the Commonwealth. If the facility fails to meet program standards the Department can recommend to DPW and CMS that facility funding be suspended.

Nursing homes have been undergoing a transition over the last decade, and have struggled with a widening gap in costs over reimbursements, and increased choices available in home care. Facilities exist as State Veterans Homes, Hospital Based, County Affiliated, Fraternal and Religiously Affiliated, some as for profits and others as nonprofits. In 2012 the number of hospital affiliated homes was 56 and Fraternal/Religious homes accounted for 81 under non-profits. The number of homes has dropped, as have total beds and could signal a lack of demand for that level of care despite the rise in the aging population. Preventative services and supports are keeping more people in their homes longer, and the increase of waivers has allowed more people to be cared for in their own homes. The need for nursing facilities will continue and their role is important but changing to one featuring shorter stays, and a contraction of rooms has increased occupancy rates to balance the need with evolving demand. While there is a definite shift in people's preference for and increased prevalence of home care options, the only "entitlement" consumers have under Medicare is currently for nursing home care.

Type of Nursing Home[196]	**Number of Facilities 2012**	**Number of Facilities 2006**	**Number of Facilities 2000**
For Profit	364	345	327
Private Not For Profit	310	338	402
County Affiliated	32	34	41
State Veterans Home	6	6	5
Totals	712	723	775

[196] Information provided to JSGC by the Dept. of Health on April 9, 2014. Additional information provided by the Pennsylvania Association of County Affiliated Homes, Hospital and Healthsystem Association of Pennsylvania, and LeadingAge PA.

More admissions and more discharges signals show the growth in need for intermediate care, for rehabilitation, short term recovery after acute hospital stays or treatment of chronic illness. The average length of stay has decreased by 25 percent over ten years and the rising discharges and falling deaths in residence point to this changing dynamic of longer term and end of life care being provided in a home care setting. Another reflection of the changing dynamic in nursing homes is the increase in rehabilitation employees. While overall employment has remained relatively stable in both full and part time employees, LPNs, aides and other direct care workers, there has been a noticeable increase in occupational, physical and respiratory therapists and their aides. Demographics have seen a decreasing population, and have shown a steady drop in population from 81,801 residents in 2003 to 79,571 in 2012. The age census of nursing homes shows they have gotten slightly younger, with the over age 60 population falling from 94 to 93 percent while the male population has risen from 27.6 to 31 percent.

The advisory committee heard anecdotal information from consumers, family members and nursing home providers that the paradigm of reimbursements has swung from a Medicare centered to a Medicaid reliant system. Hospital admissions have a dramatic effect on reimbursements, which after a qualifying three-day hospital admission are covered by Medicare for the first 100 days, when silled care is needed. A reduced instance of hospital admission shifts that funding burden to providers and consumers. With Medicare reimbursements and a larger reliance on Medicaid many consumers are forced to pay out of pocket what private or supplemental insurance will not cover. Margins of for-profit facilities have declined to near break-even and many not-for profits have dipped into benevolent care funds to cover their operating costs. Medicare rates used to provide a reimbursement rate that exceeded provider costs and that surplus made up for shortfalls in Medicaid, which have always paid under the average daily cost. Providers discussed the issue of Medicare rates that no longer cover costs, and with the prospects of adequate funding within a growing demand on Medicaid, business as usual is not an option.

With beds falling, admissions rising and occupancy rates improving, nursing homes are working to become more efficient. Those with higher Medicaid populations have seen their margins affected the most, and some have worked to improve their resident mix, expand rehabilitation and offer additional services like senior centers or adult day. The state could provide relief in certain areas of state regulation, allowing for expanded adult day options over the existing law, and eliminating burdensome rules that apply to County Affiliated Nursing Homes.[197] The reality in affecting changes from reimbursement rates to instances of hospital observation status is that decision making power rests with the federal government.

[197] At one time there were 50 counties that had their own nursing homes. As of June 2014 there are 27 facilities owned by 23 counties. County nursing homes have been impacted by state laws and regulation that put it at a disadvantage to other government and private homes, and this report recommendations to address those issues. A complete listing of county homes is available in Appendix F.

Payment for Services in Nursing Homes by Patient Days[198]							
	Medicare	**Medicaid**	**VA**	**Private Insurance**	**Self-Pay**	**Other**	**Totals**
2012	3,918,312	19,104,457	340,866	1,220,030	4,513,394	158,911	29,258,970
2008	3,901,600	19,006,519	345,278	1,075,365	5,037,868	285,815	32,360,564
2003	3,297,944	19,322,726	231,450	752,440	5,800,707	348,148	29,753,415

	Total Beds[199]	**Occupancy Rates**	**Admissions**	**Discharges**	**Av. Length of Stay**
2012	88,642	91.15	189,391	155,982	151.64 days
2008	89,193	91.57	176,205	139,815	165.60
2003	91,081	90.68	145,836	106,219	207.50

Home Health Care Agencies

Home Health Care Agencies are organizations staffed and equipped to provide skilled nursing and at least one therapeutic service—physical or occupational therapy, speech pathology, medical social services or home health aides—to disabled, aged, injured or sick persons on a part-time or intermittent basis in their place of residence. The term includes an agency that also provides other health-related services to protect and maintain persons in their own homes.[200] They were established in 1987 to provide to the aged, ill or disabled to enable them to live independent, in their own homes.

Agencies are licensed by the DOH and can provide nursing services; home aides; physical, speech or occupational therapy; and medical social work. CMS contracts with the DOH to license, and to periodically survey and inspect these agencies, in addition to their own licensure surveys. State licensed and certified agencies are recommended for federal certification to allow for reimbursement for services. All providers recommended for Medicare certification, including home care and hospice agencies, are inspected by DOH and all complaints against agencies, through the hotline or online, are investigated.[201] The DOH assures that providers are delivering health care services to consumers in a manner that adheres to minimum state and federal standards. Through on-site survey's, adherence to standards and consumer satisfaction are assessed.

Home Care Agencies

Home care agencies are playing an increasingly larger role in healthcare as providers seek to manage chronic conditions at home to maintain their independence, prevent trips to hospitals and nursing homes. Nurses, home health aides and professionals can provide medical care, skills and therapy, while other less or untrained personnel provide other non-skilled services. The most common

[198] Information taken from the Pennsylvania Dept. of Health nursing home facility surveys and utilization data for 2003, 2008, and 2012.
[199] Id.
[200] Home Health Care Agencies are set forth in Title 28, Pa. Code §601.6.
[201] Pennsylvania Dept. of Health, "Home Health Services and Hospice," http://www.portal.state.pa.us/portal/server.pt/community/home_health_service_and_hospices/14153/home_health_agencies/558572.

types of home care include rehabilitation, therapy, social and homemaker services. From companionship to transportation, meal planning or household chores, they can all provide valuable support for family caregivers in certain instances. Services can be unpaid, private pay, self-directed care, or Medicaid waiver paid through home health agencies.

Home care agencies were added to the Health Care Facilities Act in 2006, and are defined as organizations that supply, arrange or schedule employees to provide home care services, as directed by the consumer or their representative, in their place of residence or other independent living environment for which the agency receives a fee or compensation of any kind.[202]

Agencies are required to conduct criminal background checks and health screens of employees. They also are required to ensure employee competency annually and provide certain information and make disclosures to consumers The Department is required by law to maintain a Home Care Registry of workers who are licensed and/or completed a competency exam for employment. Through on-site surveys, interviews with individuals providing care and consumers, the DOH measures compliance of agencies and employees. They also identify deficiencies, establish plans for correction of deficiencies and investigate complaints.[203]

Hospice Agencies

A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals, meets the conditions of participation for hospices, and has a valid Medicare provider agreement. Since they were added to the Health Care Facilities Act in 1998, the DOH has licensed hospice agencies to ensure health and safety standards are adhered to. These standards are enforced through unannounced surveys of those agencies.[204] Hospice care is an approach to caring for terminally ill individuals that stresses palliative care (relief of pain and uncomfortable symptoms), as opposed to treatment. It provides comfort and support while offering dignity during patients last days. Services can include medication management, symptom and stress relief for patients and families through an interdisciplinary team approach of nurses, aides, physicians, social workers, clergy and other specialists.

In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient, as well as the psychosocial needs of the patient's family or caregiver. The emphasis of the hospice program is on keeping the patient at home with family and friends as long as possible. Although some hospices are located as a part of a hospital, nursing home, and home health agency, hospices must meet specific federal requirements and be separately certified and approved for Medicare participation. Many costs associated with end of life and hospice care are covered by Medicaid. While nursing homes have declined, there has been a surge in the growth of home care, home health and hospice agencies.

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[202]Title 28, Pa. Code §611.5; Act of July 7, 2006, P.L. 334, No. 69.

[203] Pennsylvania Dept. of Health, "Home Health Services and Hospice," http://www.portal.state.pa.us/portal/server.pt/community/home_health_service_and_hospices/14153/home_health_agencies/558572.

[204] Health Care Facilities Act, Act of July 19, 1979, P.L. 130, No. 48. Hospice was added by HCFA by the Act of October 16, 1998, P.L. 777, No. 95.

Department of Health Licensing[205]			
Type of Care Provided	**2003**	**2008**	**2012**
Nursing Home	737	825	712
Home Health Agency	359	424	500
Home Care Agency	N/A	1	1,333
Hospice Agency	124	179	200
Totals	1,220	1,429	2,745

Nursing Home Survey Process

As part of its survey process, DOH reviews all available information regarding a nursing home and selects a team of surveyors to send to the facility.[206] The team includes a registered nurse and may include a nutritionist or social worker. Team composition varies within the facilities depending on each facilities record of infractions. All surveyors, no matter what their professional background, have been trained as generalists. Surveys are unannounced and typically span several days, occurring during all hours of the day. The DOH conducts more than 4,000 surveys a year and each surveyor has a difficult task to perform and maintain consistency.[207]

The survey attempts to capture whether or not a resident feels at home and also evaluates minimum regulatory standards pertaining to patient care focusing on how the needs of the consumers are met. This process incorporates not only their nursing and medical needs, but nutritional, social, psychological, and other needs.[208] Surveyors attempt to determine whether the nursing home provides quality care and maintains the resident's quality of life. There must always be a good balance of quality of life and quality of care for residents to thrive in a nursing home. During the HR 255 meetings there was a concern noted by several providers that the Department "nitpicks" in minor infractions, like requiring action plans for burnt out light bulbs. However, most noted that the survey process has improved in recent years, and has taken on a constructive approach to help the facilities address any concerns and get in and maintain compliance, reducing what once was a punitive approach.

Surveyors use tools, including checklists and forms that guide what the surveyor observes, to assure a level of quality and consistency. These guides are used to evaluate nursing homes throughout the United States. The survey process involves: touring the facility and observing the environment, meals and how the staff and residents interact; watching how the staff provides direct care and treatments to residents; interviewing residents, groups of residents and family members to assess their feelings about the care they are receiving; reviewing resident charts to see if necessary services are identified and provided; meeting with staff and administrators to see if they have developed ways of solving problems in the nursing home.[209]

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[205] Information provided to JSGC by the Dept. of Health on April 7, 2014. Note: The number of individuals served under Home Health, Home Care, and Hospice were requested of both DOH and DPW, but were not provided to JSGC.
[206] Id.
[207] Id.
[208] Id.
[209] Id.

When the surveyors have gather enough information, they generate and official report they address any areas of concern identified during the survey process with the administrative staff. If applicable, the surveyors compose a "statement of deficiencies" which requires the nursing home submit a plan to correct the problems. The nursing home must submit a plan of correction which must be made available by the facility to consumers upon request, and is posted on the DOH website. Depending on the severity of any infractions, the Department may revoke the nursing facility's license, issue a provisional license to allow the nursing home to continue to operate while under strict DOH monitors to insure the health and safety of the residents.[210] In severe instances, the nursing home may lose its right to participate in Medicare or Medicaid.

The relationship between state survey agencies and the Centers for Medicare and Medicaid Services is often complex as states ensure all participating nursing homes are meeting or exceeding minimum standards. CMS has the responsibility to monitor all beneficiaries under Medicare and Medicaid, and it contracts that responsibility for nursing homes out to states. Monitoring state surveyors performance in carrying out those roles is also enforced under federal regulations and guided by the State Operations Manual. Generally, all licensed facility standards are contained in Title 42 of the Code of Federal Regulations, sections 482 – 498, which have been described by Department of Health officials as "lengthy and complex."[211]

Nursing home surveys are not announced to the facility. States conduct standard surveys and complete them on consecutive workdays, whenever possible. They may be conducted at any time including weekends, 24 hours a day. The State has the responsibility for certifying a skilled nursing facility's compliance or noncompliance, however, the state's certification for a skilled nursing facility is subject to CMS' approval. In addition to certifying a facility's compliance or noncompliance, the state recommends appropriate enforcement actions to the state Medicaid agency for Medicaid and to the CMS regional office for Medicare.

The following entities are responsible for surveying and certifying a skilled nursing facility for nursing facility's compliance or noncompliance with federal requirements:

- State-Operated Skilled Nursing Facilities or Nursing Facilities or State-Operated Dually Participating Facilities: The state conducts the survey, but the regional office certifies compliance or noncompliance and determines whether a facility will participate in the Medicare or Medicaid programs.

- Non-State Operated Skilled Nursing Facilities: The state conducts the survey and certifies compliance or noncompliance, and the regional office determines whether a facility is eligible to participate in the Medicare program.

- Non-State Operated Nursing Facilities: The state conducts the survey and certifies compliance or noncompliance. The state's certification is final. The State Medicaid agency determines whether a facility is eligible to participate in the Medicaid program.

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[210] Pennsylvania DOH, "Long Term Care Survey Process," http://www.portal.state.pa.us/portal/server.pt/community/nursing_home_care/14152/nursing_home_inspection_information/558491.

[211] The Code of Federal Regulations, Title 42, Public Health, govern the requirements for facility licensure under §483 (Long Term Care Facilities) and §484 (Home Health Services).

- Non-State Operated Dually Participating Facilities (Skilled Nursing Facilities/Nursing Facilities): The state conducts the survey and certifies compliance or noncompliance. The state's certification of compliance or noncompliance is communicated to the state Medicaid agency for the nursing facility and to the regional office for the skilled nursing facility. In the case where the state and the regional office disagree with the certification of compliance or noncompliance, there are certain rules to resolve such disagreements.[212]

In monitoring state performance, Federal Oversight/Support Surveyors from CMS accompany state surveyors. CMS also conducts comparative surveys that have been previous surveyed by state inspectors to compare the findings, along with an annual state performance evaluation to determine the quality and effectiveness of enforcement. Sanctions and remedies against states may be implemented if a state demonstrates inadequate performance on its surveys. Actions can include providing additional training, directing a quality improvement plan or requiring the state to implement an immediate plan of corrective action. More harsh measures can include placing the state on compliance, reducing the federal appropriation for surveys and initiating an action to terminate the survey contract.[213]

Conclusions

The Department of Health has been making good efforts to improve the working relationship with the providers it licenses. Moving away from punitive and towards corrective measures will help improve the quality of care delivery. Adding additional responsibilities for licensing personal care and assisted living homes, currently under the Department of Public Welfare, would further align health facility licensure with DOH's mission. Hospice reimbursements need additional clarification to continue reimbursements under Medicare, but home care licensing is working and more people are able to achieve a higher degree of independence. Better accountability for unlicensed care givers and patient directed care is needed, but must be approached with caution to balance safeguards without overly burdening those family, friends and community services providing that care and support.

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[212] Center for Medicare and Medicaid Services, "Provider Enrollment and Certification," http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs.html.

[213] Long Term Care Community Coalition, "Government Monitoring & Oversight of Nursing Home Care: The Relationship Between Federal and State Agencies," 2010, www.ltccc.org/publications/LTCCCReportCMS Oversight2010.docx.

Combined Long Term Care Facilities, by County, in Pennsylvania[214]

2012	Total Population	65 plus	85 plus	Nursing Homes	Available Beds	Personal Care Homes	Available Beds	Asst. Living-Residences	Available Beds	CCRCs	Dom Care Homes	Capacity	Adult Day Centers	Capacity	Hospice Care Agencies	Home Care Agencies	Home Health Agencies
Pennsylvania Totals	**12,763,536**	**2,042,861**	**322,052**	**712**	**88,642**	**1,243**	**65,152**	**32**	**1,993**	**280**	**582**	**1,572**	**160**	**8,856**	**200**	**1,333**	**500**
Adams	101,482	17,326	2,458	6	817	10	408	0	0	2	5	15	2	51	0	12	2
Allegheny	1,229,338	208,167	36,549	66	8,038	136	7877	1	100	26	39	178	21	1115	25	152	49
Armstrong	68,409	13,237	2,030	4	366	25	544	0	0	1	4	8	1	25	0	4	0
Beaver	170,245	32,459	5,169	6	1,198	21	1018	0	0	0	3	11	2	159	1	11	5
Bedford	49,324	9,659	1,247	2	205	3	147	0	0	1	27	73	1	12	0	5	0
Berks	413,491	62,527	9,762	15	2,415	31	2212	1	50	4	0	0	5	153	3	36	11
Blair	127,121	23,509	3,795	10	1,478	20	942	1	70	6	15	48	2	118	7	18	7
Bradford	62,792	11,598	1,519	4	439	6	240	0	0	1	0	0	0	0	2	2	3
Bucks	627,053	97,956	14,826	32	3,668	42	2394	2	143	15	4	18	6	474	9	84	29
Butler	184,970	29,633	4,856	13	1,545	32	2026	1	30	5	4	9	3	105	3	18	8
Cambria	141,584	27,356	4,713	9	941	26	1225	1	70	1	8	28	3	234	3	16	6
Cameron	4,939	1,111	183	1	40	3	38	0	0	0	0	0	0	0	0	0	0
Carbon	65,006	12,150	1,653	3	433	10	451	0	0	0	1	2	1	34	0	15	2
Centre	155,171	18,452	2,603	6	706	12	609	0	0	5	4	11	1	22	2	15	6
Chester	506,575	69,628	10,217	23	2,529	50	2864	1	70	16	2	4	4	187	5	58	16
Clarion	39,646	6,739	882	3	323	5	242	0	0	0	0	0	1	19	1	6	1

[214] Demographic data from PA State Data Center, "Annual Estimates of the Resident Population for Selected Age Groups, Pennsylvania Counties: 2012," from U.S. Census Bureau 2012 Population Estimates; Facility data from the Pennsylvania Departments of Health, Public Welfare and Insurance. Home Care, Home Health and Hospice Care Agencies as of January 2014, http://app2.health.state.pa.us/commonpoc/content/publiccommonpoc/normalSearch.asp; Adult Day Center data provided by Department of Aging, as of January 2014, and includes traditional ADCs serving older adults age 60 and over, plus LIFE centers.

Combined Long Term Care Facilities, by County, in Pennsylvania[214]

2012	Total Population	65 plus	85 plus	Nursing Homes	Available Beds	Personal Care Homes	Available Beds	Asst. Living-Residences	Available Beds	CCRCs	Dom Care Homes	Capacity	Adult Day Centers	Capacity	Hospice Care Agencies	Home Care Agencies	Home Health Agencies
Clearfield	81,184	14,814	2,243	4	671	7	383	0	0	3	0	0	1	13	2	9	6
Clinton	39,517	6,575	907	3	279	4	172	0	0	0	0	0	0	0	0	0	2
Columbia	66,887	11,108	1,655	5	685	3	179	0	0	0	3	7	0	0	2	3	3
Crawford	87,598	15,264	1,898	7	830	6	366	1	50	3	8	18	0	0	2	6	5
Cumberland	238,614	38,794	5,968	16	2,008	23	1439	1	115	9	1	5	3	179	5	27	6
Dauphin	269,665	39,033	5,574	9	1,399	20	1094	0	0	4	19	40	1	34	6	34	14
Delaware	561,098	82,189	14,558	29	4,373	32	1993	2	80	12	16	31	6	369	6	81	24
Elk	31,550	6,206	1,000	2	258	2	134	0	0	6	0	0	1	18	1	2	3
Erie	280,646	42,131	6,995	21	2,236	23	1460	1	79	6	10	25	3	200	8	30	10
Fayette	135,660	25,170	4,042	8	710	38	1006	0	0	0	24	78	2	164	4	15	5
Forest	7,667	1,573	139	1	100	0	0	0	0	0	0	0	0	0	0	0	0
Franklin	151,275	26,293	3,745	7	966	17	909	0	0	6	0	0	2	133	2	15	3
Fulton	14,772	2,738	259	1	67	1	37	0	0	0	1	3	0	0	0	1	1
Greene	38,085	6,174	869	2	232	9	198	0	0	0	0	0	2	56	0	0	1
Huntingdon	45,943	8,056	924	3	282	2	76	0	0	2	0	0	0	0	0	5	0
Indiana	88,218	14,317	2,243	5	487	24	613	0	0	2	3	6	1	70	1	7	5
Jefferson	44,764	8,403	1,295	4	375	13	429	0	0	3	7	17	1	20	1	7	5
Juniata	24,904	4,691	656	3	229	5	118	0	0	1	0	0	0	0	0	1	0
Lackawanna	214,477	39,152	6,841	18	2,366	17	1067	1	74	3	13	44	3	169	8	14	20
Lancaster	526,823	82,655	13,754	31	4,050	54	3476	0	0	23	98	271	6	270	5	53	10
Lawrence	89,871	17,336	2,993	10	821	16	620	0	0	2	0	0	1	79	3	13	3
Lebanon	135,251	23,844	3,828	12	1,207	19	756	1	60	8	0	0	3	114	1	17	3
Lehigh	355,245	54,383	9,004	16	2,752	28	1983	1	20	7	0	0	4	244	6	50	23
Luzerne	321,027	59,088	9,824	25	2,768	30	2087	0	0	5	3	6	0	0	8	24	25
Lycoming	117,168	19,756	3,091	8	1,084	14	637	0	0	2	0	0	1	90	2	17	7
McKean	43,127	7,579	1,125	6	592	3	173	0	0	1	5	15	0	0	1	5	3
Mercer	115,655	22,118	3,847	14	1,148	18	837	0	0	5	0	0	1	42	1	11	6

Combined Long Term Care Facilities, by County, in Pennsylvania[214]

2012	Total Population	65 plus	85 plus	Nursing Homes	Available Beds	Personal Care Homes	Available Beds	Asst. Living-Residences	Available Beds	CCRCs	Dom Care Homes	Capacity	Adult Day Centers	Capacity	Hospice Care Agencies	Home Care Agencies	Home Health Agencies
Mifflin	46,773	9,127	1,271	4	417	3	219	0	0	3	8	18	1	15	0	7	0
Monroe	168,798	23,337	2,502	4	510	11	549	0	0	1	0	0	1	42	1	12	9
Montgomery	808,460	127,286	22,027	61	7,164	51	3927	9	446	28	13	61	12	497	28	135	52
Montour	18,356	3,517	616	2	262	5	253	0	0	2	0	0	0	0	1	1	3
Northampton	299,267	49,216	8,501	13	2,035	29	2257	1	22	3	0	0	3	85	3	20	6
Northumberland	94,428	17,943	2,832	9	1,016	16	724	0	0	3	0	0	2	110	3	9	3
Perry	45,701	6,709	737	4	280	2	76	0	0	1	0	0	0	0	0	2	1
Philadelphia	1,547,607	189,106	28,737	47	7,601	79	3277	1	50	16	174	336	27	2409	4	113	49
Pike	56,899	10,571	987	2	110	2	100	0	0	0	0	0	0	0	1	5	2
Potter	17,577	3,614	509	2	170	1	30	0	0	0	0	0	0	0	1	3	1
Schuylkill	147,063	27,428	4,418	14	1,642	8	523	1	135	2	0	0	6	161	0	11	5
Snyder	39,672	6,427	872	1	159	1	95	0	0	0	1	1	0	0	0	3	1
Somerset	76,957	15,028	2,477	6	663	16	595	0	0	4	8	18	1	23	2	4	2
Sullivan	6,461	1,659	206	2	187	1	10	0	0	0	0	0	0	0	0	1	0
Susquehanna	42,696	8,051	931	3	253	2	101	0	0	1	0	0	0	0	0	4	1
Tioga	42,577	7,930	955	3	266	5	201	0	0	1	1	3	0	0	1	4	1
Union	44,952	6,916	1,158	3	385	4	243	0	0	2	0	0	0	0	1	9	1
Venango	54,272	10,231	1,427	5	491	4	157	0	0	1	0	0	1	8	1	4	1
Warren	41,146	8,139	1,152	3	403	6	230	0	0	1	0	0	1	28	1	5	1
Washington	208,716	37,833	6,019	12	1,424	36	1179	2	181	2	27	98	4	188	4	15	6
Wayne	51,955	10,090	1,074	3	371	6	230	0	0	1	0	0	1	9	1	7	1
Westmoreland	363,395	71,311	11,171	19	2,382	53	2404	1	100	6	16	49	3	166	7	38	9
Wyoming	28,125	4,858	622	1	124	5	108	0	0	0	1	3	0	0	0	0	0
York	437,846	65,587	9,112	16	2,211	28	2220	1	48	6	6	14	2	143	4	22	7

DEPARTMENT OF PUBLIC WELFARE

Background and History[215]

The Department of Public Welfare (DPW) is responsible for administering a vast array of programs that provide services to Pennsylvanians of all ages. These programs include the basic needs for low-income individuals, child development and early learning, for trouble children and their families, mental health and substance abuse, for developmental disabilities, and long term services and supports. Its primary role in providing services and supports for long term care comes in the administration of Medical Assistance programs that pay for nursing home care under Medicaid, and for Home and Community Based Services (HCBS) through Medicaid waivers. DPW also licenses personal care homes, assisted living residences and adult daily living centers.

DPW traces its history to 1921 when the Board of Public Charities, Commission of Lunacy, and the Prison Labor Commission were consolidated into one agency called the Department of Welfare.[216] Over the years it has evolved to include public assistance, juvenile services, mental health, long term care services and supports, which were consolidated into the current Department structure in 1967. Even today, there are continuing discussion about changing its name to the Department of Human Services to better reflect its evolving mission which is to improve the quality of life for Pennsylvania individuals and families. The DPW promotes opportunities for independence for those who are able, community living in the least restrictive setting, and institutional care and treatment when necessary. Their goal is delivering high quality services that are safe and responsive while seeking to demonstrate accountability for public resources.

The Department's Office of Medical Assistance Programs administers the joint federal/state funding program for Pennsylvania residents that meet functional and income requirements. Services covered include inpatient hospital, outpatient psychiatric, drug and alcohol clinic, prescription drug and home health care. Eligibility programs are determined locally through county assistance offices and the office is responsible for enrolling program providers, setting rates and fees, reviewing invoices submitted by providers. Approved payments are made directly to providers under a fee-for-service payment system, and administrative actions, including suspension or restitution against providers who abuse the MA system can be taken.

The Office of Long Term Living (OLTL) has responsibilities including oversight of all fiscal, policy and program operations for the programs that provide services to the elderly and adults between ages 18 and 59 with physical disabilities. Implementing a policy that seeks to provide high quality supports to individuals in the appropriate yet cost effective environment,

[215] General information on the Department of Public Welfare was taken from the Pennsylvania Manual, FY2014-15 Executive Budget presented at the Appropriations Committee hearings, and the Department's website http://www.dpw.state.pa.us.

[216] Act of May 25, 1921, P.L. 1144, No. 425 created the Dept. of Welfare and the Public Welfare Code, Act of June 13, 1967, P.L. 31, No. 21 consolidated the services into the Dept. of Public Welfare.

OLTL implements and often drives the system changes necessary to reform and rebalance the state's delivery of long term care. This office, perhaps more than any other state agency, will face many challenges in the years to come as it will need to meet the demographic and fiscal challenges posed by a rapidly aging population.

The largest Agency in the Commonwealth, DPW has 17,000 employees, is organized under nine deputy secretaries and has the largest budget at $29 billion. It serves over 2.7 million unique individuals in the Commonwealth through a wide variety of programs and services across all ages. Its share of funding in FY 2013-14 comes from 40 percent federal monies, and in addition to providing direct services and supports, it distributes federal and state funding to local agencies. Funding provided to Medical Assistance alone is $14.8 billion, the largest departmental expenditure and 55 percent funded by the federal government. Long Term Living ranks second at $5.3 billion, of which 55 percent is also from federal sources, supplemented with state monies including $330 million from the Lottery Fund. Both programs serve those over age 60 and those under age 60.[217]

Growth in funding has been constant over the last decade, when the FY 2003-04 state budget for DPW totaled $7 billion, with $3.5 billion in spending on Medical Assistance and $446 million funding Long Term Living. The percentage change from 2003 to 2012 saw a stable percentage of MA remain at 51 percent of DPW funding, but rose from 16.5 percent of the entire state budget to 18.2 percent. Long Term Living has grown more substantially from 6 percent to 18 percent of DPW funding and from 2.1 percent of the total state budget to 4.8 percent. This growth corresponds to the increasing needs of an aging population that will continue to drive costs for additional services and supports as they age.[218]

Facility Licensure

One of DPW's primary roles is paying for long term care services. However, it also licenses both personal care homes and assisted living residences. This licensure is conducted by the Bureau of Human Services Licensing within the Department's Office of Administration, who license some ten different facilities for DPW. Inspections are conducted by personnel located at four regional offices around the state in Harrisburg, Norristown, Pittsburgh and Scranton, who license both facilities. While this licensing does not pose a conflict of interests as those residences are currently not certified by CMS to receive Medicare or Medicaid reimbursements, shifting this licensure to DOH would bring into further alignment the respective missions of each respective agency.

The Department also shares licensing responsibility for adult daily living centers through a cooperative arrangement with the Department of Aging, to license and inspect centers serving those over age 60, when they are servicing a dual center that also serves those under age 60. Centers under DPW are defined as a building or portion thereof that provides services to four or more individuals, under the age of 60 with intellectual disabilities, for part of a 24-hour day, and may include assistance meeting personal needs, performing daily activities or functional activities.

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[217] Governor's Executive Budget 2014-2015, "General Fund/Tobacco Settlement Fund prepared for the Appropriations Committee Hearings by the Dept. of Public Welfare," February 2014.
[218] Budget figures taken from the Office of the Budget, Governor's Executive Budget FY 2004-05 & 2013-14.

While the majority of residents pay privately for personal care and assisted living, some under age 60 receive SSI while some over 60 may be covered by individual long term care insurance policies.

The advisory committee heard feedback that consistently supported the need for increased access to assisted living, personal care and other intermediate levels of LTC. Rural areas across the state are particularly under served by assisted living residences. Since the adoption of Act 56 of 2007, and its regulatory implementation in 2011, the number of personal care homes has decreased and the number of licensed assisted living residences has been well below the 200 plus projected at that time. Personal care homes have also struggled due to SSI rates that have not seen an increase in the last seven years. There is often a focus of services on those who accept public financing, and the state has not submitted an application to CMS to enable reimbursements, limiting resident access to those who can self-pay. The advisory committee recommends some changes to the law to increase licensure and improve access across the Commonwealth.[219]

Personal Care Homes

Personal care homes are residences with four or more adults who require housing, meals, supervision or assistance while undertaking activities of daily living. Residents are typically the elderly, or those under 60 with physical, behavioral or cognitive disabilities, who do not need nursing homes or constant medical care but cannot live at home. Services can range from help with bathing, dressing, performing housework, managing finances or engaging in social activities to more extensive assistance that includes eating, drinking, transferring from a bed or chair, personal hygiene, managing self-administered medication and managing health care. Personal care homes vary in size, and can be stand-alone facilities but are also part of many CCRCs.[220]

The Commonwealth began licensing personal care homes in 1980, standards and oversight were significantly updated in 1988. DPW inspections are required to be unannounced at least one time annually, and range from full inspections to a shortened version for those with consistently good health and safety records. Licensing fees are graduated between $15 and $50 based on the number of beds. Full inspections measure all regulations, examine required records, observe care, sanitation, safety, administration of medication and a resident's support plan. All regulations, which can be complex and extensive, are covered in the *Adult Residential Licensing Regulatory Guide* of 261 pages. A recently developed licensing indicator system is a shortened version of the full inspection process for homes with a history of high regulatory compliance. A full inspection is triggered if one or more violations are found during an indicator inspection, and these abridged versions allow DPW to focus on inspecting and providing technical assistance to homes with a history of low compliance.[221]

If violations are found, enforcement actions ranging from warnings to fines, or non-renewal of licenses, immediate revocation and relocation of residents can occur in extreme cases. Administrative fines are assessed for repeated violations and monies are deposited into a fund used

[219] Act of June 13, 1967, P.L. 31, No. 21, known as the Public Welfare Code, was amended by the Act of July 25, 2007, P.L. 402, No. 56, to revise licensing of personal care homes and added licensing of assisted living residences.
[220] Title 55, Pa. Code, Chapter 2600 governs the rules and regulations for Personal Care Homes.
[221] Pennsylvania Dept. of Public Welfare, "2012 Annual Report on Adult Residential Licensing: A report on Licensed Personal Care Homes," 2012; LeadingAge PA, "Long-Term Care 2013 Statistics and Information."

to relocate residents of homes closed by enforcement action. The Department has a focus on providing training and technical assistance to homes having difficulty complying with regulations, in an effort to develop consistent levels of high quality care. DPW helps to arrange for training courses, offers a direct care staff training online and operates a toll free support hotline to provide technical assistance and report violations.[222]

In 2013 there were 1,234 licensed personal care homes in Pennsylvania with a capacity of 45,653. The occupancy rates of those residences is 70 percent, and the average size of the facilities is 53, between those ranging from four to 250 persons. Those homes overwhelmingly serve the elderly with 89 percent of the total residents falling into the age 60 plus age group. Homes are present in every county except the states smallest, Forest County, and homes are owned by for-profits, not-for profits including some 155 with religious or fraternal affiliations. Over the last decade, the trend in personal care homes has been a decline in the total number of homes and capacity, as demand for their services has dropped at the same time as home care has risen. The average size of a facility, which stood at 40 beds in 2002, has grown over the years, and they continue to serve a higher percentage of the elderly. [223]

Personal Care Home Data Trends[224]			
	2013	**2008**	**2002**
Personal Care Homes	1,234	1,468	1,786
Capacity	65,152	69,000	79,929
Occupancy	45,653	49,960	N/A
Residents Age 60+	40,542	N/A	N/A
For-Profit	854	1,038	1,393
Non-Profit	380	430	393

Assisted Living Residences

Assisted living residences are any premises in which food, housing, assistance, supervision or supplemental health care services are provided for longer than 24 hours at a residence with four or more unrelated adults. They provide a long term care option for many elderly residents that offer dining, social and wellness activities but promote independent living. Assisted living offers optional services, customized to an individual's needs, which can include bathing, dressing, diet, financial management, managing medication prescribed for self-administration, coordinating transportation, laundry and housekeeping services.[225]

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[222] Id.

[223] Data provided to JSGC by the Dept. of Public Welfare, Bureau of Human Services Licensing, April 22, 2014.

[224] Id.; PANPHA, "Long-Term Care 2002 Statistics and Information"; PANPHA, "Long-Term Care 2008 Statistics and Information."

[225] Title 55, Pa Code, Chapter 2800 governs the rules and regulations for Assisted Living Residences; Genworth Financial, Inc., "Genworth 2013 Cost of care Survey," March 22, 2013.

Assisted living regulations were developed in 2010 and implemented beginning on January 18, 2011. During the HR 255 meetings there was discussion of this implementation and the desire to have an adapted version of the personal care home regulations to cover assisted living. While members did not reach a consensus on any recommendations to address that regulatory change, they did point to the need for a better, more inclusive process with the Department for future regulatory changes to better address provider concerns and forestall unintended consequences. Licensure and inspections are carried out by the same personnel who inspect personal care homes and the department collects an annual fee of $300, plus $75 per bed.[226]

There were 34 licensed assisted living residences in the Commonwealth in 2013, serving 21 counties. The licensed capacity of those residences is 2,173 with an occupancy rate of 60.3 percent. Little comparative data was available for assisted living facilities since they are a relatively new licensure category.[227] Pennsylvania's median monthly rate for assisted living was $3,175 according to Genworth's 2013 "Cost of Care Survey."

Assisted Living Home Data Trends[228]

Year	Assisted Living Residences	Total Capacity	Total Occupancy	For Profit	Not-For Profit
2012	22	1,219	N/A	10	12
2013	34	2,173	1,310	18	16

Financing the Long Term Care System

The Medicare and Medicaid programs were established by federal law in 1965, through Title XVIII and Title XIX of the Social Security Act and were managed by the Social Security Administration. In 1977 these programs were transferred to the Health Care Financing Administration, which was renamed the Centers for Medicare and Medicaid Services (CMS) in 2001. Medicaid is the primary payer of long term care in the U.S. Through Medicaid 1915 (c) waivers, first developed by the federal government in 1982, states are allowed to offer HCBS to individuals who would otherwise receive care in a nursing home. Medicaid covers nursing home care, hospice, fee for service and managed care programs. Pennsylvania Lottery prescription drug coverage through PACE and PACENET. HCBS waivers are covered, including the LIFE program and nursing home transitions.

Medicare is a federal health insurance program exclusively funded by the federal government that covers 49 million Americans, including 2.35 million Pennsylvanians in need of skilled care. Enrollment is handled by and tied to eligibility for Social Security benefits. Individuals age 65 plus are covered, regardless of income or medical history as are people under age 65 with certain disabilities. In Pennsylvania, 84 percent of Medicare recipients are elderly with

[226] Data provided to JSGC by the Dept. of Public Welfare, Bureau of Human Services Licensing, April 22, 2014; PANPHA, "Long-Term Care 2008 Statistics and Information."
[227] Data provided to JSGC by the Dept. of Public Welfare, Bureau of Human Services Licensing, April 22, 2014.
[228] Id.; PANPHA, "Long-Term Care 2008 Statistics and Information."

16 percent on disability. Medicare accounts for more than 20 percent of total health services with 15 percent of the federal budget going to support it. The program, financed by a portion of payroll taxes paid by workers and employers, and is also funded through premiums deducted from social security checks. The program does not cover all medical expenses of the cost of most long term care, but Medigap policies, which is supplemental insurance from private insurers, can help to supplement what Medicare does not cover. Medicare will pay some nursing home costs for who require skilled or rehabilitation services. To be covered, a consumer must receive the nursing home services after a qualifying stay in a hospital.[229]

Medicare covers care in skilled nursing facilities, after three consecutive qualifying days or more of admission to hospital as an inpatient coverage includes: 100% of the cost for days 1-20 in a nursing home; day 21-100, a $152 daily copayment must be paid by the consumer and Medicare covers the remainder; day 101 and beyond is paid, at full cost, by the consumer.[230] Medicare Part A covers inpatient hospital stays, nursing home care, hospice and home health. Part B covers physician and outpatient services, medical supplies and preventative services. Part C covers Medicare Advantage parts of A, B and D, and Part D covers prescription drugs.

Medicaid is the Medical Assistance program jointly funded by states and the federal government to cover health services for low-income individuals, including older adults and persons with disabilities. Eligibility varies by state, but Medicaid will only pay for nursing home care provided in a facility certified by the government to provide service to recipients, and most nursing home costs are paid only to people with limited income and assets. To qualify, a state application must be completed to verify one's assets. Federal policy requires states to examine financial history for the previous five years to ensure that funds were not transferred out of a person's name to avoid using them for health care costs.[231]

To receive Medicaid coverage financial assessments are done to determine the level of need when considering eligibility for public funding. These assessments can be started online by the consumer or family members through the COMPASS self-assessment. More commonly, they are completed by one of the state's 52 AAAs or 93 County Assistance Offices who have limited staff to assist consumers and families. Assessments are done in two levels, with Level I determine financial eligibility and Level II functional assessment. The Level II's include 27 required topics (domains); a doctor's review of current physical and mental condition, upon which orders are based; medical history; medications; speech; decision making ability; physical limitations on hearing, vision, paralysis or equilibration; and ADLs including bathing, dressing, eating, getting in and out of bed or a chair, walking and using the bathroom. After health needs are assessed, a care plan will be developed that can include: service needs; what health professionals should

[229] U.S. Social Security Administration, "Medicare," May 2013, http://www.ssa.gov/pubs/EN-05-10043.pdf.

[230] Days of admission do not include the day you leave the hospital, or any days under observation before being admitted. Centers for Medicare and Medicaid Services, "Medicare Coverage of Skilled Nursing Facilities," January 2014, pgs. 7, 17.

[231] The Medical Assistance application requires 12 pages of complex financial calculations and requires a listing of financial actions for multiple years to assess eligibility. Estate recovery, outlined in Section 1412 of the Act of June 13, 1967, P.L. 31, No. 21. Repayment from Probate Estates happens after the death of a Medicaid recipient, age 55 and older, who received long term care services. Federal law requires states to recover the amount spent on a consumer's behalf from their estate, to cover all nursing home, HCBS, hospital and prescription drug services.

provide those service needs; frequency of services; needed equipment and supplies to provide services; dietary needs; and health goals of services. [232]

Throughout the HR 255 meetings there was discussion of standardized assessment tools for all long term care, especially those dealing with older adults. While DPW, in its Balancing Incentive Program application stats that it does not plan to seek a single assessment for all populations, research shows a level of standardization does exist for aging waivers through the Level Of Care Assessment (LOCA). Both the Aging, LIFE, Attendant Care, Independence and OBRA waivers, which provide services for the aging and those with physical disabilities use LOCA while those with intellectual or cognitive disabilities, and others use different assessments, or have no standardized assessment at all. Under the no wrong door approach to services, AAAs may have difficulty serving individuals over a variety of assessments outside of aging specific services. The biggest concern is inter-rater (assessor) consistency and reliability, through additional training and evaluations, will help ensure that individuals receive the right level of care.[233]

Sources of Payment for Long Term Care in Nursing Facilities[234]						
	Provider Type	**Medicare**	**Medical Assistance**	**Veteran's Administration**	**Private Insurance**	**Self-Pay**
2000	Government	3.54	83.00	3.15	0.61	9.17
	Non-Profit	10.23	55.61	0.21	2.23	29.95
	For-Profit	10.64	66.70	0.33	2.89	19.03
	Totals	9.29 %	64.63 %	0.74 %	2.23 %	22.10 %
2011	Government	6.00	75.43	6.00	2.32	9.92
	Non-Profit	13.81	55.61	0.03	3.07	26.30
	For-Profit	14.95	69.18	0.33	5.05	8.90
	Totals	11.59 %	66.74 %	2.12 %	3.48 %	15.04 %

Payment for Services

Paying for long term care services is typically a combination of public health care through Medicare or Medicaid, with additional monies supplemented by the consumer. The instances of Medicaid and Medicare payment have risen as the demand for services grows, while self-pay has declined. This may point to evidence of increased home care as residents delay entry into a nursing home, or care through HCBS waivers by using family caregivers or contracting privately for caregiver services. Payment issues are very complex and often confusing, with many forms and qualifications, required records retention and financial look-backs. This topic could be a report in

[232] Centers for Medicare and Medicaid Services, "Medicare Coverage of Skilled Nursing Facilities," January 2014, pg. 25.
[233] Commonwealth of Pennsylvania, Departments of Aging and Public Welfare, "Balancing Incentive Program Application," April 18, 2014, pgs. 12-17.
[234] LeadingAge PA, "Long-Term Care 2013 Statistics and Information;" PANPHA, "Long-Term Care 2002 Statistics and Information." Each column may not total 100 percent due to the exclusion of "other" charges which represent less than 1 percent of the total.

and of itself, and reflects the difficulty consumers and their families have in navigating these systems with help, let alone on their own.

When they enter nursing home many residents pay costs out of their own pockets. When their savings and other resources are reduced many people, who stay in nursing homes for extended periods, eventually become eligible for Medicaid through a practice known as Spend Down. The process of spend down is establishing eligibility for MA by allowing the person to spend their excess net income on certain unpaid or paid medical expenses or services. Waiver individuals become eligible for in home assistance that allows them to remain in the family home, but they cannot enter waiver eligibility until income limits are met. Conversely, and individual may enter a nursing home and begin immediate spend down while a resident.

Dual eligible individuals are those who qualify for both Medicare and Medicaid. Poor care coordination between the federal and state where their payments converge, and a lack of financial alignment between levels of care, particularly at the state level, results in barriers to access, increased costs and decreased quality. Attempts to bridge the gap and better integrate regulations, service delivery and payment mechanisms have seen several CMS projects, including the Federal Coordination Health Care Office pilot programs and demonstrations as Medicaid currently bears most of the cost for duals.

Support Service Waivers for Home and Community Based Services

Waivers are Medicaid HCBS programs that provide funding for services and supports to live in the home or community. They are referred to as waivers because the federal government is required to waive the Medical Assistance/Medicaid rules for institutional care in order for Pennsylvania to use the same funds to provide services and supports for people at or closer to home. HCBS regulations that govern the authority under which states may provide waivers to serve the aging population generally referred to as CMS 1915(c) waivers.[235] Under that section the state can furnish an array of HCBS that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address a targeted population. Waivers compliment the services available through MA. [236] In 2010 AARP estimated 73 percent of the older adults that need help with daily activities of living are receiving care exclusively from caregivers. There is a movement towards self-directed care that allows recipients of waivers to hire and train their own workers.[237]

The state Medical Assistance program must follow requirements set forth by the federal government to issue waivers from certain requirements from LTC to not be provided in facilities. Waiver programs provide individuals at risk of institutionalization with an alternative to receiving facility based care for medical, non-medical. This care helps individuals remain in the community or in their own homes. MA programs must make coverage available throughout the state, follow

[235] Enid Kassner, "Home and Community-Based Long-term Care Services and Supports for Older People," AARP Public Policy Institute, May 2011.
[236] Id.
[237] Teresa A. Keenan, AARP, "Home and Community Preferences of the 45+ Population," November 2010.

the same eligibility rules and offer benefits based only on eligibility. Waiver services are not available to the general MA population who do not qualify for specific waiver program criteria.[238]

Eligibility for waiver varies for each individual program, and waivers can serve those both over and under age 60, depending on the type of program and defined need. The application process involves determinations of both functional and financial criteria. Individuals generally need to be eligible for nursing homes, as verified by a doctor's assessment (MA-51). Financial criteria is complex and views countable income up to the 300 of the federal benefit for SSI, and rules apply for assets, spousal income, and includes a five-year financial look back. Estate recover can attempt to recover costs of nursing home, HCBS and related hospital care. The same process is used to determine MA eligibility for nursing home care.[239]

Medicaid Home and Community Based Programs[240]			
Program Waiver	**Population Served**	**2008 Enrollment**	**2013 Enrollment**
Aging	Seniors, Age 60+	14,611	24,226
Consolidated*	Persons with intellectual disabilities, age 3+	15,513	16,508
Person/Family-Directed Support*	Persons with intellectual disabilities, age 3+	10,227	11,224
Attendant Care + Act 150 Under 60	Persons with physical disabilities, ages 18-59	7,131	9,258
Attendant Care + Act 150 Over 60	Persons with physical disabilities, age 60+	702	2,329
Independence	Persons with physical disabilities, ages 18-59	2,569	7,973
Living Independence for the Elderly (LIFE)	Seniors, age 55+	1,488	3,567
OBRA	Persons with physical developmental disabilities, ages 18-59	1,463	1,442
AIDS	Persons with HIV/AIDS, ages 21+	111	81
CommCare	Persons with TBI, ages 21+	493	576
Adult Autism*	Persons with Autism, ages 21+	172	324
Totals		54,480	77,508

[238] Pennsylvania Health Law Project, "Home and Community Based Services (HCBS) Waiver Programs: A Manual for Consumer Advocates in Southwestern PA," 2009.
[239] Id.
[240] Program and population served information taken from Commonwealth of Pennsylvania, Departments of Aging and Public Welfare, "Balancing Incentive Program Application," April 18, 2014, pg. 7. Enrollment numbers taken from Department of Public Welfare Balancing Report, as provided to JSGC on May 8, 2014. Waivers (*) not included on Balancing report are taken from BIP Application and dated July 2010 and Approximate 2013. Additional information on waiver programs is provided in Appendix G.

In Pennsylvania, DPW administers 10 waivers and the LIFE program, which serve the aging population and those under age 60 with mental illnesses, intellectual or developmental disabilities, and physical disabilities. Of those waivers, only two are specifically for the elderly; Aging and LIFE. However, seniors are also served by the Attendant Care, Act 150, Person/Family Directed Supports and those grandfathered in under the OBRA waiver. Almost every waiver program has grown over the last five years and the total number of persons served in the community has increased by 20,000.

The Aging Waiver has the largest enrollment and is one of only two that exclusively serves seniors. This program is a Medicaid HCBS program that provides long term care services to qualified older Pennsylvanians living in their homes and communities. To be eligible a person must be 60 or older, nursing facility eligible, with income below 300 percent of the poverty level and assets of $8,000 excluding primary residence. The local AAAs conduct functional eligibility assessments for participants, and coordinate with County Assistance Offices who conduct financial eligibility determinations. Once enrolled, service planning and ongoing care management are conducted by service coordinating entities. Unlike nursing homes there is no entitlement for eligible individuals to receive waiver services and they may be placed on a waiting list.[241] Pennsylvania also has a lottery funded HCBS program, which is similar to the Medicaid funded version of the Aging Waiver program, called OPTIONS. The OPTIONS program is administered by the Department of Aging and discussed in more detail in that section.

The Living Independently For the Elderly Program or LIFE program is the Pennsylvania version of the federal Program of All-inclusive Care for the Elderly or PACE (renamed in PA so as to not be confused with the state PACE pharmaceutical program) provides integrated services of both medical and supportive care for frail elderly through an interdisciplinary team of health care and other professionals in the community. This managed care program is for aging individuals who are deemed nursing facility eligible but wish to remain in their homes and communities as long as possible. To be eligible an individual must be 55 years or older, qualify for nursing facility care their a AAA, be eligible for medical assistance or able to private pay, reside in an area served by a LIFE provider, and meet criteria to be safely served in the community as determined by that provider. Services are centered around and offered through adult day centers, transportation is provided, and nursing home transition is coordinated when a person can no longer stay in their home.[242] Pennsylvania has 23 LIFE providers offering services in 30 countries.

The OBRA waiver is a program that helps persons with developmental or physical disabilities to live in the community. It primarily serves people ages 18-59 but some seniors, who were in the program prior to 2006, continue to be served while all new applicants over 60 are referred to the Aging waiver program. Pennsylvania's Attendant Care waiver primarily serves those ages 18-59 who have physical disabilities, but those receiving care prior to age 60, may continue in the program or transition to the Aging waiver. Act 150 waivers is a state funded version of Attendant Care that offers the same services and supports to live in the community, but may

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[241] Commonwealth of Pennsylvania, Departments of Aging and Public Welfare, "Balancing Incentive Program Application," April 18, 2014, pg. 9-10; DPW, "Alternatives to Nursing Homes," http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm.

[242] DPW, "Alternatives to Nursing Homes," http://www.dpw.state.pa.us/fordisabilityservices/alternativesto nursinghomes/index.htm.

require a graduated co-payment based on the individuals income.[243] The Person/Family Directed waiver allows individuals and their family or caregivers more choice about how and where services will be provided. The individual in need must have a disability and supports are capped at $26,000 annually. Each of these programs designed as alternatives to nursing homes to increase choices for consumers and rebalance where care is provided to those who are nursing home eligible.

Cost of Care

Economies of scale are no long at play in nursing homes the way they once were. The more people served used to equal success but facilities of all size are now under pressure to find the right balance of Medicare, Medicaid, private insurance and self-pay mix to maintain a sustainable finance structure. Anecdotally, the advisory committee have heard consistent feedback from providers that Medicare was once a "cash cow" that covered costs that Medicaid did not, with patients on Medicare being reimbursed at a much higher rate. Over the last five years Medicare reimbursements have not kept pace with costs to the extent that shortfalls are now occurring more regularly; however, the percentage of both Medicare and Medicaid have risen as a portion of the payment mix while self-pay has fallen. Those facilities serving a high percentage of Medicaid residents will be affected the most

Home care is also facing increased pressure from this same low reimbursement issue. Medicaid program pays for less than the cost of patient care, and with the continuing deficit reduction talks, which are part of the annual budget process; it is unlikely increases will be forthcoming. This rate structure will continue to put economic and social pressure on the entire health system, including hospitals, physicians and long term care facilities.[244] Workforce shortages and wage pressures affect all levels of care as well. In addition, shortages of skilled RN's, LPN's and physicians are already being seen and there will need for CRNP's and physician extenders to meet the care needs of a growing senior population.

The costs of care is often difficult to accurately assess, and while this study analyzed total costs it recognizes the shortfall of a more comprehensive review of the financials to determine the cost of care, which could be a study of its own. Incorporating acuity levels, service intensity needs, overhead costs related to staffing and facility maintenance are important aspects of a baseline comparison of facility and home based care. Unpaid, unskilled informal care in the community, by friends or families, can impact facility discharges that equate to lower cost services in home care settings.

In 2010, the national average payments for Medicare were $423, while the average Medicaid payments were $163 per day. Profit margins for facilities goes down as the Medicaid occupancy rates go up. Between 2007 and 2013 the rate for facilities has caused shrinking margins, and Medicare, which historically has sustained nursing homes with its more generous rates has received cuts and no longer fully subsidizes increasing Medicaid shortfalls.[245] There is a need to

[243] Attendant Care Services Act, Act of December 10, 1986, P.L. 1477, No. 150; DPW, "Attendant Care/Act 150," http://www.dpw.state.pa.us/fordisabilityservices/attendantcare/attendantcareact150/index.htm.
[244] The Hospital and Health System Association of Pennsylvania, "Facts About the Medicare Program," January 2014.
[245] SEIU Healthcare, "Pennsylvania's Long Term Care System: Building Careers, Enhancing Quality Resident Care;" Avalere, "Skilled Nursing Facilities in Pennsylvania/ Analysis of total Profit Margins for Freestanding Facilities,"

better align Medicare and Medicaid payments with providers costs. There is also a push at the federal level to establish a per episode copay for home care when the episode of need is not preceded by hospitalization or post-acute care. Home health care is one of the few areas in Medicare that does not currently have cost sharing and it has experienced rapid growth recently.[246] A tiered benefit system could provide increased access to those whose incomes are just over the current cut off, and help prevent seniors from falling between the cracks.

The term homecare describes two different types of care: home health care provided by a licensed medical professional and non-medical home care, such as personal care or companionship services provided by a professional caregiver. For Pennsylvania's aging population, home care that seniors require often centers around ADLs. The availability of home care services increases the likelihood that seniors can age in their home. In 2011, Act 22 standardized HCBS rates by geographic region. There are four geographic regions within Pennsylvania; in 2011, Region 1 hourly rates were $17.16, Region 2 rates $19.08, Region 3 rates $17.96, and Region 4 rates $19.12. According to the Pennsylvania Homecare Association, homecare agencies providing personal assistance services under the HCBS waiver programs have not received a significant rate increase in 10 years.[247]

In 2013, licensed homemaker services experiences an hourly rate ranging between $11 and $26 per hour, with a median rate of $19 per hour and an average annual rate was $44,044.[248] In the same year, licensed home health aide services hourly rates were between $13 and $26 per hour, with a median rate of $20 per hour; the median annual rate was $45,760.[249] The nationwide average hourly fee was $20 per hour in 2014.[250] Both homemaker and home health aide services experienced a one percent annual growth rate for a five-year period. Adult day health care service rates varied between $30 and $106 per day, with a median annual rate of $14,560.[251] Medicaid Hospice rates for 2013 can be divided into four categories: routine home care with daily rates of $153.65, continuous home care ($37.33 per hour), inpatient respite care (daily rates $167.07), and general inpatient care ($682.59 daily).[252]

February 2014; Eljay, LLC, "A Report on Shortfalls in Medicaid Funding for Nursing Center Care: Special Report on Pennsylvania," January 2014.

[246] Joe Carlson, "On the watch list: Home healthcare providers draw increasing scrutiny from anti-fraud enforces," Modern Healthcare, July 20, 2013, http://www.modernhealthcare.com/article/20130720/MAGAZINE/307209952; Medicare Payment Advisory Commission, "Report to Congress – March 2012," http://medpac.gov/documents/mar12_entirereport.pdf.

[247] Pennsylvania Homecare Association, "Increase Rates for Medicaid HCBS Waivers," 2013, http://www.pahomecare.org/_files/live/One-Pager_-_HCBS.pdf.

[248] Genworth 2013 Cost of Care Survey, 2013, pg.59, https://www.genworth.com/.../130568_032213_CostofCare_Final_nonsecure.pdf.

[249] Id.

[250] Paying for Senior Care, Home Care Financial Assistance and Payment Options. http://www.payingforseniorcare.com/longtermcare/paying-for-home-care.html

[251] Id.

[252] Dept. of Health and Human Services. Centers for Medicare & Medicaid Services, "Annual Change in Medicaid Hospice Payment Rates," September 7, 2012.

Statewide Daily Rates for Nursing Facilities[253]				
	Medicare	**Medical Assistance**	**Private Room**	**Semi-Private Room**
	Reimbursement rates		**Self-Pay rates**	
2000	$261	$133	$195	$177
2006	$305.85	$146.82	$207.91	$198.46
2011	$417.57	$175.69	$264.94	$237.80

Looking at two examples from different parts of the state, with different demographics, helps to illustrate the vast differences in rates and reimbursements within counties, to demonstrate the complexity of comparisons and pricing. Mercer County is a fifth class county with a population of 115,655 in 2012. It is located in northwestern Pennsylvania and is considered a rural county, with a population density of approximately 173 persons per square mile. Montgomery County is a second class with a population of 808,460. It is located in southeastern Pennsylvania and is an urban county with a population density of approximately 1,656 per mile. A county in Pennsylvania is rural when the number of persons per square mile within the county or school district is less than 284, the state's median population density.

According to Pennsylvania Department of Health 2012 nursing home data, Mercer County had 14 nursing facilities whose private room rates varied from $168 to $508 per day. Medicare reimbursement rates in the county varied from $185 to $463 and Medicaid reimbursement rates ranged from $143 to $188. Montgomery County had 61 facilities and rates for a private room ranged from $169 to $1,904, and its reimbursements rates for Medicare were $292 to $613 and Medicaid $168 to $465.[254]

Mercer County & Montgomery County Average Rates[255]					
2012	**Medicare**	**Medical Assistance**	**Private Room**	**Semi-Private Room**	**Private Insurance**
Mercer County	$389.07	$162.90	$240.50	$221.42	$373.27
Montgomery County	$481.25	$211.69	$380.30	$302.37	$388.90

According to Department of Public Welfare data, the average cost for care in most waiver programs is a less expensive alternative, on a cost per user basis, than nursing home care. Average cost per user for facility based case care in FY 2008-09 was $36,446, with those same costs decreasing to $35,332 in FY 2012-13.[256] The Aging waiver program costs in FY2008-09 were

[253] LeadingAge PA, "Long Term Care Statistics and Information," 2002, 2008, and 2013.
[254] Pennsylvania Dept. of Health, Bureau of Health Statistics & Research, "Private Daily Charges and Per Diem Reimbursement Rates," 2012.
[255] Id. Rates and reimbursements are shown as the average rate per day. Data from the Dept. of Health, calculation (average) performed by JSGC.
[256] Data provided by Dept. of Public Welfare, Data Warehouse, March 11, 2014. Extended care facility long term care services costs for MA were measured using total state and federal funding, divided by the number of unduplicated

$14,033.99 and in FY 2012-13 stood at $17,309. The Attendant Care Waiver costs during the same time periods were $22,468 and $20,778, while costs for those under 60 were $20,735 and $19,927. The OBRA waiver came in at $42,337 and $52,900 respectively.[257] Data shows the cost across the delivery system favors home care in a cost per user basis, however, that is not always the case. Waivers serve different people, with a vary range of needs, and depending on the particular options, nursing home care can still be provided at a proportional cost.

Nursing Home Transition

The Nursing Home Transition program coordinates services, for both MA and non-MA residents of nursing homes as they transfer to their home or into the community. This federal program was adopted in Pennsylvania in 2008 to bring more monies into the state to help rebalance the long term living system. Residents not scheduled to be discharged, but who has been a resident of a nursing home for at least 90 days, have expressed a desire to return home and have a documented barrier, are eligible. This enhanced planning for individuals develops necessary infrastructure and supports while helping to empower individuals to be involved in directing their own transition, where possible. This program is an extension of the Money Follows the Person model of self-directed care and is a federal balancing incentive demonstration program.[258]

The goal of assisting and empowering individuals with more choice is the goal of the program. Allowing people to move from a nursing home to the community allows individuals to be cared for in a setting they choose. Successful nursing home transition gives families the information to make an informed decision about the level and setting of care options, including the range of HCBS, and helps identify local resources. Helping to develop the necessary infrastructure and supports within the community, and building a collaboration between aging and disability resource networks, helps to remove barriers and connect individuals and their families with the necessary services and supports to stay in the community.[259]

Rebalancing of Long Term Care Services and Supports

Rebalancing moves long term care services and supports systems away from a dependency on institutional living and towards home and community based settings providing home care, as a level of care that embraces consumer choice and allows care to be provided in the most integrated setting appropriate. Home and community based supports often offer more access to and engagement with the consumer's family and local support networks. Rebalancing is typically measured by funding levels, is tracked with the number of individuals being served by Medical Assistance in HCBS verses those being cared for in institutions, and is spread across groups that include older persons and those under age 60 with physical, intellectual, or developmental disabilities.

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users. Extended care facilities include nursing homes, county nursing homes, respite care, rehab agencies and hospital based extended care. Waiver claims were excluded.

[257] Data on paid claim waiver services was provided by Dept. of Public Welfare, Data Warehouse, March 12, 2014.

[258] Pennsylvania Departments of Aging and Public Welfare, "Understanding the Long-Term Living Support System in Pennsylvania," April 10, 2014, presentation to the members of the Pennsylvania Long-Term Care Commission.

[259] Dept. of Public Welfare, "Nursing Home Transition Program," http://www.dpw.state.pa.us/fordisabilityservices/alternativesto nursinghomes/nht/index.htm.

The shift began after the Olmstead decision by the Supreme Court that affirmed an individual's right to receive the most integrated setting appropriate, which often means home care. In 2010, the Affordable Care Act included financial incentives for states to shift where care is provided, and continue rebalancing the long term care system to include more home and less institutional care. This incentive is important as Medicaid is a large cost driver for the states and the federal government. Economic realities have influenced states to move individuals towards home care. Cost is an important consideration, however, it should not trump providing services as the most important aspect of long term care. Many states and the federal government have established arbitrary funding targets to control costs through rebalancing.[260] Complaints about the program having an arbitrary target of 50 percent, which is the threshold established for states who apply for the incentive, bring into focus the cost control objectives.

Since 1999, when percentages of spending stood at 75 percent institutional verses 25 percent HCBS, those numbers have both moved close to the 50 percent mark. In Pennsylvania, all waiver programs that allow Medicaid monies to be expended in the communities have grown. The largest increases are in the Aging and Independence Waivers that serve those who are elderly and those under age 60 with physical disabilities. These efforts have been supported by several cooperative programs that have brought increased federal funding into Pennsylvania. Pennsylvania recently ranked third among all states in Medicaid expenditures on HCBS (2.9 billion) but the percentage of funding going to HCBS 37th in 2011 ranks 42nd amongst states. The top users of HCBS are spending near 80 percent of their Medicaid funds in the community.[261]

One demonstration program is Money Follows the Person, implemented by CMS and adopted by Pennsylvania in 2008. Forty-four states are now using this federal initiative to transition people with chronic conditions and disabilities from institutions back into the community. The Affordable Care Act of 2010 strengthened and expanded this program with a goal of increasing HCBS. Increasing the ability of Medicaid programs to provide services at home to those who choose, and eliminating barriers that restrict the state use of Medicaid funds in the home will enable people in need of LTC to reside in the setting they choose.[262]

The federal Balancing Incentive Program, which provides money to states through the Affordable Care Act, is aimed at removing barriers to providing HCBS in long term care. On June 19, 2014 the state's application for admission into this program was approved. This partnership between the Departments of Aging and Public Welfare will help to improve access through a number of new initiatives designed to help people learn about and access services and supports in their communities. Balancing Incentive will provide some $90 million over two years to allow the state to serve some additional 1,800 individuals through the Aging Waiver, and 2,800 people with physical disabilities, intellectual and autism disorders through other waivers. States must create a no wrong door approach for people looking to access HCBS. This program is designed to help reduce the "red tape and confusing" that are barriers for caretakers and consumers looking to find nursing home alternatives. Determining eligibility for waivers can take several months while

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[260] The Hilltop Institute, "Rebalancing Long-Term Services and Supports," June 14, 2011.

[261] Commonwealth of Pennsylvania, Departments of Aging and Public Welfare, "Balancing Incentive Program Application," April 18, 2014, pg. 5; Steve Gold, "State by State Data for Aged and Disabled: Institutional Bias," October 2013.

[262] Mathematica Center for Studying Disability Policy, "Rebalancing Long-Term Care Services and Supports,: Money Follows the Person Demonstration," June 2013.

nursing home access is automatic.[263] More information on the number of consumers served through waivers, a rebalancing report, and a funding summary on rebalancing are contained in Appendices H and I.

Conclusions

An assessment of the Department's performance is difficult to make due to the complexity of payment issues and intermingling of federal rules and regulations in almost every aspect of DPW payments for long term care. The state could improve coordination with providers when regulatory changes occur, and the work of the Inter-Governmental Council on Aging could help improve cohesion within a system with many moving parts. In addition, rebalancing efforts for home care should be carefully examined so not to cause unnecessary hospitalizations when discharging directly from nursing homes to the community. The Patient Protection and Affordable Care Act has increased pressure on hospital referral sources to decrease readmission to their facilities within a 30 day period; improved discharge planning and coordination of care will be key to quality assurance. Discharge planning should occur from the moment of entry into an acute care or nursing facility and will assist in the rebalancing process.

While the state has little regulatory control over the Medicaid and Medicare rules, each state establishes its MA rates. Pennsylvania could also encourage the federal government to amend qualifying hospital or acute care facility stays that determine eligibility for Medicare long term care coverage. These changes, while improving the cost structure and care options for providers and patients would come at an added cost to both the federal and state governments, who already face significant fiscal pressure with rising demand for services. There are no easy answers to these issues, but the trends will continue.

Taking the no wrong door approach is a beneficial concept that seeks to promote systemic awareness for long term care services and supports. These services involve both aging and disability services, with consumers both above and below the age of 60. Many other states have combined aging and disability services, but that colocation is problematic within Pennsylvania due to our unique use of lottery monies. These dollars are used to provide services and must be dedicated exclusively to the benefits of seniors in future allocation. The no wrong door approach must be distinct in opening a door to separate services.

[263] Dept. of Public Welfare, News Release, "Pennsylvania to Offer Additional Assistance to Older Adults and Persons with Disabilities," June 19, 2014; Christine Vestal, *Stateline*, "Health Law Spurs State Shift in Long-Term Care," January 20, 2014, http://www.kaiserhealthnews.org/Stories/2014/January/20/stateline-states-shift-on-long-term-care.aspx?p=1.

INSURANCE DEPARTMENT

The Pennsylvania Insurance Department[264] was first established under the Act of Assembly of April 4, 1873, later to be reorganized under The Insurance Company Law of 1921.[265] The Insurance Department plays a limited but critical role in the implementation and delivery of long term care services and supports (LTSS). Their primary role is administering the laws of Pennsylvania as they pertain to the insurance industry, which includes licensure of insurance companies, review and approval of insurance policy rates and language, and the promotion of said policies.

The scope of their interaction with the long term care system is twofold: regulating insurance providers who issue policies to consumers for life and long term care insurance; and licensing and regulating long term care providers who operate Continuing Care Retirement Communities (CCRCs). Long term care insurance is not licensed individually, but can be provided by any individual or entity licensed to produce insurance in the Commonwealth.[266] The Bureau of Life, Accident and Health Insurance, through the Office of Insurance Product Regulation and Administration, is responsible for regulating insurance rates and policy forms sold in Pennsylvania.

CCRCs offer the opportunity to live in the same community campus as an individual's needs change, from independent living to assisted living and even skilled nursing care. They are regulated by the Office of Corporate and Financial Regulation within the Bureau of Company Licensing and Financial Analysis. While their history in regulation of the long term care industry may seem somewhat misplaced, it is a role uniquely focused on the business side of the industry and not on the provisions of care, per se, but the model under which certain campus communities operate. That sets them apart from the health facility licensing inspections, or direct services provided by other departments. Information is primarily disseminated to the public on products and CCRC's through the Insurance Departments *PAHealthOptions* website.

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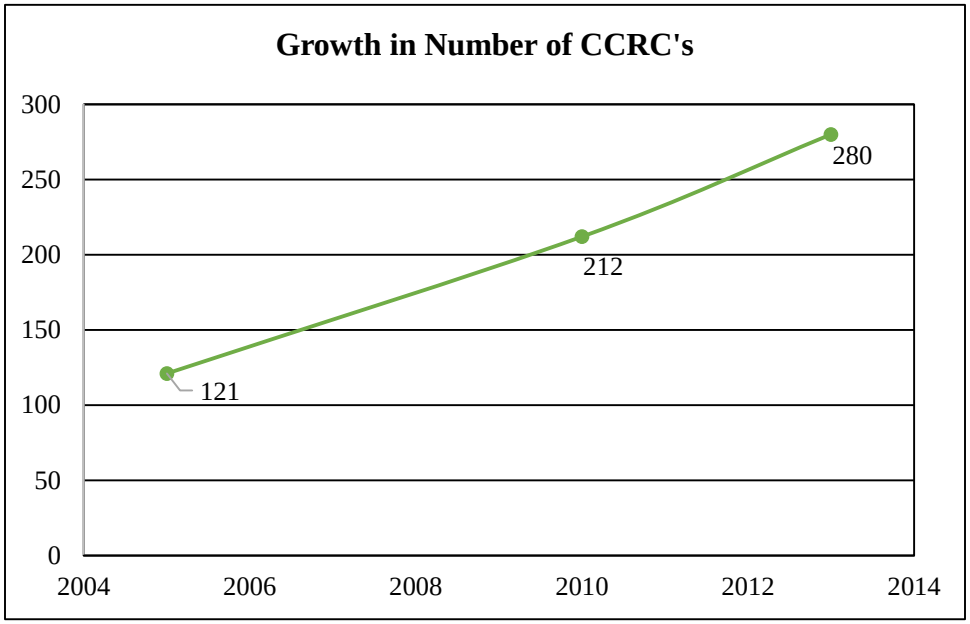
[264] This chapter contains information on the Pennsylvania Insurance Department's role in long term care, including a historical background, regulatory oversight of CCRC's and insurance licensure. While the Department provided some information for this chapter, and others were taken from their website, the majority was written by JSGC staff who utilized supplemental, non-department materials. This analysis was not written by, and should not be interpreted as an endorsement by Department of any or all statements made within the chapter.

[265] Act of May 17, 1921, P.L. 789, No. 284; A brief history of the Pennsylvania Insurance Department is available at http://www.portal.state.pa.us/portal/server.pt/community/about/5230.

[266] Insurance producers must complete a certification exam, pay a $55 licensing fee from residents ($110 for non-residents), plus a $36.25 fingerprinting fee. After receiving certification insurance may be produced for health, life, homeowners, automobile and long term care, et. al. Data collection is not required by the Department from producers or policy holders, making specific information on long term care insurance unavailable. Fees are established by the Act of June 9, 1929, P.L. 177, No. 175, §612-A, known as the Administrative Code of 1929.

Continuing Care Retirement Communities

Enacted in 1984, the Pennsylvania Continuing-Care Provider Registration and Disclosure Act assigns licensing authority of CCRCs to the Pennsylvania Insurance Department[267]. Consumers often enter a CCRC choosing to live first in independent living units and progress to assisted living facilities or nursing home care, located on the same campus, as more advanced care is needed. There is no required entry point for consumers, with some CCRCs providing assisted living services within the independent living units; the availability of nursing home care within the grounds allows for services and supports required for needing consumers while maintaining familiarity within the grounds of the community. This model of living continues to be extremely popular in Pennsylvania, and nationwide.[268] Within Pennsylvania, there are currently 280 continuing care retirement communities, a number which has more than doubled over the last ten years.[269] Nationwide, there were 1,861 CCRCs in 2009, showing how significant they are in Pennsylvania, which includes nine percent of the national total.[270]



CCRCs are licensed and inspected annually by the Department, and paperwork is relatively simple for the providers. Under the authority of Act 82, a one-page form is required to transact business in Pennsylvania as a continuing care provider. Fees for initial and annual licensing are $750 and are required to supply a statement of support for their initial application. Providers must annually provide a summary disclosure statement containing information on the resident population, monthly fees, entrance fees, admission criteria, facility information and affiliations. There is also a set of criteria required to be provided in a disclosure agreement to each resident within the facility at entry into the community.

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[267] Act of June 18, 1984, P.L. 391, No. 82; Pa Code Chapter 151, § 151.3: Continuing Care Providers.
[268] LeadingAge PA, "CCRCs Today," January 17, 2012, http://www.leadingage.org/uploadedFiles/Content/Members/CCRCs/Marketing/CCRCs_Today_01_17_12.pdf.
[269] Data provided by the Pennsylvania Insurance Dept.
[270] LeadingAge PA, CCRC Task Force, Jane Zarem, editor, "Today's Continuing Care Retirement Community (CCRC)," July 2010, pg. 5, https://www.lifesitelogics.com/docs/ccrc/Todays-Continuing-Care-Retirement-Community.pdf.

Independent living at a retirement community is designed to offer the feel of home for those consumers who choose this option. Consumers can enter CCRCs at various age and need levels, but many are healthy, may require little to no care during their stay but within the campus they are afforded the option and protection of assisted living and nursing home care. When applying for entry the income and assets of every applicant are reviewed to determine their ability to pay in a shared risk model, and is based on a formula to compare length of stay with costs. Entry fees and monthly payments are typically required but once admission is granted the resident is guaranteed care no matter how long or at what skill level. A benevolent care fund or endowment often helps offset any operational losses after residents have exhausted their funds and Medicare Gap that may result.

Both the financial and health evaluations factor into the admission criteria for this type of long term care setting. Consumers requiring assisted living, in many cases, can receive care within the independent living facilities of the CCRC. Such care could include mild to moderate assistance with activities of daily living (ADL) or short periods of recovery for the consumer. If care cannot be provided within the independent living facilities, care will be provided within a specialized unit on the community grounds. Nursing home care is also provided within the grounds of a continuing care retirement community, again within a specialized unit.

There are many benefits to the CCRC model due to the all-inclusive atmosphere of the community. Individuals may move freely throughout care types, with no mandatory point of entry. For couples, choosing this type of care allows for both individuals to live within the community while extensive medical care may be required for one individual. Upon entry into the CCRC, consumers participate in a contract whereby the CCRC provides housing, general activities, and healthcare services and supports as needed by the consumer. In exchange for an entry and monthly fee, services within the CCRC will be provided, often with extensive services required by the consumer. Pennsylvania law mandates all continuing care retirement communities provide care and specify all services to be provided to the resident, stating any liabilities to health care providers while in a CCRC.[271]

Throughout the study meetings were held with CCRC administrators and staff, who described an inconsistent history of interactions with a Department that "may not be the best fit" to oversee them. Inspections were characterized by a perceived lack of interest by personnel who seemed more bothered by an inspection process, and required review that was "obviously not a priority for them." Over the last several years a much improved relationship was noted, and administrators are pleased with the increased responsiveness and collaboration to address any issues that arise. The advisory committee considered a change in realignment, including the Department of Insurance responsibilities, in an effort to build a more seamless cross-consortium of long term care services oversight. A single licensing authority was determined to not be a feasible option, and if a goal to separate facility licensure, service providers and payment for services was ever realized, CCRC's non-health care relationship to long term care still makes it a good fit in its current location within state government.[272]

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[271] CCRC contracts must inform the consumer of any exclusions or limitations of coverage for pre-existing conditions and contain a notice of rescission rights before moving in. It is highly recommended contracts are reviewed by an attorney. *A Guide to Legal Issues for Pennsylvania Senior Citizens*. Rep. N.p.: Pennsylvania Bar Association, 2012-2013. Print.

[272] Meetings were held with seven CCRC's across the state, as are listed in Appendix E, but the names have been redacted from this footnote to ensure confidentiality.

Long Term Care Insurance

Another aspect of Pennsylvania's Insurance Department is their involvement with long- term care insurance. Long term care is a phrase that generally encompasses all care required for the aging populations of the Commonwealth; "all care" is accepted to include all degrees of care, supervision, or support required for consumers for a term of one year or more. Consumers often naively believe Medicare and Medicaid will cover all costs accrued in healthcare, however this is not the case. At best, Medicare and Medicaid together will cover only skilled, post-hospital, and recuperative care costs.[273] Long term care insurance policies can be structured to cover an individual or couple, and some employers offer group coverage as an option for employees.

Long term care insurance is a coverage that held the promise of helping preserve middle-income estates and increase policyholder care options when it was first introduced. Many life and health insurers began selling it primarily to offset the costs of nursing home care in the late 1980s. In the past, initial problems began with the creation of assisted living residences, which began causing problems with early long term care policies. Some companies allowed insured's to make assisted living facility claims against their nursing home facility benefits, even though covering assisted living facility benefits would have required a higher initial premium. Another problem occurred when insurers greatly over-estimated the projected number of policies that would go into voluntary lapse; this misestimation in lapse rates lead to significant underpricing of the product.

More recently companies have sought rate relief to price products with more realistic lapse rates, however other problems have surfaced, such as lower than expected investment earnings, increased morbidity and decreased mortality. Companies unrealistically expected to get approval for large rate increases over a short period of time. This has made it more difficult for state insurance regulators to balance consumer protection verses company solvency. After 20 years of poor product performance and heavy rate increase activity, insurers began leaving the market and the future of long term care insurance remains unclear.

The National Association of Insurance Commissioners (NAIC) working with state insurance regulators, industry and consumer representatives, developed a model regulation in an effort to promote rate stability. In addition to adopting the regulation the Department requires companies to give policyholders rate increase mitigation options. These options include, allowing policyholders to decrease their benefit periods, lengthen their elimination periods, reduce their daily benefits to lessen or eliminate the effects of a rate increase. Currently work is being done to revise the model regulation in an effort to address many of the product and pricing challenges.

With Medicare and Medicaid covering such a small portion of long-term care costs, supplemental and alternative insurances are most commonly purchased to augment cost of care and services or preserve assets. Pennsylvania's average for assisted living facility costs is $7,800 a month. Median annual rates for a nursing home semi-private room is $94,619, with median annual rates for

[273] The Pennsylvania Bar Association estimated Medicare and Medicaid coverage will cover an estimated three percent of long term care expenses. Long term care is a term used for care meeting or exceeding one year in duration. In 2011, Medicaid accounted for 40 percent of total expenditures, Medicare 21 percent, and private out of pocket and other funds make-up the remaining 40 percent, according to The Kaiser Family Foundation, "Five Key Facts About the Delivery and Financing of Long-Term Services and Supports," September 13, 2013, http://kff.org/medicaid/fact-sheet/five-key-facts-about-the-delivery-and-financing-of-long-term-services-and-supports/.

nursing home private rooms estimated to be $104,390[274]. With long term care costs on the rise, it is important for consumers to acknowledge and prepare before the potential need of care. Long term care insurance is one method for consumers to recognize and plan for potential costs for medical care and support services in the future.

The average long term care insurance consumer is in their 50's, however many people in that age bracket do not plan ahead as the "it cannot happen to me" or "I'm young and healthy" attitude still prevails. Waiting until a consumer is older increases premiums and the chance that care costs can outweigh consumer's means. The more comprehensive a policy the higher the rate would be expected as they cover care fee's associated with all types of care, ranging from in home care to assisted living and nursing home care. AARP reported in 2012 the number of new individual buyers, between 2004 and 2009, had fallen 43 percent while new policies for people age 55-65 are up an average of 30 to 50 percent. A standard policy for a person age 55 would average $2,000 annually while a couple age 65 would expect to pay $5,000.[275] Policies should be carefully reviewed with professionals to ensure comprehension of coverage by the consumer.

According to the Pennsylvania Insurance Federation, NAIC estimates for long term care insurance policyholders in the Commonwealth for 2012 numbered 207,565 individual policies and 80,516 who are covered on group policies, most likely through employer sponsored coverages. While awareness and education are a large part of long term care planning, there is currently limited inclusion of long term care insurance and broader financial planning that is advocated by the state service providers. No incentives are offered to make the coverage more affordable or widespread. Those with greater financial means often engage in more planning, but also have a greater ability to pay. No matter what the education, incentive or price of the product, experience has shown that few people prepare for long term care and often wait until an acute onset illness, chronic conditions or injury forces them to consider their options in haste.

The State Health Insurance Assistance program (APPRISE), under the Department of Aging, is a free health insurance counseling program designed to help older Pennsylvanians with Medicare. Counselors are specially trained staff and volunteers who can answer your questions about Medicare and provide you with objective, easy-to-understand information about Medicare, Medicare Supplemental Insurance, Medicaid, and Long-Term Care Insurance.[276]

Finding appropriate coverage can be tricky considering the cost of care and anticipated increase in years to come. Planning and forethought is required to ensure long-term care costs coverage, with inflation considered. Factors such as anticipated SSI benefits, facility costs, and location should also be considered. Most individuals prefer home care to facility care, and policies differ widely in how home care coverage is provided. Some policies limit covered home care expenses to those provided by skilled

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[274] According to the Genworth " 2013 Cost of Care Survey," nursing home semi-private room's costs have increased four percent over the past five years, with nursing home private pay costs increasing five percent over the past five years. Median annual licensed homemaker costs are estimated to be $44,044, with licensed home health aide services estimated to cost $45,760 annually.

[275] Jane Bryant Quinn, *AARP Bulletin*, "Prices Rise for Long-Term Care Insurance: But without it, families may face extremely high bills," June 6, 2012, http://www.aarp.org/work/retirement-planning/info-06-2012/long-term-care-hikes.html.

[276] Pennsylvania Dept. of Aging, APRISE Program, http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616587&mode=2.

services, others cover informal home care including services provided by home health aides and homemaker services. It is important to note most policies do not pay benefits to family members who perform these tasks[277]. Recent statistics shows the majority of those purchasing products choose between 100 and 150 dollars in daily benefits, with the majority of purchasers also opting for five percent inflation riders compounded for life is the hope that benefits can keep up with future cost of care within the LTSS system.[278]

According to national surveys, the current cost of long term care insurance for a 60 year old couple, in 2014, costs $3840 annually, an increase of 3% from 2013.[279] Average cost of care is higher for women, costing an estimated $542 more than males for equivalent "best" coverage.[280] For these estimates, calculations were based on $150 daily benefits with a 90 day elimination period and three year benefit; the "best" coverage is that which grows at three or more percent compounded annually.

Pennsylvania Long Term Care Insurance Partnership

Pennsylvania is one of many states that participate in a national Long-Term Care Insurance Partnership program. In July of 2007, Governor Edward Rendell signed amendments to the Insurance Company Law allowing for greater protections for consumers of long-term care insurance, as well as establishing a Pennsylvania Long-Term Care Partnership.[281] The amended law now requires all long term care insurance policies within the Commonwealth to provide "comprehensive" coverage as well as the ability for current consumers to switch to partnership policies. In Pennsylvania, Medical Assistance is the largest payer for long-term care services and supports. The qualification process for those in need of Medical Assistance is rigorous, requiring spend down of assets or exhaustion of savings. Once assets are depleted, Medical Assistance can begin, however depleting resources often leaves families with no alternative than reliance on public assistance.

The goal of the Partnership is to allow consumers to preserve assets if they exhaust insurance coverage and resort to Medical Assistance, also saving tax money by diverting prolonged use of Medical Assistance. The program allows dollar for dollar asset protection in the amount of the policy benefits paid out. In the event consumers need to apply for long term care benefits under Pennsylvania's Medical

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[277] Long term care insurance plans should be scrutinized for coverage details. Many plans will not reimburse family members for care provided, however will reimburse licensed or otherwise accepted homecare trained personnel. Aides, home health aides, custodial care aides and other qualified personnel are generally covered under most long term care policies.

[278] Information according to the "American Association for Long-Term Care 2012-2013 Sourcebook."

[279] Information according to 2014 National Long-Term Care insurance Price Index. The American Association for Long-Term Care Insurance ranks and averages annual long term care insurance policy prices. According to the most recent price index, and following a "good, better, best" ranking approach, "good" coverage for couples costs on average $1,980 annually, "better" coverage for couples costs, on average, $2,220 annually, and "best" coverage for couples costs, on average, $3,840 annually. The "best" coverage is that which grows at 3 percent or better compounded annually.

[280] The American Association for Long-Term Care Insurance ranks and averages annual long term care insurance policy prices. According to the most recent price index, and following a "good, better, best" ranking approach, women pay $300, $305 and $542 more than men for equivalent coverage.

[281] Act of July 17, 2007, P.L. 134, No. 40; Note: The Pennsylvania Partnership Program was structured and implemented by the Dept. of Public Welfare, and submitted a state plan amendment with the Centers for Medicare and Medicaid of the U.S. Dept. of Health and Human Services.

Assistance program, consumers will have greater asset protection using the partnership program than without. In addition to this protection, tax benefits and inflation protections for policy holders are built in.[282] An enhanced benefit for Pennsylvanians is the ability to receive asset protection if the consumer purchases a Partnership policy in Pennsylvania and moves to another state. Reciprocal standards apply if the consumer purchases a Partnership policy outside the Commonwealth and requires long term care services and supports within Pennsylvania. Partnership policies may be more expensive than non-partnership policies due to additional mandatory benefits, however, through the partnership, consumers are provided with additional options for long term care planning.

Innovative Insurance Provisions

More recently, there's been an introduction of innovative life and long term care combination product designs that offer an alternate way to obtain long term care coverage. A typical combination product is a universal life policy with a long term care rider. The rider is a hybrid approach to traditional long term care insurance and allows the insured to take an accelerated death benefit to pay for long term care services, if the insured meets the benefit triggers for qualified long term care coverage. Typically this trigger involves failing two of six Activities of Daily Living (ADLs) or being cognitively impaired. If the insured never needs coverage, the beneficiary will receive the full life insurance death benefit.

As the population ages and demand for services increases, life insurers have increasingly begun a "roll-out" of lower cost riders that allow the accelerated death benefit for those who develop chronic conditions. This lower cost option of pairing life insurance with long term care insurance reduces or eliminates any potential death-benefit, and the lower cost generally provides less coverage than stand-alone long term care insurance. Coverage for this type of policy can cost an additional five to twenty percent over a life insurance policy by itself, and these options have become increasingly popular over the last five years.[283]

The recently introduced Senate Bill 1296 would allow a new option in long term care coverage. This language would require Medicaid programs to "proactively notify applicants or prospective eligible individuals of life settlement conversion options."[284] This language would inform those with soon to lapse life insurance policies of their ability to convert these policies to long term care insurance. Life insurance policies that are about to lapse, if the policy holder is terminally ill, would be allowed to purchase the policy for cash and the proceeds can then be used to pay for LTC. With many consumers unaware of the status of their life insurance, notification of policy status on behalf of insurance companies could prevent coverage lapse or termination. This language shows the increased need for further long term care insurance promotion, awareness and understanding within the Commonwealth and potential for use of private monies to help offset government provided benefits.

On a national scale, the Affordable Care Act of 2010, established a now repealed long-term care insurance strategy called the Community Living Assistance Services and Supports plan (CLASS). The

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[282] According to the American Association for Long-Term Care Insurance, 41 states currently have partnership programs, with three states having pending or proposed status.

[283] Ann Tergesen, "For the Chronically Ill, a Lump-Sum Option," The Wall Street Journal, June 1, 2014, http://tream.wsj.com/story/latest-headlines/SS-2-63399/SS-2-544849/.

[284] Senate Bill 1296 of 2014, Printer's No. 1887.

CLASS Act represented a departure in the way federal government views LTSS due to the plans nationwide voluntary publicly administered insurance program. The CLASS Act was designed to assist individuals within all care levels of the LTSS structure. This law was designed to be self-sustaining, predicted by the Congressional Budget Office to reduce Medicaid spending; the CLASS Act would never use federal tax dollars and be solvent for a term of 75 years being financed through age determined premiums. Individuals participating in this program would have received cash payments of at least $50 a day in order to offset LTSS for all care in all settings. Despite efforts on behalf of the department of Health and Human Services, this program was deemed insolvent as overall participation and affordability were in question, and was repealed January 1, 2013 as part of the American Taxpayer Relief Act of 2012, known as the Fiscal Cliff Bill.[285]

Despite the failure of a national long-term care insurance plan, states have made advances in patient protections and consumer rights. Participation in Partnership plans achieve important steps in safeguarding consumers from exorbitant premiums and lack of coverage. Promotion and awareness for consumers still remains a barrier to the long term care insurance industry. Given the average consumer of long term care insurance is 59 years of age, greater promotion of this method of preparation should be developed.[286] Consumers should be aware of the language in long term care insurance policies at the time of purchase and need to more comprehensively plan for long term care in advance of their prospective need.

While consumer planning is low and costs for long term care insurance, depending on the options, can be high and unaffordable for many prospective policy holders, reviewing the options for such coverage need to be more consistently considered as a part of comprehensive planning. Insurance advisors can help determine the proper insurance plan for consumers while independent advisors such as a long term care specialist or elder law attorney can assist in many ways, including, but not limited to: reviewing fiscal suitability for potential LTC insurance consumers, ensuring potential LTC insurance retailers are financially sound, ensuring aptitude and comprehension of policy features, terms, and rates, and identifying terms in the policy that could lead to written clarification from insurance companies for policy details.

Consumer awareness tips are provided by the Department as well as many other organizations, including the Department of Aging and the Pennsylvania Bar Association.[287] Over the last several years more rate-stable companies have tightened underwriting standards, indicating to consumers it is preferable to explore LTC insurance options while at your youngest and healthiest point in life, and then decide if it is appropriate and necessary, either to protect assets, or to assist family members with your care. In Pennsylvania, as in most states, consumers have 30 days after receiving a policy to decide to keep it or opt out with no penalty. While many low premium polices are attractive, the reality is they almost always provide less coverage and a more comprehensive policy could cost five percent of an individual's annual income. No two companies or polices are alike and consumers need to thoroughly understand their needs, the coverage and what degree of disability triggers benefits.

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[285] American Taxpayer Relief Act of 2012: Section 624(a) Repeal of CLASS Program, Title VIII.

[286] The average age of long term care insurance consumers has been declining throughout the years; in 1990 the average age was 68, today that average has dropped to 59. Information according to America's Health Insurance Plans, *"Who Buys Long-Term Care Insurance in 2010-2011?"* 2012. Print. This study compared findings with those who made the active decision not to purchase long term care insurance, and other Americans age 50 and older.

[287] Consumer tips are verbatim tips from the Pennsylvania Bar Associations report, "A Guide to Legal Issues for Pennsylvania's Senior Citizens." Published by the Pennsylvania Bar Association 2012-2013.

DEPARTMENT OF MILITARY AND VETERAN AFFAIRS

Background and History

The Pennsylvania National Guard was founded in 1747 in Philadelphia by Benjamin Franklin and was created as a reserve force in 1870. The Adjutant General's Office was established in 1793, and while the current Department of Military and Veterans Affairs (DMVA) has evolved over the years, it has a dual purpose of preparing the 16,400 uniformed members of the 28th Infantry Division, Air National Guard and supporting units for combat and state service; and providing services and benefits to assist Pennsylvania's veterans. Armories and readiness centers are located in 90 communities, representing 52 counties throughout the state, and is headquartered at Fort Indiantown Gap Military Reservation. Benefits provide a mix of federal, state and local support to veterans, their spouses and dependents, including six veterans nursing and personal care homes throughout the Commonwealth.

The DMVA administers all veterans programs within the state system and manages the State Veterans Homes. The office is also the official liaison between federal, state and local government agencies on all matter concerning veterans benefits. While the state serves all veterans who are residents, both over age 60 and those under age 60, Pennsylvania is an aging state, with an aging veteran population and they comprise the vast majority of residents at the state homes. The quality care provided in these homes has been enhanced by several recent renovation and upgrades, and the state/federal funding mix provides a good value for the Commonwealth. Access to state homes, however, is the biggest obstacle for veterans. A limited number of beds at a small number of facilities create space and geographic barriers for many veterans and families who often suffer wait times then are forced to travel far from home in order to reside there.

Demographics of the Veterans Population

The United States is currently home to 21.8 million veterans, with Pennsylvania ranking fourth in total veteran population of nearly one million, behind only California, Texas and Florida. Vietnam era and peacetime veterans, a large portion of which served during the Cold War, will begin to age into the system as part of the Baby Boomer generation.[288] The number of total veterans, however, has declined over the last decade. This decline is, no doubt due to the passing of the Greatest Generation that served during WWII. Trends show that Pennsylvania saw a large percentage decrease in the number of total veterans in its population, however, because of its large veteran population, it still remains high in its overall number of veterans.

The largest total of veterans U.S. history served during WWII, numbering over 16.1 million, who combined with the Korea era's 5.7 million servicemen constitutes a huge block of veterans that

[288] Veterans data from 2012 U.S. Census; U.S. Dept. of Veterans Affairs, National Center for Veterans Analysis and Statistics, "Veteran Population, September 30, 2013, http://www.va.gov/vetdata/Veteran_Population.asp.

represent the highest census age group of 85 plus and now require the most care. Data from May 2013 shows those oldest veterans now number only 4 million, but Vietnam War veterans numbered 8.7 million and have nearly 90 percent of their ranks still living. Those are the veterans that now make up the highest total of beneficiaries including those with rights of survivorship. Gulf War era veterans are close behind but many numbers are difficult to establish with the period for service, including Desert Storm, Operation Iraqi Freedom and Enduring Freedom, have pension period end dates have not been established.[289] In raw numbers, Pennsylvania saw its number of unique patients steadily increase over the decade by 4.25 percent. In 2013, a total of 232,054 or 24.3 percent of Pennsylvania veterans were receiving a VA benefit, just slightly less than the 26 percent average of 5.7 million unique patients across the country.[290]

Pennsylvania's overall veteran population is still aging, despite the loss of many WWII veterans who for years represented the highest numbers of beneficiaries. Its percentage of veterans over age 65 represents more than half of the state's current total, with those under age 40 representing the lowest percentage totals.[291] Across all the states, 44 percent are age 56 and up, with a growing diversity of black, Hispanic and Asian veterans that now make up nearly 20 percent of the total, while women represent 10 percent of all veterans. Pennsylvania's overall veteran population fell 19.2 percent over the last decade, beating the U.S decline of 12.7 percent. Despite all the regression in terms of raw numbers, Pennsylvania still make up ten percent of its population making it not just an aging state, but also a state of aging veterans.[292]

Federal Services and Supports for Veterans

The United States of America became a sovereign nation during wartime, and its veterans, wherever they serve, continue to hold a distinguished place in society for their service and sacrifice no matter what the mission. Since April 19, 1775, tens of millions of veterans have served during wartime and peacetime, and since that time the governments at both the state and federal level have been awarding benefits in terms of monetary pensions, land grants and payments to support widows and orphans, with additional services going to support disabled veterans with service connected injures. The Civil War increased that need and President Lincoln famously stated in 1865, "…let us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan…" Homes for disabled veterans opened across the country, which expanded to care for disabled and indigent veterans whose disabilities were not service related. This expansion also included veterans outside of those from the Civil War. In the 1920's, with the addition of a large number of World War I veterans into the mix, medical care had risen to that of a hospital, and the stage was set for what would become the Veterans Administration.[293]

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[289] VA, "America's Wars Fact Sheet," May 2013, http://www.va.gov/opa/publications/factsheets/fs_americas_wars .pdf; VA, National Center for Veterans Analysis and Statistics, "Geographic Distribution of VA Expenditures," FY 2003 & FY 2013, http://www.va.gov/vetdata/expenditures.asp.
[290] Id.; Id.
[291] VA, Office of the Actuary, "Veterans Population Projection Model," 2011, http://www.va.gov/vetdata/Maps.asp.
[292] Data throughout the VA system is difficult to track with documents presenting crossover years, and having differing numbers within documents, across programs. Every effort was made to use consistent numbers that could be documented in multiple sources, specifically census data.
[293] VA, "VA History in Brief," pgs. 3-8, http://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf.

In 1921 Congress created the Veterans Bureau, and following the flood of need created by the Great Depression, President Hoover signed legislation consolidating the Bureau of Pensions, Veterans Bureau and National Soldier Home for Disabled Soldiers into the Veterans Administration in 1930. At that time there were 54 hospitals, The Selective Service and Training Act, along with other laws during WWII, created the GI Bill, serviceman's readjustment, hiring preferences and disability services to deal with the influx of the most veterans in U.S. history who were then reentering society. By 1947 the number of hospitals had expanded to 126 and a series of branch, regional and contact offices, numbering more than 700 across the country, had been established to deal with the influx of demand. During the Vietnam War outreach efforts were expanded through veteran's assistance centers, and cooperative efforts helped provide counselors and disseminate information to veterans at separation centers and through the Department of Defense. In the 1980s there was a concentration on job assistance and training.[294]

The Veteran's Administration was reorganized and as the U.S. Department of Veterans Affairs (VA) in 1989, when it was raised to a cabinet level agency. In 1995 the VA hospitals were grouped into 22 Veterans Integrated Service Networks to expand primary care, shift from inpatient to outpatient care, and measure treatment performance and outcomes. The mission of the VA is to administer benefits, health services, pensions, scholarships, home loans, insurance and burial services for veterans nationwide.

To be eligible for federal long term care services through the VA a veteran must first be enrolled in the VA health care system. Once they are enrolled and apply, eligibility is based on several factors, including the need for ongoing treatment or care; availability of local services; service connected disability status; financial eligibility; ability to pay; and insurance coverage. Long term care services, available through the VA include services and supports in the community, including home health aides; homemaker services; respite and adult day services; aid and attendance; in addition to the facility based care options available.[295]

Long Term Care Community Living Centers are a relatively new concept for the VA, but inroads are being made to provide services within the community for veterans with service connected disabilities. Veterans with a service connected disability that medically requires care are given first priority for nursing homes. When federal facilities are not reasonably available at the time of need, or an emergency event, but the veteran must have received treatment within the last 24 months, the community option is available but not the standard.[296] The Veterans Community Living Program is a pilot project available to veterans at risk of nursing home placements to help with HCBS and enable older and disabled veterans to remain in their homes. Services include housekeeping, meals and personal care assistance. In collaboration with local AAAs, who provide care planning and needs assessments or by a self-directed care model, which allows veterans to receive a budget they can use to hire and manage their own caregivers. They can choose to hire family or friends to provide services and supports, and have a flexible budget to match what best meets their needs. Veterans currently receiving care through a VA Health Center, and meet program eligibility rules, may qualify.[297]

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[294] Id., pgs. 9-16, 19.

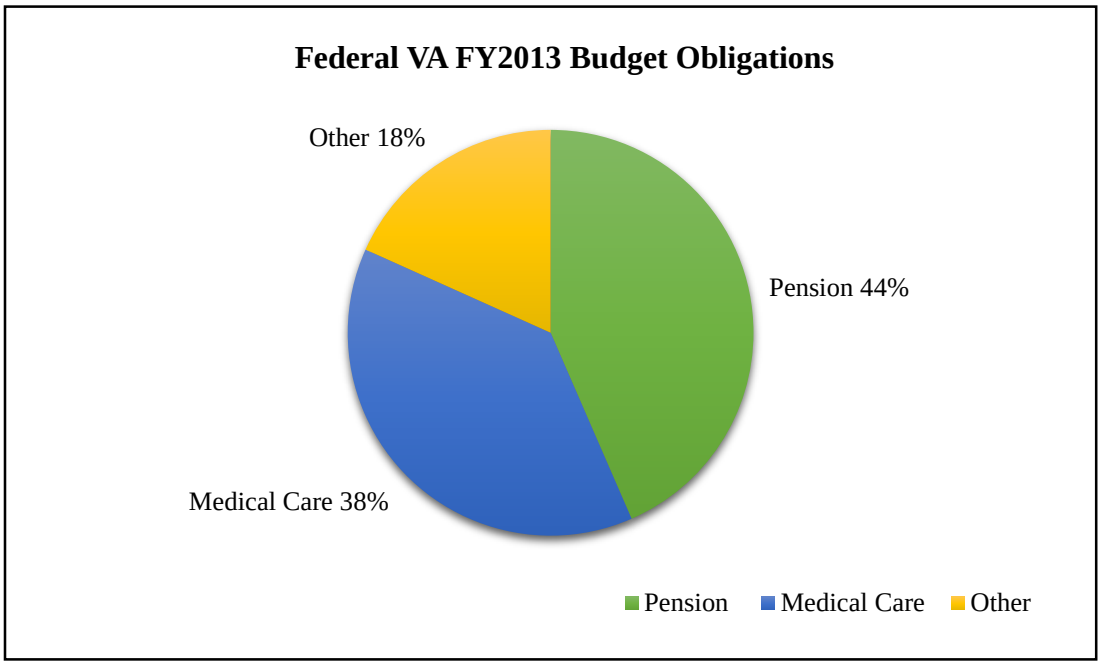
[295] VA, "Explore Long Term Care Services – Just in Case," http://www.pittsburgh.va.gov/PITTSBURGH/features/long-term-care.asp.

[296] The American Legion, "Long Term Care," http://www.legion.org/veteranshealthcare/longterm.

[297] Area Agency on Aging 1-B, "Veterans Community Living Program," http://www.aaa1b.com/caregiver-resources/community-living-programs/veterans-community-living-program.

Federal Funding

In 2013, the VA operated over 1500 facilities to serve the veteran population, including 151 medical centers, 300 veteran centers many of which include nursing home components, 825 outpatient clinics, 135 community living centers and 103 residential rehabilitation centers nationwide. Its budget was $149.6 billion and it employs 337,000 people. The majority of funding in FY 2013 was split 43.4 percent towards pensions, 38.2 percent towards medical care, and 18.3 percent towards educational training, housing, et. al.[298] It is important to note that the VA has 100,000 volunteers contributing over 13 million hours of service annually in their local communities.[299] According to the geographic expenditures, Pennsylvania is seventh in total federal expenditures among the states, sixth in medical care expenses funding and eighth in pensions.[300]



While funding for the VA has risen from $59.8 billion in FY2003, all this has taken place while the number of veterans has fallen 12.7 percent in the U.S and 19.2 percent in Pennsylvania. The Commonwealth has seen its total number of veterans rise from fifth to fourth largest among the states, and it's total of unique patients has also risen to fourth, however, despite this demographic rise the state rank in federal dollars it receives has fallen several places in all funding categories across the board.[301] These decreases are significant in Pennsylvania, but the rising costs to provide that care are reflective of the entire healthcare system, along with the unique needs of the veteran population. It was not possible, from the data, to extract specific information on aging veterans.

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[298] VA, National Center for Veterans Analysis and Statistics, 2013.
[299] VA, "VA History in Brief," pg. 36, http://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf.
[300] VA, National Center for Veterans Analysis and Statistics, "FY13 Geographic Distribution of VA Expenditures," September 30, 2013, http://www.va.gov/vetdata/expenditures.asp.
[301] VA, National Center for Veterans Analysis and Statistics, "Geographic Distribution of VA Expenditures For FY 2003," September 30, 2003, http://www.va.gov/vetdata/expenditures.asp.

State Services and Supports for Veterans

Headed by a Deputy Adjutant General for Veterans Affairs the deputate is organized into two Bureaus, Veterans Homes and Veterans Programs, Initiatives, Reintegration and Outreach. The Division of Outreach and Reintegration assists veterans who are initiating and processing benefits, pension or other claims, and administers awareness and outreach efforts to promote new ways for connecting veterans with services and supports. In addition to the uniformed complement, there are 2,700 Commonwealth employees and 3,600 full-time federal employees/Guard members. The Commonwealth also operates three field offices to provide outreach to veterans, in addition to working closely with federal VA services and each county's veteran's affairs directors.[302]

The DMVA administers support programs including Veterans Trust Fund, Veterans Education Gratuity, provides Disabled American Veterans transportation, blind and paralyzed veterans pensions, veterans real estate tax exemptions, Persian Gulf war bonuses, veterans outreach, awareness and reintegration programs to name a few. The Military Relief Assistance Program provides grants to service members and their families who have a direct and immediate financial need resulting from military service. Each program can have different eligibility criteria, income limits, or determinations of need to qualify for a whole or partial benefit.

The Governor's Advisory Council on Veterans Affairs, created by Executive Order 2013-3, is another effort to enhance veteran's services and increase accessibility to benefits. Designed to promote interagency cooperation, the initiative fosters collaboration "to increase information sharing, ensure program fidelity, coordinate complementary programs and facilitate meaningful enhancements in service accessibility…." Bringing together 17 cabinet level agencies to assess and review state veterans' programs will allow a continued discussion on issues ranging from healthcare, employment, education, specialized services and long term care.[303]

The DMVA is constantly evaluating its delivery of care to consider cost saving measures through operational modifications or efficiencies. The DMVA provides competitive organizational grants to veteran's service and non-profit organizations for programs and projects to support veterans and their families, including respite care and women veterans outreach. County director's grants help to establish and expand new and innovative programs such as healthcare enrollment initiatives or enhanced veterans outreach. These programs, through a series of grants, help treat post-traumatic stress, promote civic duty and provide valuable services in the community for a targeted, but minimal cost.

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[302] In 2009, Pennsylvania closed the Governor's Veterans Outreach and Assistance Centers, which had offices in Boyertown, Erie, Greensburg, Harrisburg and West Pittston. The centers were in operation since 1980 and helped connect veterans with pension and healthcare services and helped veterans navigate the system through applications assistance, not referrals. Their funding of $900,000 was redirected to the Career Link program.

[303] Governor's Advisory Council on Veterans Affairs, "A consolidated listing of programs, benefits and services for Veterans and their Families in the Commonwealth of Pennsylvania," http://www.milvet.state.pa.us/DMVA/Docs_BVA/gacvs_brochure.pdf; Executive Order 2013-03, "Governor's Advisory Council on Veterans Affairs," November 11, 2013.

State Veterans Homes[304]

Arguably its most important function, and one directly relating to long term care is the operation of six extended care facilities. The DMVA provides 1,562 beds that offers skilled nursing care, personal care services, domiciliary care and dementia care. Applicants for state homes may be a veteran, spouse or a surviving spouse, and eligibility requirements include: and honorable discharge from military service; a current Commonwealth resident or a resident at their time of entry into the service; must not have a cognitive or health condition that poses a threat to other residents; and admission is on a first come, first serve basis.[305] Residents are required to make monthly payments against maintenance fee liability, based on their ability to pay. There are currently no state DMVA waiver options for HCBS.

The facilities are licensed by both the Department of Health (nursing homes) and the Department of Public Welfare (personal care homes), and are certified by the U.S. Department of Veterans Affairs. Each home is served by an Advisory Council of 15 members selected by the Governor, and one each by the President of the Senate, Speaker of the House and by the residents. These councils meet quarterly to advise the Adjutant General in the management, operation and services within each respective home. Services provided to resident veterans and their spouses who are disabled, indigent or in need of care can include: medical and nursing care; rehabilitative services; social services; personal care; financial management; medication assistance; and nutritional therapy.[306] The goal of the facilities is to provide high quality, individualized care for all residents. The homes strive to maintain a high level of occupancy and cost-effectiveness, with a goal of 95 percent. Details on each state home, including occupancy levels, are listed in more detail below.

Delaware Valley Veterans Home

Located in northeast Philadelphia, this most recent addition to the state home system was opened in November 2002. The home is licensed to provide 171 beds, including 100 nursing care, 41 personal care and 30 dementia/Alzheimer's beds. The occupancy rate for the combined 130 nursing beds was 99 percent and its personal care home was at 100 percent capacity.

Geno Merli State Veterans Center

This Scranton based home, built on the site of the former Scranton General Hospital in Lackawanna County, was completed in 1993 and provides 196 beds to serve 160 veterans in nursing

[304] The data reported in each State Veterans Home is available from a variety of sources, including the Dept. of Health (nursing homes) and Dept. of Public Welfare (personal care homes). The Governor's Executive Budget presentation also contains a Veterans Home census. These numbers, of course, differ slightly due to the dates when the homes were surveyed, as well as the presentation of data on occupancy numbers, percentage of capacity, and the inclusion of data on dementia care units with nursing homes and domiciliary care with personal care homes. To be consistent, the data used in this section was provided to the JSGC from the DMVA on April 17, 2014. The information presented is based on their data listing "authorized beds," which may not exactly match the Department of Health's licensed beds capacity.

[305] Gino J. Merli Veterans Center, "Eligibility Requirements," http://www.portal.state.pa.us/portal/server.pt/community/gino_j__merli_veterans_center/11381/eligibility_requirements/576778.

[306] Gino J. Merli Veterans Center, "Description," http://www.portal.state.pa.us/portal/server.pt/community/gino_j__merli_veterans_center/11381/gmvc_description/576514.

care, 20 with dementia and 16 in personal care.[307] The total occupancy rate was 98 percent for nursing and 81 percent in personal care.

Hollidaysburg Veterans Home

Established in 1976, the Hollidaysburg home, in Blair County, is the largest in the state system at 514 licensed beds. Its totals include the ability to serve 321 in nursing care, 101 personal care, 66 domiciliary care and 26 with dementia. A total of 89 percent of its 347 licensed nursing facility beds were occupied, and 92 percent of its combined 167 personal care beds.

Soldiers and Sailors Home

The oldest home in the state system, Soldiers and Sailors Home was established in Erie in 1885. Its licensed capacity is 207 beds to serve 75 in nursing care, 80 in personal care, 20 domiciliary care and 32 with dementia. This facility's nursing home rate was the highest in the state system, showing 99 percent of its 107 beds occupied, with 86 percent of its personal care home beds being utilized concurrently.

Southeastern Veterans Center

Located in Spring City, on the Chester/Montgomery County line, this home was established in 1986 to serve 192 residents in 160 nursing care beds and 32 dementia. A 120 bed addition was completed in 2012. Those additional beds were not reflected on their licensure totals in the 2012 nursing home survey that show 98 percent of its beds occupied. Due to construction, the personal care home was not occupied during 2012 resulting in a zero total in the 54 bed unit.

Southwestern Veterans Center

Dedicated in 1997, this Pittsburgh based home provides 236 beds for 160 nursing, 32 personal care and 44 dementia. The facility was at 99 percent capacity in nursing and personal care home at 100 percent.

Type of Care Provided at State Veterans Home	2003	2012
Nursing	1,062	1,309
Dementia	192	226
Personal Care	349	366
Domiciliary Care	75	24
Totals	1,678	1,925

When the assigned beds and new admissions are combined, the number of veterans served each year reflects the level of capacity the State Veterans Homes are providing to veterans and their families across the Commonwealth.

[307] The use of 16 personal care beds has or will be discontinued but is still counted as of 2013 and their licensed total is still included in the 2012 census.

Veterans Homes in Pennsylvania consistently try to maintain a level of near capacity to not only serve the maximum number of veterans but a sustained census also maximizes federal reimbursement revenues and maintenance fees to balance the state funding obligation. Throughout the country there are 146 State Veterans Homes that had a total occupancy rate of 89 percent in 2012, with the highest percentage of 93 percent in nursing and dementia care followed by 77 percent for personal care and domiciliary care homes.[308] Pennsylvania has been shown to be on par with that average. Overall capacity for State Veterans Nursing Homes in FY2012 was 1,160 nursing home residents that were 91 percent occupied, and for personal care components is 356 residents for 70 percent. The total number of veterans served when viewing assigned beds and admissions, has grown from 1,678 in 2003 to 1,925 a decade later, with the most significant growth in nursing care, rising 18 percent. The number of individuals served in personal care side actually dropped, but that is due, in part, to ongoing renovations to the Southeastern Veterans Home. The DMVA is constantly evaluating its need for additional capacity, seeking to balance the need with its offerings and budget capabilities.

The admission rate at veterans nursing homes at 37 percent was significantly lower than nursing homes, which saw a 213 percent turnover. It is also worthy to note that State Veterans Homes have a mix that sees it serve an 82 percent male population, while private nursing homes serve a population that is only 31 percent male.[309] No data was available to compare personal care home turnover and sex ratio, or average length of stay at either type of residential facility.

State Funding

The funding breakdown across all budget categories has shifted significantly towards the federal government. Those numbers have continued a trend over the last decade that has seen Pennsylvania's spending levels on its State Homes growing from all sources, with the largest portion in enhanced veteran reimbursements from the federal government. FY2003-2004 funding was divided 60 percent by the state, and 20 percent each from the federal government and fees. That year saw the VA reimbursement for residents in state personal and domiciliary care $27.44 and nursing homes $59.36 per day. In FY2012-2013, state funding dropped to 49 percent, federal now paid 35 percent and fees made up the remaining 16 percent. The reimbursements in 2012 had risen to $41.90 and $97.07, respectively.[310]

Overall expenditures for the State Veterans Homes in the FY 2013-2014 budget were $178.882 million, with 46 percent coming from state funds, 38 percent from federal funds and resident fees estate collections and other misc. revenue account for the remaining 16 percent.[311] While overall funding has grown by $52 million, the state has seen its federal reimbursement rise 148 percent compared to a 20 percent rise in total fees and estate collections, while its own cost share have risen a modest 18 percent.[312]

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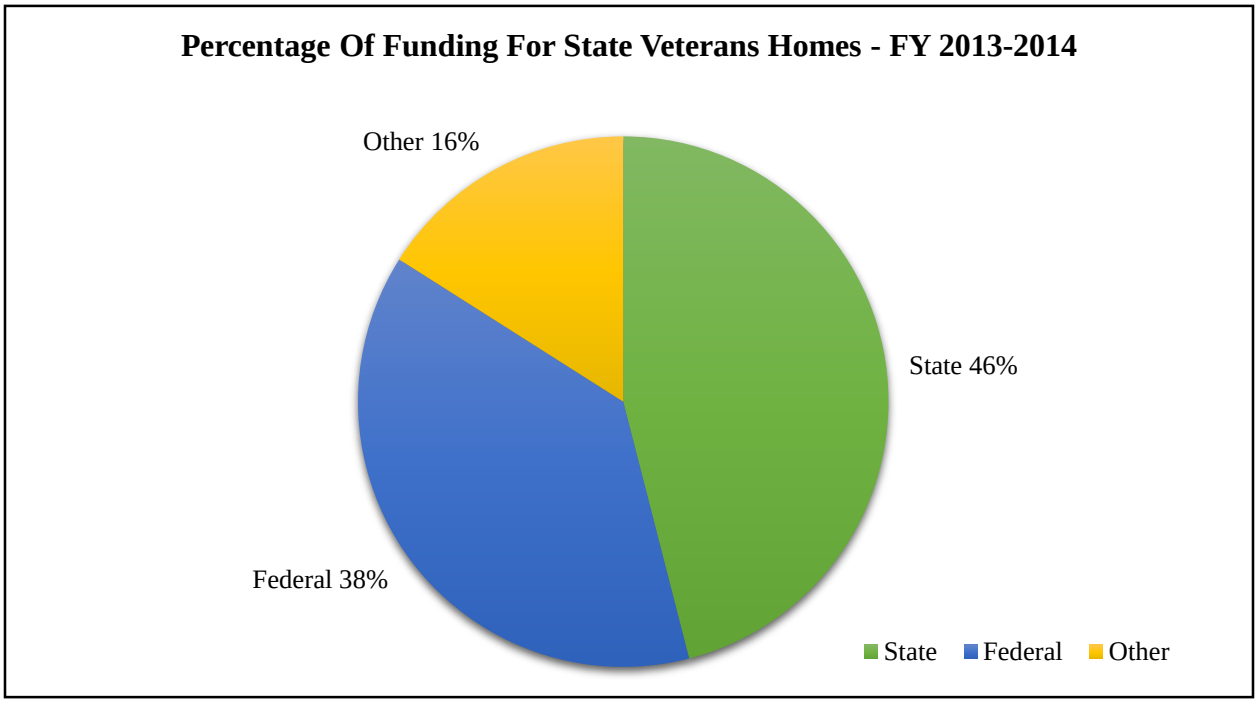
[308] DMVA, "Benefits & Services for Veterans and Their Beneficiaries in Pennsylvania," March 2011, http://www.milvet.state.pa.us/DMVA/Docs_BVA/dmvastatebenefits.pdf; Pennsylvania National Guard PowerPoint on mobilization, deployments, services and funding as of 23 August 2013.
[309] Data provided from DMVA and Dept. of Health Nursing Home Survey.
[310] Financial data provided to the JSGC from the DMVA on April 17, 2014.
[311] Commonwealth of Pennsylvania, "FY2014-15 Summary of Governor's Executive Budget, "Pennsylvania Department of Military and Veterans Affairs," Budget Hearing Presentation, February 2014.
[312] Financial data provided to the JSGC from the DMVA on April 17, 2014.

State Veterans Homes provided 266,186 patient VA days to residents, but facilities also billed for Medicaid, had some who self-paid and a few days that were covered by private insurance. In addition to those veterans served in state homes, data from the 2012 state nursing home survey shows that 82 private facilities in 55 counties around the Commonwealth provided 74,700 VA patient days to veterans. Including the days spent in state homes, the 340,000 days equals only 1.1 percent of the total 29 million plus nursing homes days accounted for in the state, the lowest payment category behind Medicaid, self-pay, Medicare and private insurance. The receipt of Medicare, Medicaid and third part revenue supplements the cost of providing a high level of care that addressed acuity of care needs at state owned facilities. State Veterans Homes do not accept Medicare Part A that covers skilled care as most residents are transferred in from other nursing homes after the three-month window of payment. They do, however, bill for Medicare Part B that covers physician and other health provider services.



Local Services

Each of Pennsylvania's 67 counties offer veterans affairs services, which provide a local resource for veterans and their families, advocate on their behalf and provide them with assistance to access the benefits to which they are entitled to at the county, state and federal levels. Awareness and education is a big part of their mission as many veterans are unaware of the benefits to which they are entitled. The HR 255 advisory committee heard from local directors who have explored outreach through nursing homes and retirement facilities, colleges and through healthcare professionals like visiting nurses, social workers, care transition coordinators as well as health and job fairs and other public officials.

In 2013, a new law was enacted that requires each veteran's affairs director to attain and maintain accreditation by the DMVA, through a statewide training program. This effort was supported by the counties and enhances the relationships that already exist, through training and services. The goal

was to standardize many functions already being performed by the veteran's affairs directors, including: serving as the local liaison between DMVA and the Commonwealth's veterans; advising veterans of their benefits; and assist veterans with forms and paperwork when applying for benefits. Upon their appointment as a county director of veteran's affairs by the respective governing body, the person shall have one year to complete the required training and certification. Annual training and refreshers are required and a five year recertification is necessary to maintain office accreditation.[313]

Volunteers and local "chartered" veteran's service agencies also provide supports, advocacy and are an additional network to connect veterans with services and benefits. The American Legion, Veterans of Foreign Wars, Disabled American Veterans, to name a few, provide resources and volunteers to help prepare, present and even prosecute claims for benefits of eligible veterans and their families.[314] Groups such as schools, boy scouts, religious and other civic, community and business organizations often engage veterans and their families to provide services and supports through volunteers, counseling and mentoring programs in conjunction with veterans groups at state and VA facilities.[315]

Conclusions

Serving veterans in the Commonwealth is a growing need, and while the overall numbers are not similar in size and scope to the total aging demographic, services are being stretched and wait times for services and entry into veterans homes are a reality. Just like Alzheimer's and related disorders, veterans require special care and services for ageing veterans include both physical and emotional needs. Veterans are more likely to suffer from post-traumatic stress disorder, have other traumatic injuries or service related disabilities and suffer high instances of homelessness, depression and unemployment. The state has great resources in its veteran's homes that provide outstanding care, and works collaboratively with each county's director of veteran's affairs to promote awareness and provide assistance to veterans seeking to connect with benefits for which they are eligible. There have been discussions over the last several years evaluating the need to build an additional veterans home in the state, however, it remains in the concept stage as DMVA officials continue to evaluate the balance between available services and demand.

Protection from pension poaching abuse is a topic that was addressed during the HR 255 informational sessions and laws need to be strengthened. Unscrupulous financial planners, insurance agents and other organizations can charge money to assist with processing a veteran's claim and in some cases, convince elder veterans to pay upfront costs or take a percentage of the benefit.[316] HCBS for veterans also need to be expanded where it can be provided in a safe setting that meets the veterans choice, health care and support needs. Home care services can provide additional efficiencies, potential

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[313] Act of May 15, 2013, P.L. 23, No. 5, amended Title 51, Military Affairs, to add §1731 on Accreditation to the subchapter on County Directors of Veterans Affairs.

[314] Veterans of Foreign Wars, "National Military Services," http://www.vfw.org/Assistance/National-Military-Services/.

[315] Pennsylvania Small Business Development Council, "Veterans' Entrepreneurship Programs," http://pasbdc.org/services/targeted/veteran-business; Pennsylvania Military Family Relief Assistance Program. http://www.milvet.state.pa.us/DMVA/Docs_AllMil/MFRAP/MFRAP_BROCHURE.pdf.

[316] VA, "Don't Be A Victim: Be Aware of Pension Poaching Scams," http://benefits.va.gov/PENSION/Pension PoachingPostcard.pdf.

cost savings and access to services outside of the traditional veteran's home settings. By allowing VA costs to be used in a waiver like approach to care, additional veterans can be served through both the VA and DMVA, and both agencies should explore a HCBS expansion. HCBS need to be expanded beyond the Community Living Center options.

Recent federal legislation, in the wake of the VA scandal of 2014, would take several steps to expand a veterans access to medical care. The bill addresses wait times in allowing those veterans, unable to get an appointment within 14 days, with the option of seeking care from private sector providers. The bill also allows veterans who reside more than 40 miles from a VA facility or community outpatient clinic to receive care through private, non-VA providers as well. Federally approved providers would need to participate in Tricare or Medicare programs, through qualifying private doctors or federally qualified health centers.[317]

The system to get benefits may not be streamlined, but the network that assists veterans to apply for pensions, services and supports is focused and statewide. Awareness and education to connect a veteran to that network and help them understand what they may be eligible for presents a continuing challenge, as it does across all efforts for long term care planning. Opportunities exist to for partnerships with local AAAs in an effort to expand that network and allow case managers social workers and others, through initial assessments at the point of application or care transition, to help identify and connect veterans with clinical, service and financial options. By casting a wider net there is less likelihood that veterans will fall between the cracks, and integrating AAAs and veterans care will help strengthen services and supports for aging veterans.

[317] Ivey DeJesus, *Pennlive.com*, "Rare bipartisanship: Senators Pat Toomey and Bob Casey vote in favor of VA reform bill," June 11, 2014, http://www.pennlive.com/midstate/index.ssf/2014/06/veterans_affairs_legislation _b.html.

Combined Availability of Veterans Services, by County, in Pennsylvania[318]

2012	Total Population	Veterans Population	Homes	Capacity	Occupied	Facilities	In-Patient	Total Beds	Nursing Homes/ Community Living Center Beds
	Demographics		State Veterans Homes			VA Facilities			
Pennsylvania Totals	**12,764,475**	**980,529**	**6**	**1562**	**1437**	**55**	**9**	**2030**	**850**
Adams	101,610	9,481	0	0	0	0	0	0	0
Allegheny	1,229,912	96,393	1	236	235	7	2	582	262
Armstrong	68,367	6,456	0	0	0	1	0	0	0
Beaver	170,274	17,846	0	0	0	1	0	0	0
Bedford	49,354	4,224	0	0	0	0	0	0	0
Berks	412,948	29,517	0	0	0	1	0	0	0
Blair	127,004	12,705	1	514	463	1	1	68	40
Bradford	62,800	6,210	0	0	0	1	0	0	0
Bucks	626,377	44,888	0	0	0	1	0	0	0
Butler	185,084	15,517	0	0	0	2	1	126	60
Cambria	141,541	14,232	0	0	0	1	0	0	0
Cameron	4,948	624	0	0	0	0	0	0	0
Carbon	65,016	6,670	0	0	0	0	0	0	0
Centre	155,100	9,505	0	0	0	1	0	0	0
Chester	506,190	31,600	1	192	188	3	1	475	169
Clarion	39,459	3,683	0	0	0	1	0	0	0
Clearfield	81,494	7,384	0	0	0	2	0	0	0
Clinton	39,738	3,689	0	0	0	0	0	0	0
Columbia	66,852	5,752	0	0	0	1	0	0	0
Crawford	87,687	8,432	0	0	0	1	0	0	0
Cumberland	239,164	21,607	0	0	0	1	0	0	0
Dauphin	269,797	22,804	0	0	0	1	0	0	0
Delaware	560,699	36,617	0	0	0	0	0	0	0
Elk	31,648	3,076	0	0	0	0	0	0	0
Erie	280,823	22,242	1	207	192	2	1	78	0
Fayette	135,668	12,545	0	0	0	1	0	0	0
Forest	7,659	680	0	0	0	0	0	0	0
Franklin	151,372	13,602	0	0	0	0	0	0	0
Fulton	14,748	1,348	0	0	0	0	0	0	0
Greene	38,088	3,801	0	0	0	0	0	0	0
Huntingdon	45,888	4,385	0	0	0	0	0	0	0

[318] Demographic data from Pennsylvania State Data Center, "Annual Estimates of the Resident Population for Selected Age Groups, Pennsylvania Counties: 2012," from U.S. Census Bureau 2012 Population Estimates; Facility data from the DMVA and the VA. VA facilities, for the purpose of this chart, include veterans centers, community service programs, community out-patient clinics, and medical centers within Pennsylvania. Of the nine in-patient facilities, beds include acute, hospice, community living, and short and long term stay nursing home.

2012	Total Population	Veterans Population	Homes	Capacity	Occupied	Facilities	In-Patient	Total Beds	Nursing Homes/ Community Living Center Beds
	Demographics		State Veterans Homes			VA Facilities			
Indiana	88,143	6,922	0	0	0	0	0	0	0
Jefferson	44,857	4,029	0	0	0	0	0	0	0
Juniata	24,913	1,814	0	0	0	0	0	0	0
Lackawanna	214,428	17,412	1	196	189	1	0	0	0
Lancaster	526,436	36,703	0	0	0	2	0	0	0
Lawrence	89,766	7,595	0	0	0	0	0	0	0
Lebanon	135,406	12,104	0	0	0	1	1	248	79
Lehigh	354,746	24,870	0	0	0	0	0	0	0
Luzerne	321,423	28,108	0	0	0	1	1	173	105
Lycoming	117,317	11,365	0	0	0	2	0	0	0
McKean	43,254	4,455	0	0	0	1	0	0	0
Mercer	115,629	10,456	0	0	0	1	0	0	0
Mifflin	46,790	4,390	0	0	0	0	0	0	0
Monroe	168,436	13,237	0	0	0	1	0	0	0
Montgomery	808,946	50,773	0	0	0	3	0	0	0
Montour	18,490	1,512	0	0	0	0	0	0	0
Northampton	299,371	23,320	0	0	0	0	0	0	0
Northumberland	94,560	9,084	0	0	0	0	0	0	0
Perry	45,724	4,204	0	0	0	0	0	0	0
Philadelphia	1,548,647	77,224	1	171	170	4	1	280	135
Pike	56,782	5,837	0	0	0	0	0	0	0
Potter	17,635	1,767	0	0	0	0	0	0	0
Schuylkill	147,372	14,479	0	0	0	2	0	0	0
Snyder	39,751	2,728	0	0	0	0	0	0	0
Somerset	77,115	6,783	0	0	0	0	0	0	0
Sullivan	6,437	836	0	0	0	0	0	0	0
Susquehanna	42,683	3,997	0	0	0	0	0	0	0
Tioga	42,595	4,416	0	0	0	1	0	0	0
Union	45,021	3,533	0	0	0	0	0	0	0
Venango	54,283	5,548	0	0	0	1	0	0	0
Warren	41,188	4,376	0	0	0	1	0	0	0
Washington	208,451	18,698	0	0	0	1	0	0	0
Wayne	51,734	4,949	0	0	0	0	0	0	0
Westmoreland	363,233	34,990	0	0	0	1	0	0	0
Wyoming	28,193	2,527	0	0	0	0	0	0	0
York	437,411	37,981	0	0	0	1	0	0	0

ADDITIONAL LONG TERM CARE SERVICES

There are many aspects of Long Term Care, primarily in community and support services, that are not provided by the five main departments involved in this study. While these programs and agencies have not been a major focus of this report, they are still important to mention as each contribution, however small, helps provide a more comprehensive set of services to serve seniors in the Commonwealth, many of whom have specific needs. Primarily focused on helping seniors maintain their independence and remaining in the setting of their choice, the services are provided across state agencies other than the main five agencies involved in this study. The programs described in this section provide many special benefits, discounts and other services, which bring resources to bear that help keep older Pennsylvanians healthy, active and social as they age.

Family Caregiving

Caregiving is something that is often done by families or friends, who provide a level of important supports for common daily needs but this casual care makes it all the more difficult to assess and equate this level of home and community based services to other similar services provided through a home health agency. Family caregiver services are primarily uncompensated care, while other HCBS receive support through a mix of federal and state dollars available through waiver programs. Pennsylvania Lottery funds, available through PDA, have a family caregiver support program which requires a cost share for eligible recipients. Family caregiving provides no mechanism to track the consumer or caregiver. The primary caregiver often provides hands on care while other secondary caregivers may provide support financially and to a lesser degree physical care. Despite the toll in can take on a caregiver, many family members feel it is their "duty" to render help to a parent or loved one, and willingly take on this responsibility.

Community supports provide a family like care network of services that can include friends, neighbors, religious, non-profits or other community service groups. In 2010 the ratio of adult children ages 45 to 64, who are most likely to care for those age 80 plus, in their high risk years of need, was 7 to 1. In 2030 that will fall to 4 to 1 as baby boomers age.[319] This is a crucial area of need, is often undocumented and overlooked but is the topic of a few studies and reports that have attempted to develop accurate projections and ratios in a system devoid of strong statistics. Providing care to a parent is something an overwhelming majority of Americans would feel obligated to, but the mentality is often one where the word caregiver does not enter into the context…they are only a wife, son, grandchild, niece, friend or neighbor.

[319] Donald Redfoot, Lynn Feinberg, and Ari Houser, AARP Public Policy Institute, "The Aging Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers," August 2013, http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf.

First hand testimony, empirical evidence and surveys have brought this reality to life as there is an increasing reliance on family caregiving. This is currently undervalued by planners and policy makers, which does not bode well for a future that will see fewer people to provide that care. At the same time the role of the family caregiver is expanding as the rebalancing efforts to shift from facility to HCBS. Burdens are likely to increase from coordinating care and household chores to providing minor medical, personal care and for longer periods. All this may come without corresponding increases in support services to deal with the financial hardships, emotional strain, increased physical work and competing demands of the caregiver's family and work.[320] Relying heavily on caregivers and a corresponding lack of supports can cause them to damage their own health and well-being. Nationwide, costs for long term care average 84 percent of median income, so while home care is generally more affordable that nursing facilities, many consumers still cannot sustain those costs on their own.[321]

According to a Genworth survey the average caregiver is 49 years of age, the average care recipient is 71 and the weekly time spent providing care is 21 hours. The vast majority of all those providing care, over 75 percent, are providing care to a spouse, parent or grandparent. Some are still in the workforce, causing missed work, fewer hours worked, loss of vacation and/or sick time, lost wages and missed job advancement opportunities. Caregiving can have side effects from depression, sleep deprivation, increased stress, negative impacts on their own family relationships or personal health, increased feelings of isolation and costs incurred by providing care, making purchases and running errands.[322] Caregiving can often start as informal, with family or friends providing transportation, supervision, performing household chores and companionship. It can evolve into a larger commitment and the need for adult day services, respite care, with the help of or eventual need for specialized caregivers to assist family members. In some cases, caregivers may move the care recipient into their home, or move into the home of the care recipient.

There is a movement towards person or family centered care that promotes an individual's needs and values in a choice based setting. Both the person and caregivers are integral parts of the care team and mutual decision makers in delivering LTSS. Caregivers monitor chronic conditions, manage medications, and communicate with health professionals in addition to arranging, coordinating, supervising or providing care. If applicable, they can help implement care plans, manage transitions from hospital or facility care to the home or make sure special needs like dementia care are addressed through advocacy and intervention. Consumer directed services are often an option for many older adults that allow them to manage a personal care budget and hire their own caregivers, including family.[323] These consumer focused initiatives run parallel to dollar follow the person, self-directed care and increased waiver funding to rebalance home and facility based care.

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[320] Donald Redfoot, "The Aging Baby Boom and the Growing Care Gap," August 2013, www.aarp.org/content/dam/research/public_policy_institute/ltc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf.

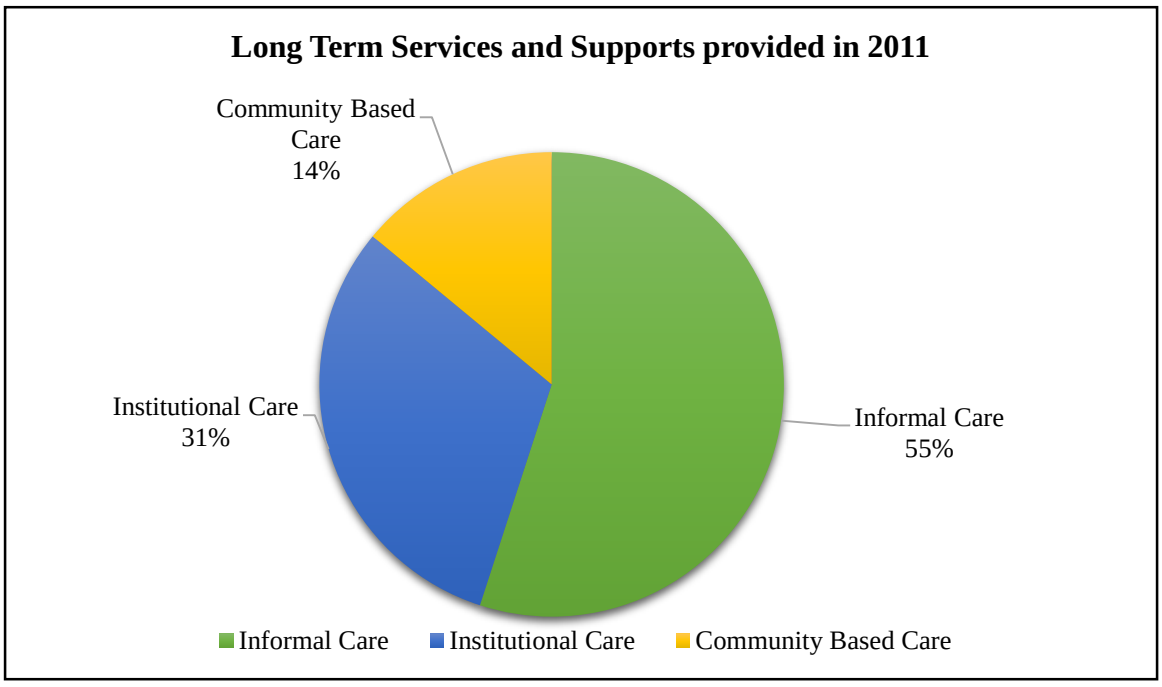
[321] S. C. Reinhard, E. Kassner, A. Houser, K. Ujvari, R. Mollica, and L. Hendrickson, "Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers," AARP, The Commonwealth Fund, and The SCAN Foundation, June 2014, http://www.longtermscorecard.org/~/link.aspx?_id=DCD2C261D26D414C971D574D577A78FE&_z=z.

[322] Genworth Financial, Inc., "A Way forward: Highlights from Beyond Dollars 2013," October 9, 2013.

[323] Lynn Feinberg, Susan Reinhard, Ari Houser, and Rita Choula," AARP Public Policy Institute, "Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving," 2011, http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf.

In its update to the Older Americans Act in 2000, the federal government provided some support to states through the National Family Caregiver Support Program. The program provides grants to states based on their share of the population ages 70 and over to help alleviate the "emotional, physical and financial toll" that many caregivers endure. Pennsylvania participates in the national program, in addition to the lottery funded state initiative, and according to the PDA was one of the first states to implement a caregiver support program. The federal government provided $145.5 million for this program in FY2013, as part of a $1.6 billion community living budget.[324] According to various estimates, the number of family caregivers in Pennsylvania has risen from an estimated 1.2 million in 2004 to 2.7 million in 2009. Those individuals are now providing 1.7 billion hours of uncompensated care worth $20 billion dollars in the state.[325]

The Congressional Budget Office, based on an actuary provided by CMS, conducted a review on the economic value of long term care services in 2011. The total value of long term care provided in the United States in 2011 was directed to 14 percent or $56 billion for community based care, including adult day services, facilities other than nursing homes, and assisted services provided in all other settings, including private homes. Institutional care provided in skilled nursing facilities and nursing homes located in CCRC's was 31 percent or $134 billion. Informal care provided by family and close friends, accounted for 55 percent of all long term care for an economic value of $234 billion.[326]



[324] U.S. Dept. of Health and Human Services, Administration on Aging, "National Family Caregiver Support Program," http://www.aoa.gov/ aoa_programs/hcltc/caregiver/index.aspx; U.S. Dept. of Health and Human Services, Admin for Community Living, "Final FY 2013 ACL Funding Budget Information," http://www.acl.gov/ About_ACL/Budget/ACLFundingBudget2013.aspx.

[325] NCSL, "Family Caregiver Support: State Facts at a Glance," 2006; Lynn Feinberg, Susan Reinhard, Ari Houser, and Rita Choula, AARP Public Policy Institute, "Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving," 2011, http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf.

[326] Congress of the United States, Congressional Budget Office, "Rising Demand for Long-term Services and Supports for Elderly People," June 2013, pg. 9.

Aging at home options provide needed choice to seniors, and is a mechanism that can effectively control cost for care, however, it is not always the answer and there are many of important considerations to determine if a home is age friendly and an individual is able to live independently, or remain at home with the proper services and supports. Most seniors want to live at home as long as they are able, but living a long and productive life at home may require the home to be secure, comfortable, functional and manageable to maintain a longer independence. The advisory committee heard from consumers and family members about their desire to remain in their own homes and surveys and reports also point to this popular opinion. Choice is important but residential facilities also meet the needs of many seniors. CCRC's are an increasingly popular model for aging in place, and many nursing homes are improving their appearance to feel more like home and less like a hospital. Being responsive to consumer demand is an important driver in admissions and activities, social services and cultural offerings are attractive to seniors across the state.

Many people cannot maintain their homes or afford age friendly upgrades like lifts up stairs, railings and handles in the toilet and shower, wide doorways for walkers or wheel chairs and safety in lifting and bending in the laundry and kitchen. Seniors who can no longer drive and do not live within easy access to transportation services, face serious challenges to maintain their independence and may rely on others for rides to doctor appointments, the pharmacy, grocery store or church. Managing chronic illnesses would be difficult without access to the people and places you love and those which provide support. Shut-ins are often referenced as targets to religious or service groups. Those who require a level of attention higher than can be provided at home, even though a qualified, in-home caregiver makes those who are the frailest and seriously disabled not the best candidates to remain in their homes.[327]

The state supports families through a number of specific initiatives which only scratch the surface of those in need of support. The Pennsylvania Caregiver Support Program is available through AAAs who assess needs of the caregiver training, reimbursement for supplies or referrals to other services. One of those services is respite care, which is growing in need to as families take on greater roles in caring for functional disabilities or in cases of Alzheimer's and dementia. This short term, temporary relief for caregivers as an option to help support families and forestall the need for more permanent care settings. Adult Day Services are an alternative for caregivers who are still active in the workforce and provides supervised and structured services ranging from therapy to meals. Respite and Adult Day are provided on a fee-for service basis, and Family Caregiver Support receives lottery funding. These programs are all designed to ease the burden on primary caregivers but acknowledge the need for wider availability, increased awareness and greater coordination of services and with other support service networks.

While most people, including advisory committee members and JSGC staff have been exposed to or in some cases have provided family caregiving, it was surprising to see the lack of resources expended on those caregivers while recognizing the toll it often takes. This key group is underestimated, and is only starting to get the recognition they deserve and the support they need. Connecting aging consumers with services is not a new concept but connecting caregivers with support is only scratches the surface among policy makers and health care professionals despite a decade or more of having services in place. Caregiver supports has undoubtedly taken a back seat to direct services but it will need to move to the forefront with continued rebalancing efforts and an increase in HCBS. If family care was

[327] Rachel Adelson, "When Aging at Home Isn't the Answer," The Third Metric, April 8, 2013.

not provided, the costs to the state and federal government could increase substantially, and recognizing the role of family caregiving is consistently cited as the key component of aging consumers remaining in their homes and in the community.

Senior Farmers Market Nutrition Program

The Senior Farmers Market Nutrition Program provides Pennsylvania seniors with fresh fruits and vegetables, locally grown produce and herbs, all unprepared, from approved farmers' markets within the Commonwealth. Farmers authorized to accept payments under this program must be growers and not exclusively retail or wholesale distributors, and there are currently 1,000 participating farmers at 800 farm stands and 190 farmers market throughout Pennsylvania. The program is funded by the state and is administered by the Department of Agriculture, Bureau of Food Distribution. The US Department of Agriculture provides funding to states who submit an application and approved plan. In 2014, $19.123 million will be distributed to states, with Pennsylvania's total estimated at $1.663 million, down slightly from prior years.[328]

To participate, seniors in Pennsylvania must be at least 60 years old, meet income eligibility based on 185 percent of the federal poverty income guidelines. All income including Social Security and all pension information, must be included and proof of age and residency is required. In 2014, income guidelines are $21,590 for one person, increasing by $7,511 for up to four people. Recipients receive the program by going to distribution sites, typically through the Area Agencies on Aging and senior centers within the counties where the seniors reside, and are provided with a list of participating farmers markets when they receive their checks. Each eligible recipient receives four $5 checks that can be redeemed at a qualified market or roadside stand. Seniors must sign a register when they receive the vouchers but home bound consumers can assign a person to collect and deliver their proxies.[329]

Pennsylvania Housing Finance Agency

The Pennsylvania Housing Finance Agency was created in 1959 to "promote the health, safety and welfare of the people of the Commonwealth by broadening the market for housing for persons and families of low and moderate income and alleviating shortages thereof, and by assisting in the provision of housing for elderly persons."[330] The PHFA was offered a seat on the advisory committee, but declined to participate in the HR 255 study.

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[328] U.S. Dept. of Agriculture, Food and Nutrition Service, "Senior Farmers' Market Nutrition Program," http://www.fns.usda.gov/sfmnp/senior-farmers-market-nutrition-program-sfmnp; Section 4231 of the Food, Conservation, and Energy Act (FCEA) of 2008 amends Section 4402 of the 2002 Farm Security and Rural Investment Act of 2002, to be codified at 7 U.S.C. Section 3007.

[329] Pennsylvania Dept. of Agriculture, "Farmers Market Nutrition Program (FMNP) & Seniors Farmers Market Nutrition Program (SFMNP)," http://www.agriculture.state.pa.us/portal/server.pt/gateway/PTARGS_6_2_75292_10297_0_43/AgWebsite/ProgramDetail.aspx?-Senior-Farmers-Market-Nutrition-Program-SFMNP&palid=17; Sunbury Daily Item, "Pennsylvania Farmers Market Nutrition Program Vouchers will be available for Northumberland County Senior Citizens on June 3," May 28, 2014, http://www.dailyitem.com/shikregion/x1396867979/Pennsylvania-Farmers-Market-Nutrition-Program-Vouchers-will-be-available-for-Northumberland-County-Senior-Citizens-on-June-2.

[330] Housing Finance Agency Law, Act of December 3, 1959, P.L. 1688, No. 621.

The mission statement of the Pennsylvania Housing Finance Agency is as follows: "In order to make the Commonwealth a better place to live while fostering community and economic development, the Pennsylvania Housing Finance Agency provides the capital for decent, safe, and affordable homes and apartments for older adults, persons of modest means, and those with special housing needs." Through a mix of grants and low interest loans the agency provides a number of homeownership programs, including mortgage assistance, rental housing development, urban and core community transformation and emergency mortgage assistance. Programs can benefit homeowners or developers who build in areas of specific need. Qualifications for homeowners are based on income and are typically 150 percent of the statewide median household income, and developers face strict, site specific eligibility guidelines. Funding comes from a variety of sources including program fees, investment income and the sale of the agencies securities. Many programs have the ability to impact senior populations, and ensure secure, stable and safe housing.[331]

Access to safe and affordable housing is a service that is vitally important to seniors. The advisory committee heard the importance of safe, secure, and affordable housing for seniors during its informational sessions. Needs change as people age and modifications like railings for added safety, housekeeping, maintenance and upkeep, along with taxes and utilities can all prove cost prohibitive for seniors on fixed incomes. The Pennsylvania Housing Affordability and Rehabilitation Enhancement Program created a Fund in 2010 to serve seven different types of projects, including safety improvements and repairs and upgrades, in part, for low-income seniors and the disabled through grants and low interest loans. This project was primarily funded with HUD monies available through the Housing and Economic Recovery Act of 2008.[332]

Additional funding support for the Housing Affordability Program was provided in 2012 through the local impact fee amendments to the Pennsylvania Oil and Gas Act. Under the unconventional gas well distribution fee, the Fund received $2.5 million in 2011 and $5 million in 2012 and each year thereafter. [333] The Public Utility Commission collects and distributes those monies to the fund for the purposes of increasing the "availability of quality, safe, affordable housing for low-income and moderate-income individuals or families, persons with disabilities or elderly persons" and rental assistance to persons or families under the median income of the county where monies are used. Fifty percent of the funds available must be used in counties of the fifth, sixth, seventh or eighth class, to address the housing needs of low-population areas.[334]

Low-Income Home Energy Assistance Program

Low-Income Home Energy Assistance Program or LIHEAP is a federal program that has been in place since 1981 to allocate funding to states for programs to help low-income heating, cooling, crisis, weatherization and energy assistance services, such as counseling. In Pennsylvania, the program is focused on heating bills and is administered by DPW, which provides cash benefits to help-low income customers, either homeowners or renters, pay for home energy costs. The grant payment is typically

[331] Pennsylvania Housing Finance Agency, http://www.phfa.org/about/organization/programs.aspx.
[332] Pennsylvania Housing Affordability and Rehabilitation Enhancement Program, Act of November 23, 2010, P.L. 1035, No. 105.
[333] Act of February 14, 2012, P.L. 87, No. 13 (Title 58, Chapter 23, §2314 (f)).
[334] Id., §2314 (f) (2), (3)).

sent directly to the utility company or fuel provider. A crisis component of the program may be provided in cases where heating equipment needs to be repaired, fuel is expended, utility services have been terminated, or are in danger of being shut off. Income eligibility begins for a single person at $17,235, which is 150 percent of the federal poverty income guidelines and increases by $6,030 for each additional person residing in the household.[335]

Pennsylvania residency is required applicants are notified of eligibility within 30 days of proper submission, and they need not be current Welfare recipients or have an unpaid heating bill to receive assistance. Recipients of other benefit programs like SNAP, SSI, TANF or Veterans benefits may automatically be eligible for the LIHEAP program. Assistance is a full grant with no money having to be repaid or matched.[336] Funding for the program that provides block grants to states has been inconsistent, and over the past eight years Pennsylvania has seen dramatic increases and decreases, and funding was further affected in FY2013 due to sequestration. Applications were collected in Pennsylvania between November 4, 2013 and April 18, 2014, but often close sooner when the available monies have been depleted. The FY2014 budget would see Pennsylvania get $163 million, towards the program.[337]

Applications may be submitted through their local county assistance office, online through the COMPASS System, or can request a paper application through the statewide LIHEAP hotline. Information is often distributed by Area Agencies on Aging. In 2011-12 $220 million was distributed to 460,000 eligible applicants, for an average benefit of $480, including supplementals. An additional 124,000 households received crisis funding for $44.8 million, with an average benefit of $362. Seven percent of the total federal funding allocation was used for program administration, while ten percent is allowed to be expended.[338] While this program is not targeted specifically to older Pennsylvanians, it is an important program that, in conjunction with other supports and discount programs, can help seniors remain in their homes and maintain their independence.

Pennsylvania Lottery Programs

The Lottery Fund receives the net proceeds from lottery ticket sales, which in turn fund programs for older Pennsylvanians. One of the oldest lotteries in the country, Pennsylvania was visionary when it established a lottery in 1971 to exclusively benefit older Pennsylvanians. Forty-two other states currently have lotteries and of those, only one, West Virginia devotes any specific funding

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[335] Pennsylvania Department of Public Welfare, "Heating Assistance/LIHEAP," http://www.dpw.state.pa.us/foradults/heatingassistanceliheap/S_000960.

[336] York County Area Agency on Aging, "Low Income Home Energy Assistance Program (LIHEAP)," https://yorkcountypa.gov/health-human-services/agency-on-aging/financial-benefits/low-income-home-energy-liheap.html; Benefits.gov, "Pennsylvania Low Income Home Energy Assistance Program," http://www.benefits.gov/benefits/benefit-details/1536.

[337] DPW carry forward of $17.6 million, added to the federal block grant would see Pennsylvania's total reach $180 million. Fifteen percent would support weatherization programs, ten percent would be used for administrative costs and $140 million would be available for LIHEAP benefits. Libby Pearl, Congressional Research Service, "LIHEAP: Program and Funding," July 18, 2013, pgs. 1, 33, http://neada.org/wp-content/uploads/2013/08/CRSLIHEAPProgram RL318651.pdf; Commonwealth of Pennsylvania, "Low-Income Home Energy Assistance Program, Fiscal Year 2014, Final State Plan," http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/p_036099.pdf.

[338] Legislative Budget and Finance Committee, "The Administration of Pennsylvania's LIHEAP Grant and Crisis Program," June 2012, http://lbfc.legis.state.pa.us/reports/2012/67.PDF.

to seniors, and it is one of more than five programs to benefit from lottery funds in the state. The majority of states' lotteries contribute to education funding.[339]

Programs benefitting older adults in Pennsylvania include the Property Tax/Rent Rebate, PACE, PENNCARE, Free Transit and Shared Ride, Alzheimer's Outreach, Pre-Admission Assessments, Long Term Living Services and Family Caregiver Supports. Costs for general governmental operations and administration are provided for in the Department of Aging, Pennsylvania's network of 52 AAAs, and program affiliated costs with PennDOT, Revenue and DPW. There are a myriad of good sources available to show the positive impact the lottery has had on the seniors, and over the last ten years the lottery income and revenue have both risen steadily. Revenue in FY2003-04 was $2.235 billion and nearly $3.7 billion in FY2012-13 but the percentage of revenue from net sales has fallen from 34 to 29 percent over that same timespan.[340]

The dynamics of the lottery have evolved since its inception and there has been a shift over the last ten years. In FY 2003-04, pharmaceutical assistance was the top program recipient, followed by AAAs, property tax abatement and transportation. In FY 2006-07, long term care services under DPW were brought into the mix and they immediately shot to the number one recipient of lottery funds, followed by AAAs, pharmaceutical assistance, transportation and property tax. In FY 2012-13, long term care services was still number one, followed by property tax, AAAs, pharmaceutical assistance and transportation programs.[341] Incorporating slots revenue has upped the property tax revenues and changes to Medicare have impacted pharmaceutical assistance.

Controlling operational costs, expanding sales and growing revenue have been the hallmark initiatives of the lottery program in order to provide more monies for the services that will support an increasing senior population, which is and will remain at the forefront of discussions in the current and succeeding Administration and General Assembly. There are some nuances to the funding formulas that have required 30 percent (27 percent since 2008) as the minimum rate of return, and that temporary reduction was implemented to allow increased marketing to further enhance sales and overall returns.

The programs described below fall under the Departments of Revenue and Transportation, which are not covered elsewhere in this report.

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[339] North American Association of State and Provincial Lotteries, "Cumulative Lottery Contributions to Beneficiaries," June 30, 2009, http://www.naspl.org/UploadedFiles/files/new_cumulative_lottery_contributions_to_beneficiaries.pdf.

[340] Pennsylvania Dept. of Revenue, Pennsylvania Lottery Bureau, "Pennsylvania Lottery Annual Reports: Comparative Statement of Income and Expenditures," 2003- 2004 and 2012-2013; Pennsylvania Dept. of Revenue, "Pennsylvania Lottery Profit Report: As Required by Act 53 of 2008," 2013, http://www.palottery.state.pa.us/About-PA-Lottery/Annual-Economic-Reports.aspx.

[341] Pennsylvania Dept. of Revenue, Pennsylvania Lottery Bureau, "Pennsylvania Lottery Economic Benefit & Impact Reports," 2012-2013, 202006-2007 and 2003-2004, http://www.palottery.state.pa.us/About-PA-Lottery/ Annual-Economic-Reports.aspx. Note: Changes to Medicare Part D in 2006 have reduced the need for lottery support for the PACE program.

Property Tax/Rent Rebate

Property Tax/Rent Rebate Program benefits eligible Pennsylvania older adults age 65 and older, widows and widowers age 50 and older, and adults age 18 and older who have disabilities. Administered by the Pennsylvania Department of Revenue, the program was implemented under Act 3 of 1971, known as the Citizens Rebate and Assistance Act, to provide rebates to both homeowners and renters, and in addition to support from the Lottery program receives funding from slots gaming. Social Security income is excluded from the income limits, which are $35,000 for homeowners and $15,000 for renters. Standard rebates range from $650 to $250 for homeowners and $650 to $500, with supplementals that can boost rebates to $975 per month. Seniors living in Philadelphia, Pittsburgh and Scranton have a formula that accounts for their tax relief due to local wage and income tax rates.[342]

Funding for this program in 2012 totaled $247,718,096, with 57 percent of the total being distributed towards homeowners. Supplementals kicked in an additional $28 million for 129,295 individuals over the standard rebates. The largest share of renters receiving the benefit came from the lowest income bracket of $0 - $8,000 while the largest share of homeowners receiving the benefits came from the highest bracket of $18,001 - $35,000. Overall claimants totaled 383,621 homeowners and 198,629 renters. The average payout, including supplementals, was $440.78 for homeowners and $583.62 for renters. Participation, as reported by the Department of Revenue, was down slightly from the previous year of 594,000 total applicants and over a five year period has risen gradually from 572,000 claims in 2007. Philadelphia County had the highest total of both overall claims at 74,833 and distributions $36,160,220, as well as having the highest individual totals of renters and homeowners being served.[343]

Department of Revenue costs for administration of the lottery program and monies spent on advertising, promotions and commissions all come out of ticket sales and in FY 2012-13 consumed 3.78 percent of all ticket sale proceeds. The end of year report for 2013 showed 63 positions in the lottery complement for a cost of $5.606 million. Specific costs included monies to operating costs ($8.241 million), advertising ($37.000 million) vendor commissions ($62.873 million) and payouts of prize money ($414.739 million).[344]

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[342] Act 3 of 1971 was amended several times, including Act 272 or 1978, Act 131 of 1979, Act 56 of 1982, Act 53 of 1985, Act 36 of 1991, Act 30 of 1999 and most recently Act 1 of 2006. The Taxpayer Relief Act, (Act of June 27, 2006, Special Session 1, P.L. 1873, No. 1), included a modified income eligibility for Property Tax/Rent Rebates in §1304.

[343] Pennsylvania Dept. of Revenue, Bureau of Research, "Report to the Pennsylvania general Assembly on the Property Tax Rent Rebate (PTRR) Program for Property Taxes or Rent Paid in 2012," September 30, 2013, http://www.portal.state.pa.us/portal/server.pt/community/reports_and_statistics/17303/property_tax_rent_rebate_program_reports/602461. NOTE: There were discrepancies in the FY2012-13 totals of property tax and rent rebates presented in the three documents analyzed by JSGC. In fact, all three sources, including the report to the legislature, Governor's Executive Budget 2013-14 and Lottery Economic and Benefit Impact Report 2012-13 had differing totals. Differing figures of available and actual, inclusions of supplements from licensing fees and property tax relief from slots gaming may account for the differences.

[344] Based on information provided by the Pennsylvania Dept. of Revenue to the House and Senate Appropriations Committees on February 5, 2014.

Older Pennsylvanians Transit Options

Two programs are administered under the Pennsylvania Department of Transportation to provide Senior Free Transit and Shared Ride services to those age 65 and older. Since the first program began in 1973, free rides on local fixed route, public transportation services that operate along designated routes, with specified schedules and stopping points. The program includes bus, trolley, subway and commuter rail systems and free services are offered during all hours of the provider's regular hours of operation. This program is administered by PennDOT and funded by lottery deposits made in the Public Transportation Trust Fund, which are distributed to transit systems as part of an annual operating assistance grant. Grants are available to private non-profits or public transportation providers.[345]

The program is open to eligible seniors age 65 and older, is free of charge for bus but requires a $1 fee for each commuter rail trip. While there are no income limits the local transportation provider will require the senior to receive and a present a Commonwealth identification card, available locally by presenting proof of age to that provider. Ridership has decreased from 42,525,999 in FY2001-02 to 36,006,217 in FY 2010-11. Over that same time funding has increased from $77 million to $88.2 million. The trust fund's health has also grown, which enables it to distribute more funding for free ridership. Ridership is projected to increase as the population ages, but costs will proportionally rise as well. The program is available in 50 Pennsylvania counties.[346]

Shared ride programs began in 1980 and enables Pennsylvanians age 65 and over to use demand responsive services at a significantly discounted rate. This program, which operates on a non-fixed route schedule is available in all 67 counties and helps supplement the needs of seniors who do not have access to fixed route transportation services. Passengers must request a ride at least 24 hours in advance and must be willing to share the vehicle with other passengers. The program is administered by the PennDOT, eligible seniors pay 15 percent of the trip cost and the remaining 85 percent is reimbursed to the shared ride operator from the Lottery Fund. PennDOT has contracts with 58 providers statewide. In some cases a third party sponsor, or the local AAA, may pay the 15 percent share of the individual.[347]

Workforce

Workforce issues were heard during the course of the advisory committee work and staff site visits. Views advocating greater staff hours spent on direct patient care signals the need for smarter regulatory review when considering the balance between quality care and resident safety. Staffing flexibility between job classifications, training, assigned record keeping and administering of medications is a mix of state and federal requirements. There is a need to balance training requirements for cross consortium of practice with certain HCBS and facility based skill sets. Workers cite the need for increased staff to provide better patient care, and noted nursing home workers have high incidents of health related injuries. They would also like to increase the number of hours spent on direct patient

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[345] Legislative Budget and Finance Committee, "Pennsylvania Lottery Funding of Programs and Services for Older Pennsylvanians," February 2012, pgs. 51-54, http://lbfc.legis.state.pa.us/reports/2012/62.PDF.

[346] PennDOT, Bureau of Public Transportation, "Services and Programs Map," http://www.dot.state.pa.us/bptmap/index.htm; Legislative Budget and Finance Committee, "Pennsylvania Lottery Funded Programs and Services for Older Pennsylvanians," February 2012, pgs. 51-54, http://lbfc.legis.state.pa.us/reports/2012/62.PDF.

[347] Id.; Id., pgs. 54-55.

care. Direct care workers can include home health aides, nurse aides, personal care aides and attendants. LTC employs 192,000 workers in direct care and 282,000 in supports in 2013, making this the eight largest industry in Pennsylvania. Ensuring a stable, professional workforce across the continuum of care is critical to ensuring high quality care to a growing senior population. Numerous studies point to a relationship between staffing levels and quality care and high rates of staff turnover also impact resident care and can be a result of wages, work environment and stress.[348]

Recruitment and retention issues were discussed at informational session and were the topics brought forward by administrators and staff during facility tours. Recruitment, retention and training were the topics most frequently mentioned, and echo many of the findings from studies dating back a decade in Pennsylvania. This work is very personal, with daily interaction between staff and the same residents, who can come to know them and their families and develop strong caregiver bonds. At the same time, workers need to be respected for their roles, their hard work and this level of responsibility requires mental and physical strength, a mature individual with special demeanor and commitment as it can often become as more than a job. Wages, emotional support, child care services, health benefits, involvement with developing care plans, and training that allows more responsibilities and understanding are all important to long term care workers.[349]

Pennsylvania labor force statistics show an aging workforce for long term care workers and a listing on the statewide high priority occupations list. In the health care industry cluster, home health aides and nursing aides, orderlies and attendants have seen an increasing demand for services but have relatively low salaries that average in the low $20,000s in 2010, and demand and pay scale in 2013 is similar.[350] In 2012 nursing facility workers numbered 88,955, community care workers for the elderly 63,331 and home health care services numbered 42,365 and they continue to be in demand as they have 25 percent of workers who themselves are over age 55.[351] Since 2007 the health care and social assistance sector has seen employment increase 10% and as a sector, since 2003, has seen expansion from 13.7 percent to 16.4 percent of the total state workforce.[352]

The advisory committee considered recommendations that would increase the minimum standard for nurse aid hours, standard contracts and require a minimum amount of a home care agency or facility's Medicaid reimbursements to be spent on direct resident care, there was ultimately not a consensus on these issues. While the committee members are supportive of more, highly trained, flexible and focused workforce, these recommendations could not be made without further analysis of spending on patient care, reimbursements and overall margins for the long term care industry which is beyond the scope of HR 255's macro focus.

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[348] SEIU Healthcare, "Pennsylvanian's Long Term Care System: Building Careers, Enhancing Quality Resident Care;" Journal of the American Medical Directors Association, "Nurse Staffing Impact on Quality of Care in Nursing Homes: A Systematic Review of Longitudinal Studies," February 14, 2014, http://www.jamda.com/article/S1525-8610(13)00796-2/abstract.

[349] Pennsylvania Intra-Governmental Council on Long Term Care, "In Their Own Words: Pennsylvania's Frontline, Workers in Long Term Care," February 2001; Pennsylvania Intra-Governmental Council on Long Term Care, "In Their Own Words Part II: Pennsylvania's Frontline, Workers in Long Term Care," October 2002.

[350] Pennsylvania Dept. of Labor and Industry, "Pennsylvania Workforce Development Facts," January 2014, http://www.portal.state.pa.us/portal/server.pt?open=514&objID=1217887&mode=2.

[351] Pennsylvania Dept. of Labor and Industry, Center for Workforce Information and Analysis, "Pennsylvania Fast Facts: January 2014 Edition," January 31, 2014.

[352] Id.; The Levin Group, "Volume I: The Economic Impact of Nursing Homes in the Commonwealth of Pennsylvania," March 31, 2005, pg. 5.

LONG TERM CARE INIATIVES OF NOTE

Through its informational sessions and JSGC staff research, this study encountered several unique programs and services that have focused on innovation, consumer demand, and developing new best practice models within long term care. These microcosms of a much larger discussion are recognized here not because they are the only unique approaches, but each one encapsulates an important aspect of the discussions held throughout this study. As the demand for long term care services and supports continues to rise, these innovative approaches will be key to meeting those needs more efficiently and effectively, and leadership on these difficult issues will help to engage providers and serve consumers plus their families.

Aging in other states is also discussed in brief as a review was done of the ten most populous aging states. State scorecards of long term care performance, taken in context, can also show opportunities that exist for improvement.

Penn Asian Senior Services

Culturally and socially sensitive services were observed throughout this study as one of the most needed yet least available service delivery models. With an increasingly diverse population, one of the biggest needs of seniors is cultural competency in order to break down barriers and enhance service delivery. One model is Penn Asian Senior Services, which provides for, advocates on behalf of and connects seniors with services by helping to build a support system with more culturally sensitive long term care infrastructure. Penn Asian currently serves nine different languages, including the Korean, Chinese, Cambodian, Filipino, Vietnamese and Indian communities.[353] Its mission is to "promote the well-being of Asian American seniors and other adults who are disadvantaged by their language and cultural barriers."[354]

A community based non-profit in Jenkintown, it was established in 2005 to serve those who have been disenfranchised by language and cultural barriers to long term care services and supports. The founder, Im Ja Choi was inspired to found the service after suffering hand in hand through her mother's own struggles, where she recognized both a need and opportunity. Budget limitations at facilities, home care and support service providers made addressing these special needs difficult, and while care could be provided it was not always culturally appropriate. This initiative had a vision that responded to an emerging need for seniors. In addition to a growing client base, Penn Asian has also provided employment for the Asian population that will have a welcome side effect of helping to increase competence and cultural sensitivity to the language, dietary and cultural needs for the future as that population grows in Pennsylvania.

[353] Testimony of Im Ja Choi, presented to the JSGC Advisory Committee on Long Term Care Services and Supports, October 24, 2013.
[354] Penn Asian Senior Services, http://www.passi.us/.

LGBT Elder Initiative

The Lesbian, Gay, Bisexual & Transgender Elder Initiative is focused on providing those older adults with the "rights and opportunities to live vibrant, creative, mutually supportive lives…[through services that are] competent, culturally sensitive, inclusive and responsive to the needs of LGBT elders." Serving the greater Philadelphia area, this grass roots organization is focused on building bridges between LGBT services and community organizations, consumers and aging services. Founded in 2010, the initiative was in response to an LGBT senior summit on the growing need for identified "physical, emotional health services, housing, case management and social services, and social networking as the most pressing needs of LGBT elders." The Initiative is governed by a diverse board of directors and is staffed by volunteers of all ages, orientations and backgrounds.[355]

The Elder Initiative has started the conversation within LGBT communities about long term care in an effort to break the stigma that has seniors, in some cases, fearing hostility and discrimination in nursing homes. Breaking the stigma is key to increasing culturally competent and sensitive approaches, and engaging in collaborative dialogue will help ensure respect in legal, social and health care supports. Within the community, challenges include fragmented family structures that are barriers to LTSS and in-home caregivers.[356] Inroads to serve all minority communities will be key to meeting the needs of our seniors as a more diverse population continues to age.

Integrated Service Delivery/Veterans Elder Care models

Over the past two decades Dr. Bruce Kinosian of Philadelphia has worked on countless efforts and clinical demonstration projects to develop integrated service delivery models, and while they have worked in the past on small scales, with targeted programs, they are finally gaining traction for wider use in Pennsylvania. There is a need for integrated VA and Commonwealth efforts for LTSS, as home based primary care programs could yield increased efficiency and savings for both, and consequently provide more effective consumer care in the community. The integration of complex medical management, LTSS and senior housing options all work to improve the lives of elderly consumers. Financial integration is not the same as clinical integration, and past success has been found in financing mechanisms that reinforce care models. The current health care system lets financing drive the care more than reinforcing it as service availability is driven by cost in spite of need.

Throughout the HR 255 study, and in each informational session, the topic of compartmentalized services and payment for those services was discussed at length. The three most prominent services include: complex medical management; housing; and supportive and supervising services. These three services are all provided within nursing homes, but not through home care models. Housing is often the biggest issue for seniors whose income is too high for Medicaid or waivers, but not high enough to reasonably support themselves at home. There is a great need for innovation in home care models, and VA non-institutional targets have begun to make small inroads. Hospital at home, house call programs, and integration of AAA and VA services all have barriers, but working within

[355] LGBT Elder Initiative, http://www.lgbtei.org.

[356] Testimony of Heshie Zinman, presented to the JSGC Advisory Committee on Long Term Care Services and Supports, October 24, 2013.

current efforts like Elder PAC and LIFE programs can help to take apart the current triangle and increase that integration.

The Greenhouse Model of Care

Greenhouses are licensed for residents that require skilled nursing care, but care is provided in a small, homelike settings for 10 to 12 people, which includes common living, dining and kitchen space, but private bedroom and bath. By creating a space that looks more like home, it has proven successful in both acting and feeling like a household, with the staff and residents working as a team to complete tasks, participate in activities and dine together. They can engage in meaningful conversation that grows into stronger bonds between residents and staff. This deeper relationship helps to sustain and nurture the residents, caregiving becomes more personal and staff provides a higher quality of care and increased quality of life. The daily schedule is not regimented and is built around what a resident might do at home. Residents decide when they want to wake-up, go to bed, eat, and often help to pick the menu and develop activities. While they receive nursing support that care is not the focus in their home.

Staffing ratios are higher in this level of care, which was developed in the mid-2000's, and it has proved to be a successful model that is growing and helping to make traditional nursing care less intimidating. The residences are staffed 24/7 by specially trained LPN's who provide all-inclusive care from personalized nursing care to cooking, leading activities and performing some light housekeeping tasks. This model is not designed to be a new level of care but is responding to consumer needs to develop a way to deliver that care in a new way.[357]

Brookside Homes of America, Inc.

An innovative approach to providing personalized care has been implemented by Brookside Homes of America, Inc. of Erie. Through small partnerships that create shared environments, more personalized care is attained that keeps the spirit of home in place while fostering increased quality of life and quality of care. This concept, founded by Jim Fetzner in Erie, focuses on creating system change through the implementation of innovative shared housing models. These alternatives to traditional nursing home placement also focus on efficiencies and process improvements to the home and community based services system.

Founded in 2007, it introduced the concept, known as micro-communities, to long term care. Care managers versus coordinators provide a high level of services which can include housekeeping, dispensing medication, meal preparation and laundry with more focused care placed on a relationship built between caregiver and resident. These settings can include assisted living, personal care, short term rehabilitation, respite, hospice or specialized Alzheimer's care as alternatives to what is often less personal, more regimented facility based care. Housing and services are viewed by Brookside as two sides of the same coin, and this model could be applied to others areas of the Commonwealth where there is a need to leverage existing housing stock to bring consumers with similar needs together.[358]

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[357] Tour of Lebanon Valley Brethren Home, Palmyra, PA on October 1, 2013. Information provided by Lebanon Valley staff on their green houses, both written and oral, was used to complete this section; Howard Gleckman, "A Nursing Home That You Can Call Home," *Kiplinger*, June 25, 2008, http://m.kiplinger.com/article/insurance/T036-C000-S001-a-nursing-home-that-you-can-call-home.html.

[358] Jim Fentzer, presentation to the JSGC Advisory Committee on Long Term Care Services and Supports, November 7, 2013; http://thebrooksidehomes.com/; https://www.ourparents.com/pennsylvania/erie/brookside_homes.

Residential Lock For Life Program

The Lock for Life Program was initiated in March 2009 by Lower Merion Township to help expedite access to residences for older adults and disabled adults who live alone. When responding to an emergency, police, fire and EMS personnel often need to force entry into a residence when a person is unable to unlock their doors. A metal box, resembling a realtor's lock box with a code pad, will be secured near the entrance of each residence that enters the program. The crime prevention unit of the local police department is responsible for administering the program and access to the code will only be available to police, fire and EMS personnel, and used only during and emergency where a resident cannot unlock their door. The program is free and residents need only furnish a key for the box. Residents may withdraw from the program at any time.[359]

Small, localized programs like Lock For Life can have a huge impact on elderly and frail adults who live alone. As a person ages they are more likely to be living alone, and perhaps a widower, they may live at a distance from their families, caregiver support may be informal and neighbors or friends who help provide that support may not have access to their home or stop on any regular schedule. The onset of an acute illness, or worsening of a chronic condition or disease makes hospitals a common entry point for long term care. These programs can help bring peace of mind as even subscribers to a Life Alert type system will still need to provide access to emergency responders. This program partners with a grassroots, volunteer based service known as ElderNet. Serving residents in Lower Merion Township and Narbeth Boro, Montgomery County, the program helps older adults and disabled clients live safely in their own homes for as long as possible.[360]

Health Care Technology Initiatives

The use of technology to improve healthcare has grown over the past decade and digitization of what in the past were paper charts used by doctors, nurses and other health care providers have helped keep pace with an ever changing health care delivery system. Electronic health records allow all of a patient's healthcare providers to coordinate care, reduce unnecessary testing and procedures, reduce paperwork, give patients direct access to their records and get accurate patient information into the hands of those who need it securely and efficiently. Patient direct and indirect relationships with health care and long term care delivery systems will improve dramatically with the increased use of health information technology. There are many health care and long term care providers who have already embraced this technology and are currently using Electronic Health Records, but these efforts are far from statewide and there is a need for more integrated efforts to improve care transitions through this technology.

The Pennsylvania eHealth Partnership Authority was created in 2012 with the goal of improving health care delivery and outcomes by enabling the secure exchange of health information. The authority engages stakeholders and works collaboratively by providing leadership and strategic planning for both public and private investments in health information technology efforts, creates a network of networks,

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[359] Lower Merion Township, Pennsylvania, "Lock For Life: Don't Lock The Good Guys Out" http://www.eldernetonline.org/node/397.

[360] ElderNet of Lower Merion & Narbeth, http://www.eldernetonline.org/.

recommends technical infrastructure, creates standards for privacy and security policies, and ensures ongoing interagency cooperation.

Certified Health Information Service Providers (HISPs) and Health Information Exchanges (HIEs) interface with pharmacies, laboratories, hospitals, clinics, long term care facilities, patients, providers, care coordinators, payers, EMS, home health, individual physician practices and other health care and support team members. Point-to-point clinical data exchanges through bi-directional interfaces provide connections to help promote smooth transitions of care, including emergency department visits, acute discharges from hospitals to home health or nursing homes, nursing home discharges to home care and home health visits by visiting nurses.[361]

The American Recovery and Reinvestment Act of 2009 provided $19.2 billion to increase the use of Electronic Health Records. Under the Act, the Commonwealth received $17.1 million to help enable health information exchange, and also provides incentives through Medicare and Medicaid to healthcare professionals and hospitals to encourage the adoption and use of electronic health record systems. Over 6,000 health care providers have signed up for DIRECT messaging, a secure way to transmit patient care records, testing results, referrals, discharge summaries and other clinical documents. This simple program requires both the sender and recipient to be DIRECT subscribers, and is most often utilized by doctors and other providers who don't have the resources or capacity to have more comprehensive HIEs. Uniform patient ID's (not Social Security numbers) also need to be adopted. A further incentive of free DIRECT messaging was offered for one year to all those who signed up with a certified health information service provider.[362]

The Pennsylvania eHealth Initiative is a non-profit, multi-stakeholder coalition to provide leadership for the future of health information technology in secure exchange of health information, to improve impatient care through the effective and efficient use of health information technology. Through education and awareness their goal is to achieve and sustain greater health information technology implementation and meaningful use. Enabling faster access will be a benefit for providers by making care transitions more efficient and to patients who receive better care transition, more comprehensive care and earlier identification and treatment.[363]

Pennsylvania Regional Extension and Assistance Centers for HIT (PA REACH) helps engage end users to accept new technologies and incorporate them into work processes. While CMS currently mandates much information to be submitted electronically, formats and standards are different to what HIE's exchange but contain similar information. Breaking down barriers of readiness, attitudes and workflow are important offerings to reduce information exchange obstacles.[364] The Keystone Initiative for Network Based Education and Research (Kinber) is a non-profit, member based organization that promotes innovative use of next generation digital technologies. These resources can help not only health care, but there is an opportunity to overlay new technologies and help support education, economic development and public media applications. Innovative healthcare applications include faster

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[361] Jim Younkin, Geisinger Health System, Keystone Information Exchange, "Long Term Care and HIE," PowerPoint Presentation to JSGC Advisory Committee on Long Term Care Services and Supports, January 9, 2014.
[362] Hospital and Healthsystem Association of Pennsylvania, "Facts About the Pennsylvania eHealth Partnership Authority," April 2013.
[363] Id., May 2013.
[364] Anita Somplasky, "PA REACH; Facilitating LTC's Transition to HIT," PowerPoint Presentation to JSGC Advisory Committee on Long Term Care Services and Supports, January 9, 2014.

sharing of eHealth records and diagnostic images, mobile and home health monitoring, improved public health reporting and management and high-definition telemedicine.[365]

The advisory committee also heard of advances in Telemedicine, where "using proven technology, like interactive audio and video equipment, physicians and patients [are] now able to connect from remote locations…and allows for two-way, real-time, interactive communication…"[366] This practice is especially important to expand access to additional specialists and help diagnose, monitor conditions, order testing or prescribe medication. Telemedicine has applications for facilities or home care, and has the potential to help physicians and extenders provide more efficient care. Concerns brought forward in the advisory committee discussion that involved the lack of in-person interaction that all technology cannot replace, and the lack of high speed internet and technology access in more rural areas of the Commonwealth, where this service has the potential to pay the biggest dividends.

It is important to note the distinction between eHealth initiatives and Telemedicine, and while both are important features to advancements in health care technology, they have distinctly different applications and purposes within that sphere.

Aging in Other States

While reviewing other states was not a major focus of the advisory committee, JSGC staff reviewed the other top ten ageing population states including California, Florida, New York, Texas, Ohio, Illinois, Michigan, New Jersey and North Carolina. The organization of long term care systems, structure of licensing, service providers, payment for services and unique or best practices were researched. While this review was not exhaustive, several notable findings are described below. These findings need to be taken in context of the differences that exist between state budgetary structures, service systems, waiver programs, support services and models of care.

Increased use of long term services and supports and home care has been a major focus of the states and federal government, but implementation and results have been mixed. These analysis include home care, adult day services, respite care, assisted living, nursing homes, family support services and how those services are financed and delivered. Evaluations of performance in all these areas shows Pennsylvania ranking 39th amongst the states in 2011 for its performance, across dimensions, within a national context. Dimensional rankings include affordability and access, choice of setting and provider, quality of life and quality of care and support for family caregivers. Pennsylvania fared best in choice and quality but was in the bottom quarter in affordability and family supports. [367]

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[365] Ken Barber, "KINBER Overview," PowerPoint Presentation to JSGC Advisory Committee on Long Term Care Services and Supports, January 9, 2014.

[366] PR Newswire, "Pennsylvania Governor Corbett Improves Access to Quality Health Care through Telemedicine Initiative," May 22, 2012, http://www.prnewswire.com/news-releases/pennsylvania-governor-corbett-improves-access-to-quality-health-care-through-telemedicine-initiative-152677955.html.

[367] Susan C. Reinhard, Enid Kassner, Ari Houser and Robert Mollica, AARP, The Commonwealth Fund, The Scan Foundation, "Raising Expectations: A State scorecard of Long Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers," September 2011, http://www.longtermscorecard.org/2011-scorecard.

In 2014 the analysis added a fifth category to include Effective Transitions Between Care Settings, but Pennsylvania fell to 42nd overall amongst the states. The report noted that "progress is notable in many areas where public policy has a direct impact," including family caregiver support and Medicaid, but chided states for not accelerating improvements in the wake of demand. Incremental progress is being made, but states shoulder this burden alone as there is currently no national policy solutions. Pennsylvania remained a ranking in the bottom quarter of affordability and had improved slightly in family supports. The transitions and quality of life and care fared only slightly better but the state did well again in offering choice.[368]

While this report may be helpful in a macro sense, the specific indicators used within the analysis need to be taken within the context of state populations, budgeting, structure of service providers, et. al. Similar analysis have been done on overall health quality, ranking the United States with other countries around the world. One recent study ranked the US 11th overall and dubbed it the most expensive and least efficient system when comparing quality, access, cost and efficiency. Many other industrialized nations have universal health insurance coverage and health systems that make accurate comparisons to the US difficult. Specific shortfalls included coordination of care, lagging technology initiatives, investment in prevention methods and financial incentives for achieving value and healthy outcomes.[369]

Ohio Office of Strategic Initiatives

Within the Ohio Department of Aging is the Division of Strategic Partnerships, whose mission is to support the "development of a comprehensive, integrated and coordinated system of elder friendly, person-centered programs and services." Staff identify not only innovative partnerships and alliances but new ways to meet organizational objectives within the Ohio state plan on aging, explore opportunities to promote policy and system change, and identify new funding opportunities. The Division staff research and disseminate best practices and innovations, engage state agencies, establish and follow alliances, and perform due diligence in meeting objectives aimed at helping communities to meet the needs of their elders. The division coordinates cross-system, internal and external initiatives and partnerships.[370] Other initiatives include gerontological education through academic partnerships, employing emerging best practices to develop and incentivize elder friendly communities and earlier preventative measures and healthy choices initiatives to improve outcomes.[371]

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[368] S. C. Reinhard, E. Kassner, A. Houser, K. Ujvari, R. Mollica, and L. Hendrickson, "Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers," AARP, The Commonwealth Fund, and The SCAN Foundation, June 2014, http://www.longtermscorecard.org/~/link.aspx?_id=DCD2C261D26D414C971D574D577A78FE&_z=z.

[369] Karen Davis, Kristof Stremikis, David Squires and Cathy Schoen, "Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally," The Commonwealth Fund, June 2014, http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror.

[370] Ohio Dept. of Aging, "Structure of the Ohio Department of Aging," http://www.aging.ohio.gov/information/oda/structure.aspx.

[371] Ohio Dept. of Aging, "Toward 2020 and Beyond," Annual Report SFY 2013, http://www.aging.ohio.gov/resources/publications/2013_AR_Web.pdf; Bonnie Kanton-Burman, Director, Ohio Department of Aging, "HB 59 – SFY 2014-2015 Biennial Budget Testimony Before the Ohio Senate Finance Medicaid Subcommittee," https://aging.ohio.gov/resources/publications/t_20130424.pdf.

North Carolina Consolidated Services

The state of North Carolina was the only state within this review that had a consolidated delivery system of long term care. While this approach was discussed during the advisory committee process, research shows all other states with the top ten aging populations had decentralized systems of organization and operation, with between two to five agencies involved in providing, regulating, licensing and paying for long term care and support services. Organized under one Department in North Carolina, the Department of Health and Human Services is responsible for collaborating with their partners to "ensur[e] the health, safety and well-being of all North Carolinians, [and] providing human service needs for special populations." In that role they touch almost every citizen from "birth to old age," through 30 divisions and offices, 18,000 employees and a budget of $18.3 billion in FY 2012-13.[372] It has identified the need to be actively engaged in "identifying and responding to challenges and opportunities presented by our rapidly expanding and aging society…" and promote aging in place through a system of well-coordinated community based services.

Texas Coordinated Aging Services

Under the Health and Human Services Commissioner, Texas is organized into several very specific Departments including a combined Aging and Disability Services (DADS) and has Assistive and Rehabilitative Services, Family and Protective Services and State Health Services. DADS administers long term care services and supports for older adults, along with those who have intellectual and physical disabilities in a fully integrated office to provide long term care. In addition to supporting the states elderly population through a variety of services including Area Agencies on Aging, ombudsman and guardianship DADS also licenses and regulates providers, and operates state supported living centers. The Agency was created in 2004. The Deputy Commissioner oversees the Center for Policy and Innovation to identify best practices and innovations within regulatory and non-regulatory policy and helps people live in the most appropriate care setting by promoting independence. They also host workshops, conduct training and engage in quality assurance and improvement reviews.[373]

California Community First Choice Option

Under the Affordable Care Act[374] states can receive six percent increase in their federal Medicaid share for community-based attendant services and supports for disability services under a managed care organization. This expands the state's ability to provide personal attendant services to persons with disabilities and seniors through community based services. These services and supports

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[372] North Carolina Dept. of Health and Human Services, http://www.ncdhhs.gov/aboutdhhs/index.htm.

[373] Texas Dept. of Aging and Disability Services, http://www.dads.state.tx.us/news_info/about/.

[374] The Patient Protection and Affordable Care Act established Community First Choice under Section 1915(k) of the Social Security Act as a new Medicaid state plan option that allows states to provide statewide home and community-based attendant services and supports to individuals who would otherwise require an institutional level of care. States taking up the option receive a 6 percent increase in their federal medical assistance percentage for CFC services. There is no time limit or expiration on the enhanced FMAP, and CMS has indicated the enhanced FMAP also will be available for required CFC activities such as assessments and person-centered planning. Kaiser Family Foundation, "Section 1915 (k) Community First Choice State Plan Option," http://kff.org/medicaid/state-indicator/section-1915k-community-first-choice-state-plan-option/.

are available to those who are eligible for institutional care, in an effort to provide board based service options to certain Medicaid beneficiaries, diverting them from what would otherwise be stays in nursing homes or other institutional settings. California was the first state, in 2012, to receive CMS authorization for this increased funding under their federal medical assistance percentage, and the funding increase is available as long as the state's Medicaid program includes the Community First Choice option. There are currently ten states participating in the option plan.[375]

These states' goals for greater coordination and integration of service delivery resonate with other states, and were common themes heard throughout the course of the HR 255 study. However, these services are being provided under one roof in one state. Some studies have shown that a single administer system in some states has proven successful and could improve efficient and enhance coordination. There are many challenges to reforming and reorganize any system, let alone one that serves millions of people and spends billions of dollars annually. Through in-depth research and analysis, policy makers are always looking to identify best practices as each state determines how best to organize its system of providing LTSS. A notable AARP study concludes "there is no magic formula to accomplish system change without strong leadership and the political will to do so." "An analysis of the hallmarks of a balanced system identified the components of an ideal LTSS system."[376]

[375] California Health and Human Services Agency, "California Receives First-In-The-Nation Approval of New Community-Based Care Option For At-Risk Seniors and Persons With Disabilities," September 4, 2012, http://www.dss.cahwnet.gov/cdssweb/entres/pdf/PressRelease/CommunityFirstChoice.pdf.

[376] Enid Kassner, Susan Reinhard and others, "A Balancing Act: State Long-Term Care Reform," AARP Public Policy Institute, July 2008, http://www.aarp.org/health/doctors-hospitals/info-07-2008/A_Balancing_Act__ State_Long-Term_Care_Reform.html.

PARALLEL ANALYSIS OF REPORTS ON LONG TERM CARE SERVICES AND SUPPORTS

This historical analysis of other reports on long term care services and supports covers a 25 year span, between 1990 and 2014. The goal is to present both similarities and differences in the recommendations to show how the issues have evolved since the real recognition of an aging population. How the state and, to a lesser extent, the federal governments have reacted to meet this ongoing and increasing need will help to show how those needs are being met at present, and if we are positioned to meet them in the future. The studies are presented in chronological order by the date they were published.

The Studies

White House Conference on Aging

The White House Conference on Aging has traditionally been a once in a decade national forum held to make policy recommendations and focus attention on aging issues. The forum's purpose is to "promote the dignity, health and economic security of Older Americans." Born in 1950 when President Harry Truman ordered the first such conference convened, succeeding conferences were held in 1961, 1971, 1981, 1995, and 2005. Conferences have historically been directed by Congressional Act, and have expanded to multi-day citizen forums, policy committees, advisory committees and even mini-conferences around the U.S. Early conferences produced some notable recommendations including the Older Americans Act and the Seniors Citizens Housing Act. More recent conferences have produced scores of recommendations and led to some amendments to the Older Americans Act.[377] While these forums are good to bring attention to seniors issues and help focus a call to action on policy issues, but recommendations are often hard to filter and focus in such large groups with diverse interests. The President has included $3 million is his FY1015 budget request for a new conference.[378]

OPTIONS in Long Term Care

In 1988 Governor Casey established the Inter-Governmental Council on Long Term Care in response to the growing "policy revolution" underway in Pennsylvania, and around the country, as a growing recognition of the priority needed to address both financing and delivery of long term care services. This initial report of the Council points to the growing elderly and functionally disabled population, need to improve the service mix to incorporate both HCBS and facility-based care, fragmented delivery and financing systems, and the recognition of both rising public and out of pocket costs for care.

[377] White House Conference on Aging, http://www.whcoa.gov.

[378] Barbara Gay, "2015 Budget: Obama Administration Proposals for Funding Aging Services," http://www.leadingage.org/Fiscal_2015_Budget_Proposals.aspx?sz=320.

Recommendations were comprehensive and addressed service needs, access to services, system structure and system finance, with multiple options offered for consideration under each. Options are limited and there is an overreliance on nursing home care as many communities are not equipped to offer in-home care or support services for seniors. Eligibility criteria for services and supports features programs that each have their own income, functional and age criteria and some form of universal eligibility for initial long term care coverage was desired. Developing a single point of entry was desired but maintaining services will require a coordinated system of care management. The lack of consolidated licensure creates barriers, allows inefficiencies and increases the potential for gaps to develop in services and the Council presented four options, including new matric of how a consolidated long term care coordinating body or agency would function.

Even in the early stages of discussions on the issue the status quo was not a desirable option, especially for system finance, as there is a need for increased public and private financing options to help share costs and maintain the health of the lottery fund. This is the first Pennsylvania specific report on long term care for older adults and points to many issues that are still relevant in 2014. In fact, it articulates the issues well by stating, "Making policy decisions from a complex, interrelated list of possibilities must reflect the Commonwealth's unique demographic, administrative, political and budgetary environments." It will require"…major structural changes in the current system and a willingness to implement these changes." [379]

The Pepper Commission

The Pepper Commission consisted of a bi-partisan group of 16 lawmakers tasked with a two year study on national healthcare problems. Its recommendations, published in October 1990, were split into two distinct parts: health care reforms that promoted universal insurance coverage while promoting measures to more efficiently deliver health care; and long term care reforms that promoted shorter nursing homes stays for rehabilitation and more home care. The first recommendation was deadlocked eight to eight over its huge funding requirements and the second on long term care passed eleven to four.[380]

The Commission's report called for action on long term care due to the current and impending future need "imperative," saying growth in numbers makes improvements to the financing of care will impact all Americans. The report goes on to say:

> "It is highly unlikely that service availability will keep up with these growing needs. Demographic trends predict that fewer family members will be able to care for disabled relatives. The private marketplace seems unable to develop an adequate home care delivery system even for those who can pay. The two major public programs –Medicare and Medicaid—have structural limitations that prevent them from meeting the projected need. Without a change in public policy, more and more Americans will have difficulty getting the care they need in nursing homes as well as at home."

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[379] Pennsylvania Intra-Governmental Council on Long-Term Care "OPTIONS in long term care: Interim Report of the Pennsylvania Intra-Governmental Council on Long-Term Care," February, 1990. Quote taken from page 5 of the report.

[380] Robert P. Hey, Christian Science Monitor, "Pepper Commission Offers Expensive Health-Care Remedy, May 5, 1990, http://m.csmonitor.com/1990/0305/apep.html.

The nine recommendations for long term care included many of the topics being addressed in reports 25 years later. Topics included building a long term care system that integrates public programs to meet diverse needs in the treatment, delivery and management of services; extending insurance for HCBS and for the first three months of nursing home care; a floor of protection against impoverishment from nursing homes costs; increased use of case managers and development of care plans.[381] The report also cautions that a "minefield of vested, powerful and politically active interests" await as they "all have a strong stake in any action we take, and one group's gain is often another's loss."[382]

In Their Own Words

This report, also by the Pennsylvania Intra-Governmental Council on Long Term Care was issued in February 2001 to focus on the situation of a shortage in the long term care workforce. A total of 15 focus groups were held, across the state, to identify issues affecting direct care workers including home health aides, nurse aides, personal care aides and attendants. Main topics included recruitment and retention, fair compensation and benefits, orientation and training which can all have an impact on quality care. Caregivers require special skills that cannot be taught, including patience, compassion, dedication, respect and the ability to be a team player. Some of the eleven recommendations included developing a career path within the profession, improved marketing including partnerships and referrals to recruit direct care workers, supports including child care and emotional support, improved pay and benefits and enhanced training and development for workers and supervisors.[383]

Barriers Elimination Report

Popularly known as the Barriers Report, this third report of the Pennsylvania Intra-Governmental Council on Long Term Care addressed HCBS in an effort to determine what barriers exist to receiving care and how those obstacles can be overcome. Three main issues were identified, including: procedural, pertaining to the process of actually obtaining care or services within the home; informational, including the way people are made aware of and receive information about HCBS; and systematic problems that require additional policy or cultural changes in mindset within the long term care system. Twenty-two barriers were identified.

The highlights of those barriers include: the prohibitive length of time it takes in determining eligibility for and arranging for services; the need for a simple, seamless system between levels of care; lack of information about available services and supports; lack of availability statewide; lack of entitlement for HCBS while there is an entitlement for nursing home care; lack of system coordination in quality assurance; inadequate workforce; and lack of funding for assisted living services. Many of the identified recommendations are related to findings of the HR 255 study and shows that while progress has been made, many barriers to home and community based services and supports still exist.[384]

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[381] The Pepper Commission, "A Call for Action," Final Report, September 1990, pgs. 14-16, http://www/allhealth.org/publications.Uninsured/Pepper_Commission_Final_Report_Executive_Summary_72.pdf.
[382] Senator John D. Rockefeller, IV, The New England Journal of Medicine, "The Pepper Commission Report on Comprehensive Health Care," October 4, 1990, http://www.nejm.org/doi/full/10.1056/NEJM199010043231429.
[383] Pennsylvania Intra-Governmental Council on Long Term Care, "In Their Own Words, Pennsylvania's Frontline, Workers in Long Term Care," February 2001.
[384] Pennsylvania Intra-Governmental Council on Long Term Care, "Home and Community-Based Services Barriers Elimination Work Group," March 2002.

Long Term Care for the Elderly in Pennsylvania

House Resolution 618 of 2004 directed the Legislative Budget and Finance Committee to study existing long term care in Pennsylvania given the expected population increases of those over age 65. Focusing on the continuum of services, including nursing homes, home care, adult day and other supports, the study weighed the ability of the networks to meet that demand and of the role of public and private payers to meet the current and future costs. Findings included the Medicaid increases are outpacing the rate of inflations; nursing home census shows a decline since the mid-1990s but the number of beds has fallen as well; those receiving HCBS are receiving less public funding than those in nursing facilities; and there are many differences in the clinical and financial eligibility requirements for the variety of programs that exist. The two major recommendations include additional data collection of those receiving HCBS in the community as little is known about them to enable an accurate assessment of program costs; and current DPW and PDA policies regarding waivers allow works not required to take part in training programs, as well as those without criminal background checks to conduct home care, and additional safeguards are needed.[385]

Senior Care Services Study Commission

The Pennsylvania Senior Care Services Study Commission was created in amendments to the Public Welfare Code[386] and was formed in May 2008. It was charged with reviewing the current care, resources and services available to those age 65 or older in the Commonwealth, to project future care needs, evaluate the ability of the current system to meet that projected need, and make recommendations to meet those needs given current resource limitations. The Commission consisted of 19 members and concluded that "Pennsylvania will need to make hard choices…[in] prioritizing our programs to assist those with the greatest social and economic needs."

Recommendations were comprehensive and spanned six major departments within the Governor's administrations, and were organized by the main themes of finance, care coordination, wellness and workforce/caregivers. Specific recommendations included improved awareness, education and incentives in long term care planning and self-funding; eliminating care and funding silos to better coordinate and timely provide services; increase the use of eHealth technology and telemedicine; improve care coordination and transitions by eliminating gaps and barriers that exist in service delivery; improve cross-agency collaboration; promote employer initiatives to support elder caregivers; fund, develop and implement new workforce training and senior and family care; and promote cross-training in blended job roles to increase efficiency and quality of care. These four critical areas identified by the Commission continue to offer opportunities for system change and improved success.[387]

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[385] Legislative Budget and Finance Committee, "Long Term Care for the Elderly in Pennsylvania," April 2005.
[386] Act of June 30, 2007, P.L. 49, No. 16, §§ 801-D, 802-D, 803-D, amendments to the Public Welfare Code (Act of June 13, 1967, P.L. 31, No. 21).
[387] Pennsylvania Office of Long Term Living, "Pennsylvania Senior Care Services Study Commission: Final Report," November 2010.

Innovations in Aging

George Mason University's Center for State and Local Government Leadership published this 2011 guidebook as a resource on the "innovative local and state programs to address the service needs of aging Americans by state and local governments as the nation embarks upon untested demographic challenges." The growth in the aging population is unprecedented and governments will need to reexamine how they do business, adapt infrastructure within communities, raise revenue and connect people with needed services. Across five broad categories, including quality of life, infrastructure, tax policies, workforce and technology impact will be dramatic from federal spending policies to state service coordination and local delivery. In particular, HCBS will strain families, communities and local agencies as they seek to meet this growing demand.[388]

Among the 92 programs and initiatives reviewed from 29 states, Pennsylvania was highlighted in five programs. One of those programs helped with senior infrastructure through the use of specially designed Elder Cottages, which are modular homes with 500-900 square feet that can be located in close proximity to family or caregiver supports can provide mobile ways to age in place. Of the ten states with dedicated funding for senior services, Pennsylvania's lottery is far and away the leader in providing that funding. The use of technology is also helping to provide better services through Pennsylvania TeleCare Services, which through an incentivized wavier program, employs wireless technology for health status, remote monitoring, medication dispensing and monitoring. While not all of these programs may be right for today's seniors, the continuing research and pilot project model programs will help filter and identify ideas that can be employed on a larger scale, to have a wide ranging impact on long term care delivery.[389]

Pennsylvania Lottery Funded Programs

This recent report, also by the Legislative Budget and Finance Committee, helped to reinforce the need for expanded lottery monies to meet the growing need for senior services. Published in February 2012, this report of lottery funding expenditures provides a historical context of sales and revenue over a ten year period, reviews specific lottery games that support the fund and what programs it benefits. The report shows that project program needs well outpace the projected funds and that certain programs, like family caregiver and other supports that allow individuals to remain in their homes as they age, show an increased need. Recommendations include expanded retail network and lottery sales; consider innovative technology approaches used in other states to stimulate sales; improving lottery program need projections to more accurately determine future growth needs; and limit the use of lottery monies to programs and services currently being funded.[390] The use of and growth in lottery sales and revenue will certainly be a hot topic in years to come, as Pennsylvania is the only state whose lottery solely benefits older adults.

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[388] George Mason University, Centers on the Public Service, Department of Public and International Affairs, "Innovations in Aging," http://publicservicecenters.gmu.edu/state-and-local/focus-areas/demography/innovations-aging.

[389] The State and Local Government Leadership Center at George Mason University, "Innovations in Aging: Innovative Programs in State and Local Governments that Address the Service Needs of a Growing Population of Seniors," Spring 2011.

[390] Legislative Budget and Finance Committee, "Pennsylvania Lottery Funding of Services for Older Pennsylvanians," February 2012. Some observers have noted, privately, that this study may have helped to precipitate the 2013 push by the Corbett Administration to privatize the Pennsylvania Lottery with a goal to guarantee returns and increase funding.

Federal Commission on Long Term Care

Easily one of the most controversial and adversarial reports, the Commission was established by the American Taxpayer Relief Act of 2012. The 15 appointees were made by the White House and Democratic and Republican Congressional leadership. The act was signed into law in January 2013 but it took six months for the Commission to be formed, hire a staff and begin a series of four hearings held from June 27 to August 20, and was required to have its report released by September 12, 2013. The hearings included panel discussions and hear testimony on the topics of The Current System, Populations in need and Service Delivery, Public and Private Funding of Services and Supports, Service Delivery and Workforce Issues of regarding long term care. The goal of the Commission was to "develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high quality system that ensures the availability of long-term care services and supports for individuals in need…"[391]

As part of the fiscal cliff deal that developed "sequestration," the need to reform Medicare and Medicaid services, who have become the major source of long term care services, cannot sustain the current pace of spending as seniors become more dependent on long term care. Consensus on a comprehensive report was elusive, as the commissioners split nine to six for the report which addressed many services and supports but did not agree on any funding solutions. The Commission also passed on its option of preparing legislation, which congress was not obligated to consider under the original Act. The report was described by pundits as a "poor man's version of the Pepper Commission."[392]

Recommendations included 28 specific recommendations categorized under service delivery, workforce and system finance. Recommendations under service delivery included care integration and development of a single point of contact; standard assessment mechanism across care settings; expanded consumer access to "no wrong door" information, assistance and care transitions, including technology; improved focus on quality; and new models of payment reform to provide post-acute and LTSS on a service rather than setting basis. Workforce include greater recognition of and supports for family caregivers, including their inclusion in care planning; revisions to the scope of practice to broaden workforce opportunities but expands background checks; and improving state standards, certifications and integration of the direct care workforce. Finance featured ideas for Medicare and Medicaid improvements and for personal savings, but could not agree on an approach to strengthen social insurance programs or balance those with increased private options for financing LTSS. Reconvening the White House Conference on Aging and establishing a subsequent national advisory committee to recommend a financial framework was also recommended.[393]

The full Commission report included an extensive appendix which outlined 63 additional ideas, representing the divergent views of the individual commissioners. One week after the report publications five members of the Commission released an alternative report, stating their frustration with the vision and action plan of the majority chose to endorse. Stating on page one that, "We are convinced that no real improvements…can be expected without developing social insurance financing."

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[391] Federal Commission on Long-Term Care, http://www.ltccommission.senate.gov.index.cfm; The American Taxpayer Relief Act of 2012, P.L. 112-240, Section 643.
[392] John O'Connor, Editorial Director, McKnight's Long-Term Care News & Assisted Living, September 20, 2013.
[393] United States Senate, Commission on Long-Term Care, "Report to the Congress," September 30, 2013, http://ltccommission.lmp01.lucidus.net/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf.

Their six recommendations to reform included the creation of a broader financing solution; a national strategy to improve and strengthen LTSS workforce; a national strategy to recognize and support family caregivers; a broadened and improved Medicare post-acute benefit; a strengthened and improved Medicaid; and new ways to access LTCSS for both aging and disability consumers.[394]

Embracing Aging Initiative

York County Community Foundation invited the national organization, Partners for Livable Communities, to join with them in 2013 to explore ideas and engage stakeholders to develop age friendly communities. With the demographic shift in seniors making up a growing percentage of our communities, which are also growing more diverse, present opportunities to not only improve existing aging services but to expand diversity, amenities and cultural offerings that allow all seniors to age with dignity, health and independence. "When older adults are fully integrated into…their neighborhoods and towns, they contribute significantly-with their skills and experiences, knowledge of the past, desire to make a difference, and so much more." With society getting older and living longer, changes are needed and inevitable.[395]

Embracing aging involves staying connected through transportation services including existing public transit and shared ride services, volunteer drivers, transportation vouchers and coordination of transportation services. Living in York County requires safe and affordable housing options and many seniors need home repairs and maintenance, providing financial options and consider new ideas such as a resource center to matching older adults in need of housing to share costs. Health and wellness programs are key to keeping seniors active, involved, engaged in events, activities and exercise through easy access to programs, parks, trails and walk that are safe and easily navigable. Engaging educational, workforce, arts, culture, through civic activity, volunteering, community clubs, schools and non-profits will help keep seniors connected and engaged. In October 2013, the Embracing Aging Initiative was selected by the National Association of Area Agencies on Aging to be one of six communities from around the country to participate in a MetLife Foundation funded Livable Communities Collaborative.[396]

Pennsylvania Alzheimer's Disease Planning Committee

Established by Executive Order on February 7, 2013, the Governor established the Pennsylvania Alzheimer's Disease Planning Committee. The goal of this 26 member committee was to "develop and recommend…a State Alzheimer's Plan that will serve as a comprehensive approach to addressing the growing Alzheimer's disease crisis." There was an acknowledgement of the growth of Alzheimer's disease and related disorders that will only get worse as the population ages. Individuals suffering from cognitive disorders require special care and their families need unique supports. The report included seven major recommendations, including goals and strategies, which were the product of six regional public meetings that were held across the state. Workgroups dealing with Prevention and Outreach,

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[394] Long-Term Care Commission, "A Comprehensive Approach to Long-Term Services and Supports," September 23, 2013.
[395] Embracing Aging Study, "Making York County a Community for ALL Ages," Fall 2013, pg. 6, http://www.yccf.org/publications-and-forms.
[396] Id.; York County Community Foundation, "Embracing Aging Initiative Selected to Participate in National Collaborative," October 9, 2013, http://yccf.org/news-100913A.

Healthcare and Workforce and Research and Metrics aided in developing and refining the committee's recommendations.[397]

Published in February 2014, the recommendations included recommendations to improve awareness and knowledge of and a sense of urgency about the disease; identify and expand financial resources, including innovative public-private-partnerships; improved services and supports from detection to end of life care; increased social and cultural diversity; enhanced support for family caregivers; growth in retention of a competent and knowledgeable workforce; improved prevention, treatment and research among others. On June 12, 2014 Governor Corbett approved the action plan and embraced its "strategic approach to addressing the growth of the disease and related disorders in Pennsylvania."[398] This study produced a valuable set of recommendations addressing a very important subset within the overall issue of the growing aging population within the Commonwealth. Many of its recommendations could be applied to the larger aging discussion as all seniors need improved urgency, financial resources, innovative partnerships, a skilled workforce and increased diversity to meet the growing demand for services and supports.

Long-Term Care Initiative

The Bipartisan Policy Center is a non-profit organization conducts analysis, dialogue and negation to combine politically balanced policymaking and proactive advocacy. The goal of the Center's Long Term Care Initiative is designed to "raise awareness about the importance of finding a sustainable means of financing and delivering long-term services and supports…" and in its April 2014 White Paper the Center's initiative explores options to "improve the quality and efficiency of publicly and privately financed long-term care." The report details financing and delivery as a crisis, service delivery as fragmented and as the population ages demand will outpace available services and funding will quickly become unsustainable. This is only the first step in a continuing discussion the Center is committed to keeping stakeholders and policy makers engaged in the progressive, and hopefully productive discussion.[399]

Conclusions

While these projects and reports ranged in elapsed time from months to decades, they touched on many continuing themes that were relevant throughout, and remain a struggle for policy makers today. Warnings have been issued since the 1980s, predictions that showed the demographic trends projected an growing, perhaps exploding, aging population. Those years of the Baby Boomers aging into the long term care system are now upon us and many topics are still waiting for action. The largest issue of contention is, and assumedly always will be funding. Expanding services to share costs and change the face of entitlement programs requires systematic change to break down a compartmentalized payment and fragmented delivery system. Home care has greatly expanded over the years, support services are struggling to keep pace, family caregivers are in need of more recognition and support, and

[397] Pennsylvania Dept. of Aging, "Pennsylvania State Plan for Alzheimer's Disease and Related Disorders," February 2014.
[398] Pennsylvania Office of the Governor, "Governor Corbett Approves State Action Plan to Aid Pennsylvania Families Affected by Alzheimer's Disease and Related Disorders," News Release, June 12, 2014.
[399] Bipartisan Policy Center, "America's Long-Term Care Crisis: Challenges in Financing and Delivery," April 2014, pg.2 & 25, http://bipartisanpolicy.org/library/report/long-term-care-crisis.

communities still lag in age friendliness. More coordination of services and better care transitions are needed across the long term care consortium. These themes were also consistent topics within this study and show that problems, which have been consistently identified through many studies, now require a sense of urgency.

APPENDIX A
HOUSE RESOLUTION 255

PRIOR PRINTER'S NO. 1538 PRINTER'S NO. 2098

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 255 Session of 2013

INTRODUCED BY BROOKS, HENNESSEY, GILLEN, GINGRICH, QUINN, SWANGER, BIZZARRO, PASHINSKI, MAJOR, SAYLOR, CALTAGIRONE, CLYMER, COHEN, D. COSTA, DAY, DeLUCA, DENLINGER, FABRIZIO, HAGGERTY, MILLARD, R. MILLER, MILNE, MUNDY, PICKETT, ROCK, SONNEY, TALLMAN, THOMAS, TOEPEL, WATSON, LONGIETTI, BAKER, PARKER AND BOBACK, APRIL 17, 2013

AS REPORTED FROM COMMITTEE ON AGING AND OLDER ADULT SERVICES, HOUSE OF REPRESENTATIVES, AS AMENDED, JUNE 19, 2013

A RESOLUTION

Directing the Joint State Government Commission to study the Commonwealth's delivery system of long-term care services and supports for INDEPENDENT AND care-dependent older adults, <-- including: a review of the current infrastructure that exists for providing services and supports; consumer access to the system, including an identification of barriers that exist; and financing issues; and to report its findings and recommendations to the General Assembly.

WHEREAS, The Commonwealth's long-term care services and supports delivery system is a joint responsibility of the Departments of Aging, Health, INSURANCE and Public Welfare and a <-- wide array of for-profit and not-for-profit providers of long-term care services and supports; and

WHEREAS, Each department is statutorily responsible for regulating and overseeing certain specific long-term care services and supports designed to provide the most appropriate level of care and services for consumers in an efficient, effective and fiscally accountable manner; and

WHEREAS, There is a need for a comprehensive bipartisan ongoing review of issues relating to the Commonwealth's long-term care services and supports delivery system; review of access to long-term care services and supports necessary to meet the needs of INDEPENDENT AND care-dependent older Pennsylvanians, including the affordability of services; ~~and~~ the role of public and private sectors in paying for services; AND THE PREPARATION OF PENNSYLVANIANS TO PLAN FOR LONG-TERM CARE COSTS; therefore be it

RESOLVED, That the House of Representatives direct the Joint State Government Commission to study the long-term care services and supports delivery system in this Commonwealth in order to ascertain whether the system is meeting the needs of INDEPENDENT AND care-dependent older consumers and families; whether current public and private programs for financing services can continue to meet the needs of consumers and their families; and, if servicing and financing needs are not being met, to recommend appropriate corrective measures; IF AND HOW PENNSYLVANIANS ARE PREPARING FOR FUTURE LONG-TERM CARE COSTS AND HOW CURRENT PROGRAMS AND SERVICES CAN BETTER PREPARE PENNSYLVANIANS FOR FUTURE LONG-TERM CARE NEEDS; and be it further

RESOLVED, That the commission create an advisory committee composed of an equal geographic representation of individuals involved in the delivery of long-term care services and supports and the financing of such services and supports, consumers, families of individuals in need of such services and supports, as well as local area agencies on aging and other State government agencies responsible for oversight and regulation of long-term care services and supports; and be it further

RESOLVED, That the commission conduct public hearings and

other comprehensive studies deemed appropriate to identify and prepare for the implementation of measures designed with the goal of ensuring that Pennsylvania's long-term care services and supports delivery system is safe, accessible and affordable for consumers and their families; and be it further

RESOLVED, That the commission prepare a report to the General Assembly with information including an analysis of the current long-term care services and supports delivery system, including the costs associated with that system, and projected future costs of providing long-term care services and supports; ~~and~~ <-- recommendations for a system that preserves and promotes consumer choice and ensuring an efficient, effective and fiscally accountable long-term care services and supports system in this Commonwealth; AND PROPOSED LEGISLATION SUPPORTING ANY ONE OR MORE OF THE RECOMMENDATIONS; and be it further <--

RESOLVED, That the commission report its findings ~~and~~, <-- recommendations AND PROPOSED LEGISLATION to the General Assembly within one year of the adoption of this resolution. <--

APPENDIX B
GLOSSARY OF TERMS

While this glossary of terms is not a comprehensive listing, it provides a convenient reference and is designed to reflect the main topics considered by the Advisory Committee on Long Term Care Services and Supports. [400]

Activities of Daily Living and Instrumental Activities of Daily Living (ADL/IADL) refer to activities that include basic daily functions such as bathing, eating, dressing, using the toilet or transferring from a bed or chair. IADLs are tasked associated with running a household and include managing money, medications, performing housework, preparing meals, doing laundry, shopping for groceries that are all required to live independently. These are activities are often used in assessments to determine the level of care needs.

Adult Day Services or Older Adult Daily Living Centers are centers that typically provide a program of activities, health monitoring, socialization or assistance with some activities of daily living that allow individuals to needed support in a community based setting. The added benefit is to family caregivers enabling them to remain in the workforce, or to receive respite support. These are fee for service programs that are typically not covered by public or private insurance, but are sometimes covered under long term care insurance policies.

Area Agencies on Aging are local organizations that serve residents age 60 and older to provide information, assistance and protective services through a variety of programs for older adults, their families and caregivers There are 52 AAAs that cover each of the state's 67 counties through contracts with the Department of Aging, are county affiliated and in some cases have non-profit status. They are the primary point of contact most again adults and their families for to engage with services and supports.

Assessments are used to determine functional and financial eligibility for services. They provide a filter to find the appropriate level of care and service needs of consumers who apply for a variety of benefits from Medical Assistance and lottery funded programs. These pre-admission tools are used in facility based, home care, and support services.

Assisted Living Residences offer personal care and supports 24 hours a day, some health care, meals in congregated residences. Most residents pay privately some states have their payments subsidized by Medicaid or states. Any residence that provides food, shelter, living services, assistance or supervision or supplemental health care services, for a period exceeding 24 hours. These residences provide an environment that provides housing and support services to allow people to age in place while maintaining their independent and exercising decision making and choice.

[400] Definitions were used from the following sources: Congressional Budget Office, "Rising Demand for Long-Term Services and Supports;" Avalere Health LLC, "Long-Term Care in America/An Introduction;" Pennsylvania Older Adults Protective Services Act; and the Older Americans Act.

Case Mix Index within LTC reflects the diversity of patients, clinical complexity, and resources needed to care for the population of nursing homes, assisted living residences, personal care homes, and those being served through in-home care. Reimbursements provided by Medicare, Medicaid, SSI, veterans, and private pay rates vary, and a good mix of residents spread across these payment types reflects a good business model.

Centers for Medicare and Medicaid Services (CMS) is an agency within the U.S. Department of Health and Human Services who is responsible for administration of Medicare and works with states to jointly administer the Medicaid program. The agency enforces federal rules and regulations, works with states to establish reimbursement rates, and assures quality standards through surveys and certification standards.

Continuing Care Retirement Communities offer independent living lifestyles who do not need constant services or nursing supervision. Different levels of care, from independent living units to skilled nursing care, allows individuals to move to higher levels of care as they age, physically decline and need more care with activities of daily living.

Domiciliary Care provides a homelike environment for those who cannot live independently by matching residents with a settings that best meets their needs and matches their preferences. Homes can serve anyone age 18 and older, including the frail elderly, to live in a family like setting with supervision, support and assistance with certain activities of daily living. Residents enter into a contract to pay the home provider on a monthly basis, at a rate determined by the Department of Aging.

End of Life Care can refer to hospice or palliative care that is provided in a person's home or place of residence, when facing a terminal illness, and focuses on pain management and comfort care. Services can include medication management, symptom and stress relief for patients and families through an interdisciplinary team approach of nurses, aides, physicians, social workers, clergy and other specialists. Many costs associated with end of life and Hospice care are covered by Medicare.

Facility/Institutional Based Care is a facility that providers 24/7 residential care, services and supports to residents, including supervision of medical care, social services, recreational activities, assistance with activities of daily living, medication management and other skilled services. Private or single rooms as well as communal meals and other recreational or social activities are common options in these settings. While most often referring to nursing homes facility settings can also refer more generally to assisted living or personal care homes.

Family Caregiver can generally refer to relatives, friends or neighbors of an older person who provides that individual with emotional support, physical assistance with activities of daily living, companionship or financial support. It can be simple tasks such as getting groceries and running errands or medication management, supervision and daily assistance. Many supports are provided in an informal, unpaid service but some can be more formal, paid care with partial reimbursement through federal waivers or state programs.

Home Care is playing an increasingly larger role in healthcare as providers seek to manage chronic conditions at home to emergency rooms, prevent trips to hospitals and nursing homes. These can include non-medical supports for bathing, feeding, grooming and house work. Nurses, home health aides and professionals can provide medical care, skills and therapy, while other less or untrained personnel

provide other services. The most common types of home care include rehabilitation, therapy, social and homemaker services. Services can be unpaid, private pay, self-directed care, or Medicaid waiver paid through home health agencies.

Home and Community Based Services (HCBS) refers to assistance with dialing living provided to older adults and people with functional limitations or cognitive impairments to remain in their own homes. Assistance with Daily Living include bathing, dressing, using the toilet, and Instrumental Activities of daily Living like shopping, managing money, managing medication or supportive housing.

Independent Living in some cases is federally subsidized housing projects that help residents age in place through Section 202 subsidized rental housing. In many states there are long waiting lists for these services. In other cases it refers to senior housing options in a residential community that allows the resident to maintain their own home, townhouse or apartment. While enabling a resident to live independent and self-sufficient lifestyles, these communities feature amenities such as transportation, laundry, homecare, activity planning and meal options.

Long Term Care is the collective group of services and supports needed to meet and individuals' personal care and health care needs over an extended period of time.

Long Term Services and Supports (LTSS) encompasses a variety of supportive services designed to help people who need help with activities of daily living. These services can be provided in home care, community based settings or in nursing facilities, and typically excludes medical care. Many community based services fall into the category of "preventative" services that are generally designed to keep people functioning in their homes for longer periods of time and avoid unnecessary stays in facility based care. A mix of state and federal dollars from Medicaid and lottery monies pay for certain services and supports.

Medicaid is the medical assistance program jointly funded by states and the federal government to provide health care for low income individuals, including older adults and persons with disabilities.

Medicare is the federal health insurance program which covers individuals age 65 and over, regardless of income or medical history and people under 65 with certain disabilities.

Nursing Homes is a general term used to describe a long term care facility that provides residential personal care, which can include skilled nursing services, meals, medication management, supervision, social and recreational activities, medical care and assistance with, in most cases, a large number of activities of daily living. In some cases this care includes specialized Alzheimer's or dementia settings. Short term stays are typically covered by Medicare while stays of 100 days or longer are covered by Medicaid, but in some cases individuals may need to pay privately for their stay.

Personal Care Homes are optional Medicaid benefits provided by some states since 2007, to provide some assistance with daily living, typically to older people, who need physical, behavioral or cognitive help. Social and recreational activities are provided in addition to assistance with: food, hygiene, toileting, mobilization, medical needs, medical care, managing medications, transportation to appointment, laundry, shopping, communications and financial management. Personal Care Homes in Pennsylvania are all private pay settings.

Respite Care typically refers to the temporary relief provided to family caregivers who are caring for older adults, in order to give them a rest or break to run errands, take a vacation or even to simply rest, reduce stress and spend time away from what can be an emotionally and physically demanding task. Services are often community based, coordinated services that operate on a fee for service basis.

Skilled Nursing Facilities are facilities where health care is given if a consumer needs skilled nursing, therapy or rehabilitation staff to observe, treat, manage or evaluate care. Skilled care must be provided by professional staff including RNs, LPNs, VNs, PT, OT, speech-language pathologists and audiologists. Skilled nursing facilities are typically used to describe post-acute care side of nursing homes that are covered by Medicare.

APPENDIX C
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APPENDIX D
INFORMATIONAL SESSIONS

The Advisory Committee on Long Term Care Services and Supports held four informational sessions around the Commonwealth to gather feedback from consumers, family members, caregivers, transition coordinators and providers on the frontlines of care in facilities, assisted living and in-home settings. At each session the panelists were given the opportunity to make brief statements, or provide written handouts but presentations were not required and the format was roundtable discussion with advisors asking questions of the panel. Many comments provided during the discussion were consistent across the Commonwealth and in some cases formed the foundation for recommendations presented within this report.

On **October 24, 2013** the advisory committee held an informational session in Norristown, Montgomery County. The purpose of this session was to gather feedback from southeast Pennsylvania on the topic of "entry into and navigation of the long term care system in Pennsylvania." Invitees were broken into four panels, and participants included nursing and home care providers, consumers, aging advocates, family caregivers and other stakeholders. The panelists were given the opportunity to provide written comments, which were distributed to the members of the advisory committee in advance.

Participants

Daryl Andress, Division Director, Bayada Home Health Care, Inc., Philadelphia

Paul Bach, Sr. Vice-President, Genesis Healthcare, Kennett Square

Wendy Campbell, President and CEO, Alzheimer's Association, Delaware Valley Chapter, Philadelphia

Im Ja Choi, Executive Director, Penn Asian Senior Services, Home Health, Jenkintown

Sheri Gifford, Associate Administrator, Philadelphia Nursing Home/ Fairmount LTC

Lydia Hernández-Vélez, Deputy Managing Director for Aging, City of Philadelphia

Bruce Kinosian, M.D., Divisions of General Internal Medicine and Geriatrics, University of Pennsylvania School of Medicine, Philadelphia

Joanne Kline, Executive Director, Montgomery County Aging and Adult Services

Dene Liott, Family Caregiver, Pottstown

Kathy Manderino, Senior Vice President, Intercommunity Action, Philadelphia

Diane Menio, Executive Director, Center for Advocacy for the Rights and Interests of the Elderly (CARIE), Philadelphia

LeAnn Moyer, Family Caregiver, Norristown

Sylvia Myers, Consumer of long-term care services and supports, Philadelphia

Tracy Pennycuick, Director, Montgomery County Office of Veterans Affairs

Pam Walz, Esq., Unit Director, Community Legal Services of Philadelphia

Heshie Zinman, Chair, Board of Advisors, LGBT Elder Initiative, Philadelphia

On **November 7, 2013** the advisory committee held its next informational session in Greenville, Mercer County to gather feedback from northwest and western Pennsylvania. The topic of this meeting was also "entry into and navigation of the long term care system in Pennsylvania." Invitees were broken into five panels, and participants included social workers, discharge planners, family caregivers, visiting nurses, admissions and marketing coordinators, aging program innovators and other stakeholders.

Participants

Jan Anderson, Family Member, Westlake Woods Community, Erie

Susan Anderson, RN, Staff Nurse, UPMC Jefferson Regional Home Health

John Beagle, Administrator, PALFUND Assn. Senior Housing, Linesville

Lloyd Berkey, Administrator, Reliant Senior Care Management, Greenville

Jane Byham, Social Worker, UPMC-Venango County VNA

Betty Carr, Administrator, Countryside Convalescent Home, Mercer

David Coolidge, Admissions and Marketing Coordinator, Cambridge Springs Rehab & Nursing Care

Jasen Diley, CEO, The Rouse Estate, Warren

Jim Fentzer, CEO, Brookside Homes of America, Inc., Erie

Robert Freed, Vice-President of Operations, The Nugent Group, Hermitage

Debra Hansen, MSOL, BSN, RN-BC, Director, Case Management, Social Services and Behavioral Health, UMPC Horizon

LuAnn King, RN, MSN, Clinical Director, Quality Improvement & Patient Relations, UPMC Horizon

Eleanor Meade, Consumer, PALFUND Assn. Senior Housing, Linesville

Linda Mong, Family Caregiver, Greenville

Kim Moody, Administrator, Rolling Fields, An Eden Alternative Eldercare Community, Conneautville

Mary Beth Newell, Clinical Director, VNA Alliance, Conneaut Lake

G. Bryan Oros, N.H.A., Executive Director, St. Paul's, Greenville

Bill Orzechowski, Executive Director, Cameron, Elk, McKean Office of Human Services

Mary Ann Reeher, RN, Executive Director, The Good Sheppard Center, Inc., Greenville

Cathy Schatzel, Social Worker, Sharon Regional Medical Center

Larry Scheetz, Director, Mercer County Office of Veterans Affairs

Stephanie Wilshire, Executive Director, Clarion Area Agency on Aging, Inc.

On **January 9, 2014** the advisory committee held its third informational session in Dallas, Luzerne County on the campus of Misericordia University to gather feedback from northeastern Pennsylvania. The topic of this meeting was "provider issues, including regulatory and workforce issues of the long term care system in Pennsylvania." Invitees were broken into four panels, and participants included health IT innovators, academics, elder law attorneys, veteran's advocates, healthcare workers, home care providers, senior program coordinators, facility administrators and other stakeholders.

Participants

Ken Barber, Member Relations Manager, Keystone Initiative for Network Based Education and Research (KINBER)

Mary Erwine, RN, MSN, President, Erwine Home Health and Hospice, Inc.

Sam Greenberg, Commander, Jewish War Veterans in Wyoming Valley & Geno Merli Veterans Center Advisory Board

David Grinberg, Program Manager, Pennsylvania eHealth Partnership Authority

Brenda Hage, Ph.D., CRNP, Director of Graduate Nursing, Misericordia University

Cathy Ann Hardaway, Director of Older Adult Programs, United Neighborhood Center of Northeast Pennsylvania

Frances Iannaccone, R.N., C.R.R.N., M.S.H.A., N.H.A., Administrator, Good Shepherd Home Raker Center

Clayton Jacobs, Vice-President of Programs and Services, Alzheimer's Association, Greater Pennsylvania Chapter

Susan Kahlau, Owner/Operator, Visiting Angles of Northeast PA

MaryLou Knabel, Vice President, Home Care Services, Allied Services

Owen Lavery, retired Administrator, Riverside Adult Day Care Center & Board Member, Pennsylvania Adult Day Services Association

Paul McGuire, Regional Director, Genesis Healthcare

Tonya Morrow, CNA, Phoebe Nursing Home & Rehab in Allentown, facility Chapter President and Executive Board Member, SEIU Healthcare Pennsylvania

Edward Ryan, Lackawanna County LINK Coordinator, The Northeast Pennsylvania Center for Independent Living

Anita Somplasky, Executive Director, Pennsylvania Reach East & West
Leslie Wizelman, J.D., CELA, Law Office of Leslie Weizelman

Jim Younkin, Director, Information Technology, Feininger Health System

On **February 6, 2014** the advisory committee held its final informational session at the Main Capitol Building in Harrisburg, Dauphin County to gather feedback from central and south central Pennsylvania. The topic of this meeting was "insurance and payment services relating to the long term care system in Pennsylvania." Invitees were broken into four panels, and participants included care coordinators, insurance providers, care providers and state government program specialists. The program specialists provided overviews of programming and associated funding that passes through the state, and there were also a number of providers advocating for a Medicare Managed Care approach. Other providers discussed long term care insurance and financial planning as an important part of overall planning for care while care transition coordinators and care providers discussed matching consumers with the right level of care when they enter the system, most times from an acute care setting.

Participants

Michael Baker, Director, Brokerage and Affinity Markets, Target Insurance Services of PA & National Association of Insurance and Financial Advisors – PA

Jeffrey Bechtel, JD, Senior Consultant at Sellers Dorsey & PA Coalition of Medical Assistance MCO's

Paula Bussard, Senior Vice President, Policy and Regulatory Services, The Hospital and Healthsystem Association of Pennsylvania

Raymond Calhoun, Chairman of the Board, Guardian Eldercare, Inc.

Angela Dohrman, Vice President of Senior Living, Lutheran Social Service of SCPA & Chair, Board of Directors, LeadingAge PA

Daniel Drake, Executive Director/CEO, LIFE UPENN, University of Pennsylvania School of Nursing

Benjamin Glatfelter, JD, Attorney at Kennedy, PC Law Offices

Anne Henry, Director, Bureau of Finance, Office of Long Term Living, Pennsylvania Department of Public Welfare

Stephen Holt, President & CEO, the Visiting Nurses Association of Greater Philadelphia
Brian Long, Coordinator, Lancaster & Lebanon County LINK to Aging and Disability Resources

Rebecca May-Cole, Executive Director, Pennsylvania Behavioral Health and Aging Coalition

Brian Natali, Chief, Division of Veterans Services and Programs, Pennsylvania Department of Military and Veterans Affairs

Kelly O'Donnell, Director, Operations and Management Office, Pennsylvania Department of Aging

Carol O'Hara, RN, Manager, Care Transitions Coordinator, Holy Spirit Health System

Patrick Reeder, JD, Director of Government and Industry Relations, Genworth Financial

Andrew Ruscavage, Director, Bureau of Veterans Homes, Pennsylvania Department of Military and Veterans Affairs

Ross Schriftman, RHU, LUTCF, ACBC, MSAA, Insurance Agent & Legislative Chair for the Pennsylvania Association of Health Underwriters

Terry Shade, VP of Community Health Services, Executive Director of Lutheran Home Care & Hospice, CEO of LIFE Lutheran Services, Lutheran Social Services of SCPA

Ann Torregrossa, JD, Executive Director, Pennsylvania Health Funders Collaborative

APPENDIX E
SITE VISITS AND MEETINGS

The Joint State Government Commission conducted several site visits to familiarize the staff with the different types of long term care facilities, and other senior services. The conversations with staff and administrators at those facilities was beneficial to gaining some insight into their day to day operations, and the activities and living arrangements of those residents they serve. Tours were conducted on October 1, 2013 in the Harrisburg area, with additional site visits conducted on November 6 and 7 in conjunction with the informational session in northwest Pennsylvania.

SITE VISITS

Lebanon Valley Brethren Home, Palmyra, Lebanon County
Jeff Shireman, President
Mary Lee Harpel, the Director of Resident Services

Licensing information: Not For-Profit facility
Continuing Care Retirement Community (Insurance)
Long-Term Care Nursing Facility (Health) 100
Personal Care Home (Public Welfare) Capacity of 58
Independent Living – 340 units
On-site Senior Center/Adult Day Services (Aging) 19

Cornwall Manor, Cornwall, Lebanon County
Steve Hassinger, President
Ed Peiffer, Vice-President of Operations
Lee Stickler, Vice-President of Finance

Licensing information: Not For-Profit facility
Continuing Care Retirement Community (Insurance)
Long-Term Care Nursing Facility (Health) 108
Personal Care Home (Public Welfare) 35
Independent Living – 140 units

Friendship Senior Center, Friendship Community Center, Lower Paxton Township
Recreation Manager Lynn Wuestner

Licensing information:
Senior Center (Aging)

White Cliff Health & Rehabilitation Center, Greenville, Mercer County
Lloyd Berkey, Administrator
Wendy Borett, Admissions Coordinator

Licensing information: For-Profit Facility
Long-Term Care Nursing Facility (Health) 154 beds

Avalon Springs Nursing Center, Mercer, Mercer County
Nate Hamilla, Administrator
John Hughes, Principal
Kathy Orr, Marketing Director

Licensing information: Not For-Profit Facility
Continuing Care Retirement Community (Insurance)
Long-Term Care Nursing Facility (Health) 100 beds
Independent Living – 15 units

Overlook Health and Rehabilitation Center, New Wilmington, Lawrence County
John Reichard, Administrator

Licensing information: For-Profit Facility
Continuing Care Retirement Community (Insurance)
Long-Term Care Nursing Facility (Health) 115 beds
Personal Care Home (Public Welfare) 32 beds
Independent Living – 15 units

Shenango Presbyterian Seniorcare, New Wilmington, Lawrence County
Caroline DeAugustine, Executive Director
Tina Danka, Quality Liaison

Licensing information: Not For-Profit Facility
Continuing Care Retirement Community (Insurance)
Long-Term Care Nursing Facility (Health) 25 beds
Personal Care Home (Public Welfare) 54 beds
Independent Living – 41 units

Juniper Village, Meadville, Crawford County
Mandy Maruska, Marketing Director

Licensing information: For-Profit Facility
Personal Care Home (Public Welfare) 90 beds

Rolling Fields, Inc., Conneauteville, Crawford County
Kim Moody, Owner/Operator
Sara King, Administrative Assistant
Lisa Yuhaschek, Nursing Director

Licensing information: For-Profit Facility
Continuing Care Retirement Community (Insurance)
Long-Term Care Nursing Facility (Health) 181 beds
Independent Living – 4 units

Pleasant Ridge Manor - West, Erie County Nursing Home, Girard, Erie County
Robert Smith, Executive Director
Elia Grustia, Chief Financial Officer

Licensing information: Not For-Profit Facility
Long-Term Care Nursing Facility (Health) 312 beds

St. Paul's, Greenville, Mercer County
G. Bryan Oros, Executive Director
Tammy Lininger, Vice-President and Administrator of the Villas

Licensing information: Not For-Profit Facility
Continuing Care Retirement Community (Insurance)
Long-Term Care Nursing Facility (Health) 192 beds
Personal Care Home (Public Welfare) 153 beds
Independent living – 120 apartments

MEETINGS

Lawrence County Area Agency on Aging, Challenges: Options in Aging, New Castle, Lawrence County
Amy Cervo, Executive Director
Dottie Trott, Financial Director
Sheryl Pieri, In-Home Services Coordinator

United Way of Western Crawford County, Meadville, Crawford County
Amy Woods, Executive Director, United Way
Duane Koller, Director of Ancillary Support Services, Meadville Medical Center
Amy Woodrow
Shawnel Toomey, Center for Family Services
Karen Miller, Active Aging of Crawford County
Kathy Friedman, Active Aging of Crawford County
Becky Little

Pennsylvania Coalition of Medical Assistance MCO's
Michael Rosenstein, Senior Government Affairs Specialist
Jeffrey Bechtel, Senior Consultant, Sellers Dorsey

Health Management Associates
Michael Nardone, Principal

SUBMITTED TESTIMONY

Stephen Holt, President and CEO, The Visiting Nurse Association of Greater Philadelphia

Dequilla Hurt, Family Caregiver

Russell Jirik, Owner/Administrator, Family Matters Adult Day Center and President-Elect of the Pennsylvania Adult Day Services Association

Tammy Lininger, N.H.A, Administrator of The Villas Nursing Home, St. Paul's

APPENDIX F
COUNTY AFFILIATED NURSING HOMES

County Affiliated Nursing Homes

County	Nursing Homes and Status	Beds
Adams	Sold to Transitions Healthcare in August 2011	
Allegheny	County Owned	
	John J Kane Regional Center Glen Hazel	210
	John J Kane Regional Center McKeesport	360
	John J Kane Regional Center Ross Twp.	240
	John J Kane Regional Center Scott Twp.	314
Armstrong	County Owned – Managed by Affinity Health Services	
	Armstrong County Health Center	115
Beaver	Sold to Comprehensive HealthCare Management Services LLC of New Jersey in November 2013 (Closing in March 2014)	
	Friendship Ridge	589
Berks	County Owned – Managed by Complete Healthcare Resources	
	Phoebe Berks Health Care Center	120
Blair	Sold to Reliant Senior Care Management in June 2013	
	Valley View Home	240
Bradford	County Owned - Managed by Complete Healthcare Resources	
	Bradford County Manor	200
Bucks	County Owned – Managed by Genesis Healthcare	
	Neshaminy Manor Home	360
Butler	County Owned – For sale and reviewing prospective buyers on January 24, 2014	
	Sunnyview Nursing & Rehabilitation Center	220
Cambria	Sold to Grane Healthcare on January 1, 2010	
Carbon	Sold to Guardian Healthcare on July 1, 2010	
Centre	County Owned – Converted to private non-profit on November 1, 2013	
	Centre Crest	240
Chester	County Owned	
	Pocopson Home	275
Clarion	Privatized – Managed by Extendicare	
Clearfield	Privatized - Managed by CHR	
Clinton	County Owned – Managed by Premier	
	Susque-View Home	146
Crawford	County Owned	
	Crawford County Care Center	157

County	Nursing Homes and Status	Beds
Cumberland	County Owned – (Authorized Bonds for renovation and expansion on 1/30/2014)	
	Claremont Nursing & Rehabilitation Center	290
Dauphin	Sold to Global Securities House in January 2007	
Delaware	County Owned	
	Fair Acres Geriatric Center	908
Elk	Privatized – Managed by CHR	
Erie	County Owned – two individual nursing homes	
	Pleasant Ridge Manor East (plan to sell 88 beds and privatize while consolidated County facility will operate at Pleasant Ridge Manor and reduced to 300 beds – not yet finalized)	76
	Pleasant Ridge Manor West	312
Fayette County	Privatized – local management	
Franklin	Sold to Mid-Atlantic Health Care of Maryland in December 2013	
	Falling Springs Nursing & Rehab Center	186
Fulton	Private – Managed by Fulton County Medical Center	
Huntingdon	Private – Managed by Foundation Health Services	
Indiana	County Owned – Managed by Affinity	
	Beacon Ridge, A Choice Community	118
Jefferson	Privatized – local management	
Lackawanna	Sold to Millennium Management of Florida March 1, 2010	
Lancaster	Privatized - Complete Healthcare Resources	
Lebanon	County Owned – (Sold to complete HealthCare Resources in June 2014)	
	Cedar Haven	324
Lehigh	County Owned – Managed by LW Consulting (Undergoing operational assessment in December 2013)	
	Cedarbrook Fountain Hill – Bethlehem	680
	Cedar Brook Allentown (141 nursing homes beds closed and converted to 42 independent living apartments by County)	
Luzerne	Privatized – Managed by CHR	
Lycoming	Privatized – local management	
Mercer	Sold to South Western Alpha on December 31, 2009	
Monroe	County Owned – Managed by Premier	
	Pleasant Valley Manor	174
Montgomery	Sold to Mid-Atlantic Health Care of Maryland on October 17, 2013 (not yet closed)	
	Parkhouse Providence Point	467
Northampton	County Owned – Managed by Premier (Sale referendum defeated in May 2011)	
	Northampton County Home Gracedale	725
Northumberland	Sold to Complete Healthcare Resources in 2009	
Philadelphia	County Owned – Managed by Fairmount Long Term Care	
	Philadelphia Nursing Home	451
Schuylkill	County Owned – Managed by Service Access and Management	
	Schuylkill County Home Rest Haven	142

County	Nursing Homes and Status	Beds
Somerset	Privatized – Managed by Complete Healthcare Resources	
Venango	Privatized – Managed by UPMC Senior Communities	
Warren	County Owned	
	Rouse-Warren County Home	176
Washington	County Owned	
	Washington County Health Center	288
Wayne	Privatized – Managed by local Health System	
Westmoreland	County Owned – Managed by Complete Healthcare Resources	
	Westmoreland Manor	408
York	County Owned – (Cost Reduction Initiatives introduced in December 2013)	
	Pleasant Acres Nursing & Rehabilitation Center	375
Totals on January 1, 2013	32 Facilities operated by 28	9,868

Note: At one time there were 50 counties that had their own nursing homes. Now there are 27 facilities owned by 23 counties. Some small counties not listed here have never operated county nursing homes. Information current as of June 2014.

APPENDIX G
LONG TERM LIVING WAIVER PROGRAMS

Selected Department of Public Welfare Waivers for Older Adults[401]				
Program Name	**Waiver Authority**	**Program Office**	**Background/Eligibility Requirements**	**Services Offered**
Aging Home and Community Based Waiver	1915 (c)	OLTL	Aging Home and Community Based Waiver Services may be available to Pennsylvanians over the age of 60+ to enable them to continue to live in their homes and communities with support and services. The applicants must be nursing facility clinically eligible. Eligibility criteria includes: • Be a resident of Pennsylvania • Be a U.S. citizen or a qualified Non-citizen • Have a Social Security Number • Be 60 years of age or older • Meet the level of care needs for a Skilled Nursing Facility • Meet financial requirements as determined by the local County Assistance Office.	Services include: Adult Daily Living Services; Personal Assistance Services; Respite; Service Coordination; Home Health Services; Accessibility Adaptations, Equipment, Technology and Medical Supplies; Community Transition Services; Home Delivered Meals; Non-Medical Transportation; Participant-Directed Community Supports; Participant-Directed Goods and Services; Personal Emergency Response System (PERS); TeleCare; and Therapeutic and Counseling Services.
Living Independently for the Elderly (LIFE) Program	42 C.F.R., Part 460	OLTL	An option that allows the seniors age 55+ to live independently on their own while receiving services and supports that meet the health and personal needs of the individual. Living Independence for the Elderly (LIFE) is a managed care program that provides a comprehensive all-inclusive package of medical and supportive services. The program is known nationally as the Program of All-Inclusive Care for the Elderly (PACE). All of the PACE providers in Pennsylvania have the name 'LIFE' in their name. The first programs were implemented in Pennsylvania in 1998. Eligibility criteria includes: • Be age 55 or older • Meet the level of care needs for a skilled nursing facility or a special rehabilitation facility	Services include: Adult Day Health Services, Audiology, Dental, Emergency Care, End of Life Services, Hospital and Nursing Facility Services, In-home Supportive Care, Lab and X-ray Services, Meals, Medical and Non-medical Transportation, Medical Specialists, Optometry Services and Eyeglasses, 24/7 Nursing and Medical Coverage, Nursing Care, Personal Care, Pharmaceuticals, Physical, Speech and Occupational Therapies, Primary Medical Care, Recreational and Socialization Activities, Social Services, and Specialized Medical Equipment

[401] Information provided to JSGC by the Dept. of Public Welfare, June 12, 2014, supplemented with waiver information from the DPW website, http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/index.htm.

Selected Department of Public Welfare Waivers for Older Adults[401]				
Program Name	**Waiver Authority**	**Program Office**	**Background/Eligibility Requirements**	**Services Offered**
			• Meet the financial requirements as determined by your local County Assistance Office or be able to privately pay • Reside in an area served by a LIFE provider • Be able to be safely served in the community as determined by a LIFE provider	
PA OBRA Waiver	1915(c)	OLTL	OBRA is a Home and Community Based Waiver program that helps persons with developmental physical disability to live in the community and remain as independent as possible. Other related conditions (ORCs) that may apply include physical, sensory, or neurological disabilities which manifested before age 22 and are likely to continue indefinitely. Eligibility requirements include: • State residents, age 18-59 who are currently in the waiver since prior to 7/1/2006 may age in place. Individuals age 60 and older will be referred to the Aging Waiver. • Have a severe developmental physical disability requiring an Intermediate Care Facility/Other Related Conditions (ICF/ORC) level of care. • The disability must result in substantial functional limitations in three or more of the following major life activities: Self-care, communication, learning, mobility, self-direction and capacity for independent living. • Meet the financial requirements as determined by the local County Assistance Office.	Services include: Accessibility Adaptations, Equipment, Technology and Medical Supplies, Community Integration, Community Transition Services, Personal Assistance Services, Education Services, Personal Emergency Response System (PERS), Respite, Service Coordination, Non-Medical Transportation, Therapeutic and Counseling Services, Home Health, Adult Daily Living, Supported Employment and Financial Management Services.
PA Attendant Care	1915(c)	OLTL	Attendant Care waivers are available to state residents, age 18 to 59, to provide home and community-based services to mentally alert adults with physical disabilities between the ages of 18 and 59. The waiver Individuals age 60 and over who meet the eligibility requirements for the Attendant Care Waiver and who were receiving waiver services prior to reaching their 60th birthday may choose to continue to receive services under the Attendant Care Waiver or transition to the Aging Waiver.	Services include: Personal Assistance Services, Service Coordination, Community Transition Services, Participant-Directed Community Supports, Participant-Directed Goods and Services, and Personal Emergency Response System.

Selected Department of Public Welfare Waivers for Older Adults[401]				
Program Name	**Waiver Authority**	**Program Office**	**Background/Eligibility Requirements**	**Services Offered**
			Eligibility requirements include: • Meet the level of care needs for a Skilled Nursing Facility for the Medicaid Waiver. Those who do not meet the Skilled Nursing Facility level of care MAY qualify for the PA State funded Act 150 Program • Be capable of hiring, firing, and supervising attendant care worker(s); managing your own financial affairs; and managing your legal affairs • For the Medicaid Home and Community Based Waiver Services Attendant Care Program, meet the financial requirements as determined by your local County Assistance Office. • Have a medically determinable physical impairment that is expected to last of a continuous period of not less than twelve (12) calendar months or that may result in death • To take advantage of the Attendant Care Act 150 Program, you may be assessed a minimal co-payment. This co-payment is based on your income and will not be more than the total costs of services.	
Person/Family Directed Support	1915(c)	ODP	The consumer family directed HCBS gives more choice about how and where a person receive services. This program primarily serves individuals under age 60 with a disability who need services and support. This HCBS is also available to those over age 60. Eligibility requirements include: • Eligibility is limited to individuals age three and above who require an ICF/MR level of care as determined by the County MH/MR Program/ Administrative Entity • This waiver is primarily aimed at individuals residing in their own homes or with family members. The waiver provides a limited array of services and supports up to a maximum of $26,000 per recipient per FY based on their authorized support plan (the limit excludes supports coordination services).	Services include: Home and community habilitation, supports coordination, respite, environmental accessibility adaptations, transportation, therapy and nursing services, personal support services, prevocational services, transitional work services, day habilitation, supported employment, adaptive appliances and equipment, and homemaker/chore services.

APPENDIX H
Long Term Living Rebalancing Report

Long Term Living Rebalancing Report

	Fiscal Year 2008-2009				Fiscal Year 2009-2010				Fiscal Year 2010-2011				Fiscal Year 2011-2012				Fiscal Year 2012-2013			
	1st QTR	2nd QTR	3rd QTR	4th QTR	1st QTR	2nd QTR	3rd QTR	4th QTR	1st QTR	2nd QTR	3rd QTR	4th QTR	1st QTR	2nd QTR	3rd QTR	4th QTR	1st QTR	2nd QTR	3rd QTR	4th QTR
Statewide																				
AC over 60	702	734	756	781	819	875	936	976	1037	1099	1134	1174	1220	1267	1291	1352	1413	1471	1546	1582
Act 150 over 60									751	770	792	818	834	838	821	830	818	820	826	813
AC under 60	4,901	5,084	5,325	5,512	5,829	6,127	6,236	6,439	6,525	6,647	6,701	6,497	6,506	6,683	7,024	7,189	7,295	7,421	7,628	7,544
Act 150 under 60	2,230	2,243	2,263	2,282	2,219	1,968	1,880	1,899	1,861	1,864	1,815	1,737	1,648	1,546	1,452	1,393	1,328	1,283	1,228	1,174
Aging Waiver	14,611	15,011	15,397	16,004	16,712	17,217	17,645	18,112	18,700	19,045	18,979	19,441	19,929	20,427	20,901	21,363	23,113	23,630	24,058	24,226
AIDS Waiver**	111	105	119	131	116	111	119	117	103	88	86	87	85	93	84	84	86	88	85	81
Commcare Waiver	493	536	569	595	617	659	672	688	694	679	663	659	639	629	623	615	604	594	586	576
Independence Waiver	2,569	2,744	2,947	3,137	3,293	3,562	3,824	4,120	4,529	4,743	4,967	5,231	5,448	5,894	6,329	6,608	6,960	7,318	7,747	7,973
Obra Waiver	1,463	1,553	1,605	1,685	1,765	1,746	1,726	1,698	1,656	1,640	1,619	1,604	1,570	1,557	1,536	1,514	1,492	1,474	1,463	1,442
LIFE Community	1,488	1,569	1,663	1,790	1,854	1,990	2,084	2,255	2,397	2,489	2,477	2,658	2,815	2,960	3,034	3,142	3,232	3,307	3,505	3,567
HCBS Total	**28,568**	**29,579**	**30,644**	**31,917**	**33,224**	**34,255**	**35,122**	**36,304**	**38,253**	**39,064**	**39,233**	**39,906**	**40,694**	**41,894**	**43,095**	**44,090**	**46,341**	**47,406**	**48,672**	**48,978**
Nursing Facility Residents	60,986	61,549	61,706	61,403	61,744	61,965	61,830	61,800	62,212	62,418	62,428	61,792	61,925	61,940	62,127	61,900	62,140	61,942	61,828	60,849
LIFE Facility Residents	214	248	245	241	269	231	272	305	332	361	409	379	388	364	348	414	436	494	434	487
NF Facility residents	**61,200**	**61,797**	**61,951**	**61,644**	**62,013**	**62,196**	**62,102**	**62,105**	**62,544**	**62,779**	**62,837**	**62,171**	**62,313**	**62,304**	**62,475**	**62,314**	**62,576**	**62,436**	**62,262**	**61,336**
Total Served	*89,768*	*91,376*	*92,595*	*93,561*	*95,237*	*96,451*	*97,224*	*98,409*	*100,797*	*101,843*	*102,070*	*102,077*	*103,007*	*104,198*	*105,570*	*106,404*	*108,917*	*109,842*	*110,934*	*110,314*
Percent HCBS	*31.8%*	*32.4%*	*33.1%*	*34.1%*	*34.9%*	*35.5%*	*36.1%*	*36.9%*	*38.0%*	*38.4%*	*38.4%*	*39.1%*	*39.5%*	*40.2%*	*40.8%*	*41.4%*	*42.5%*	*43.2%*	*43.9%*	*44.4%*
Percent NF	*68.2%*	*67.6%*	*66.9%*	*65.9%*	*65.1%*	*64.5%*	*63.9%*	*63.1%*	*62.0%*	*61.6%*	*61.6%*	*60.9%*	*60.5%*	*59.8%*	*59.2%*	*58.6%*	*57.5%*	*56.8%*	*56.1%*	*55.6%*

****Enrollment numbers shown for the AIDS Waiver is representative of only those in FFS programs; the number does not include those in Managed Care Programs**

Source: Rebalancing Report as provided to JSCG by DPW, Office of Legislative Affairs, May 8, 2014. Minor modifications were made to include Michael Dallas Waiver with Independence Waiver, and Elwyn Waiver with the Aging Waiver.

APPENDIX I
Long Term Living Funding Summary

OLTL Summary by Fund and Appropriation (Dollar Amounts in Thousands)	2008-09 Actual	2009-10 Actual	2010-11 Actual	2011-12 Actual	2012-13 Actual
GENERAL FUND					
Nursing Facility Residents					
Provided funding for the Elwyn Waiver when active					
Long-Term Care (195-267)	$672,597	$540,266	$728,907	$737,356	$770,903
(F) Medical Assistance-Long Term Care (782-161)	$2,568,941	$2,092,636	$2,346,646	$2,044,507	$2,063,864
(F) ARRA - Medical Assistance - Long Term Care (032-919)	$0	$398,910	$366,949		
(A) Special Revenue	$81,797	$38,188	$38,187	$0	$0
(A) Nursing Home Assessments	$397,134	$416,638	$305,660	$456,870	$416,029
(A) Long Term Care	$0	$0	$0	$223	$0
Subtotal--Federal Funds	$2,568,941	$2,491,546	$2,713,595	$2,044,507	$2,063,864
Subtotal--Augmentations	$478,931	$454,826	$343,847	$457,093	$416,029
Total--Long Term Care Facilities	$3,720,469	$3,486,638	$3,786,349	$3,238,956	$3,250,796
Aging Waiver					
Home and Community - Based Services (087-016)*	$0	$0	$0	$175,162	$184,500
(F) Medical Assistance-Home and Com Based Svs (798-959)	$0	$0	$0	$217,070	$236,250
(A) Small Games of Chance	$0	$0	$0	$0	$0
Subtotal--Federal Funds	$0	$0	$0	$217,070	$236,250
Subtotal--Augmentations	$0	$0	$0	$0	$0
Total--Home and Community - Based Services	$0	$0	$0	$392,232	$420,750
LIFE Community and Facility Residents					
Long-Term Care Managed Care (088-025)**	$0	$0	$0	$65,551	$74,935
(F) Medical Assistance-Long-Term Care Managed Care (949-960)	$0	$0	$0	$88,601	$99,266
Subtotal--Federal Funds	$0	$0	$0	$88,601	$99,266
Total--Long-Term Care Managed Care	$0	$0	$0	$154,152	$174,201
Obra, Commcare, and Independence Waivers					
Services to Persons with Disabilities (128-243)	$74,268	$95,063	$115,635	$163,987	$195,135
(F) Med Asst-Services to Persons with Disabilities (716-126)	$128,899	$148,639	$182,929	$199,981	$230,688
(F) ARRA-MA-Services to Persons with Disabilities (033-920)	$0	$28,988	$28,587	$0	$0
(A) Intergovernmental Transfer	$9,256	$0	$0	$0	$0
Subtotal--Federal Funds	$128,899	$177,627	$211,516	$199,981	$230,688
Subtotal--Augmentations	$9,256	$0	$0	$0	$0
Total--Services for the Developmentally Disabled	$212,423	$272,690	$327,151	$363,968	$425,823
AC under 60 and Act 150 under 60					
Attendant Care (116-234)	$83,917	$99,488	$97,869	$102,704	$107,830
(F) Medical Assistance-Attendant Care (938-181)	$79,286	$82,925	$99,723	$78,479	$92,767
(F) ARRA-Medical Assistance-Attendant Care (034-921)	$0	$16,703	$14,178		
(A) Attendant Care Patient Fees	$978	$103	$103	$901	$646
(A) Attendant Care Parking Fines	$103	$889	$945	$103	$103
(A) Intergovernmental Transfer (IGT)	$15,282	$0	$0	$0	$0
Subtotal--Federal Funds	$79,286	$99,628	$113,901	$78,479	$92,767
Subtotal--Augmentations	$16,363	$992	$1,048	$1,004	$749
Total--Attendant Care	$179,566	$200,108	$212,818	$182,187	$201,346

Cont.

Provides funding for AIDS Waiver Recipients in Managed Care					
Medical Assistance--Capitation (001-226)	$2,688,387	$2,121,765	$2,478,449	$3,301,109	$3,631,373
(F) Medical Assistance-Capitation (946-186)	$4,556,147	$4,401,865	$5,297,749	$5,210,745	$5,456,287
(F) ARRA-Medical Assistance-Capitation (928-852)	$0	$748,072	$805,813	$0	$0
(F) Asthma Control Program 885-283)	$0	$39	$103	$62	$11
(A) Managed Care Assessment	$398,226	$177,158	$6,758	$70	$0
(A) Medicaid Managed Care Gross Receipt Tax	$0	$505,000	$582,008	$642,798	$658,360
(A) Statewide Quality Care Assessment	$0	$0	$159,263	$190,426	$232,077
(A) DOH Pediatric Dental Assoc	$550	$0	$0		
(A) Center for Health Care Strategies	$0	$40	$121	$26	$0
Subtotal--Federal Funds	$4,556,147	$5,149,976	$6,103,665	$5,210,807	$5,456,298
Subtotal--Augmentations	$398,776	$682,198	$748,150	$833,320	$890,437
Total--Medical Assistance-Capitation	$7,643,310	$7,953,939	$9,330,264	$9,345,236	$9,978,108
Provides funding for AIDS Waiver Recipients in FFS					
Provided Funding for Michael Dallas Waiver when active					
Medical Assistance--Outpatient (120-237)	$555,085	$435,939	$467,929	$645,095	$450,835
(F) Medical Assistance-Outpatient (739-138)	$1,118,274	$1,061,211	$1,165,384	$1,204,135	$1,038,102
(F) ARRA-Medical Assistance-Outpatient (918-843)	$0	$213,000	$204,866	$0	$0
(F) State Health Access Program (025-767)	$0	$0	$0	$0	$0
(A) Ash Institute Access	$0	$10	$0	$0	$0
(F) State Health Care Innovation (893-842)	$0	$0	$0	$0	$40
(A) Statewide Quality Care Assessment	$0	$0	$4,495	$5,717	$5,324
(A) Chronic Care Management	$1,050	$0	$5	$0	$0
(A) Hospital Assessment	$50,716	$82,137	$121,433	$125,706	$140,252
Subtotal--Federal Funds	$1,118,274	$1,274,211	$1,370,250	$1,204,135	$1,038,142
Subtotal--Augmentations	$51,766	$82,147	$125,933	$131,423	$145,576
Total--Medical Assistance--Outpatient	$1,725,125	$1,792,297	$1,964,112	$1,980,653	$1,634,553
LOTTERY FUND:					
Nursing Facility Residents					
Medical Assistance-Long-Term Care (198-753)	$300,707	$178,438	$178,438	$178,438	$309,081
Aging Waiver					
Home and Community- Based Services (041-058)	$0	$0	$0	$0	$0
TOBACCO SETTLEMENT FUND					
Aging Waiver					
Home and Community-Based Services (207-032) (EA)	$25,086	$23,783	$18,973	$9,396	$42,401
(F) Medical Assistance-Community Services (063-070) (EA)	$43,102	$37,698	$31,298	$11,583	$48,490
(F) ARRA-Medical Assistance-Community Services (883-500) (EA)	$0	$7,390	$6,190	$0	$0
Subtotal--Federal Funds	$43,102	$45,088	$37,488	$11,583	$48,490
Total--Home and Community - Based Services	$68,188	$68,871	$56,461	$20,979	$90,891
Nursing Facility Residents					
Medical Assistance Long-Term Care (074-875) (EA)	$134,112	$130,923	$103,599	$162,583	$121,713
Funding for the ACT150 Over 60 and Attendant Care Over 60 is provided by the Department of					

*Prior to July 1, 2011, Home and Community Based Services were funded through both the Medical Assistance-Long-Term Care appropriation and the Tobacco Settlement Fund Home and Community Based Services appropriation.

**Prior to July 1, 2011, Long-Term Care Managed Care services were funded through the Medical Assistance-Long-Term Care appropriation.

Source: Funding information as provided to JSCG by DPW, Office of Legislative Affairs, May 8, 2014.