Blue Bell, PA

June 6, 2014 1:00 pm - 4:00 pm
Montgomery County Community College; Central Blue Bell Campus, 340 Dekalb Pike

Pennsylvania Behavioral Health and Aging Coalition
Opening Doors for Older Pennsylvanians

Long Term Care Commission Testimony
June 6, 2014

Good afternoon members of the Long Term Care Commission. My name is Rebecca May-Cole and I am the Executive Director of the Pennsylvania Behavioral Health & Aging Coalition.

Thank you for your invitation to provide testimony about the important issue of behavioral health in Pennsylvania's long term care system. When I refer to behavioral health, I am referring to mental health and substance use disorders.

Please let me begin with a story from several years ago:

> Mrs. Smith is an 84 year old woman with a history of schizophrenia, residing in an assisted living facility. On a Wednesday afternoon at 4:30, Mrs. Smith became increasingly anxious, and began throwing things in the dining room. She threw a walker at another resident. The staff was unable to calm her down so they called Crisis Intervention. Crisis said they could not help her because she is an older adult and recommended calling the Area Agency on Aging. The local AAA said they were not equipped to help and recommended the Emergency Department. Rather than being admitted to an inpatient psychiatric unit, she was admitted to a medical floor and was put in four point restraints. It was determined that Mrs. Smith needed nursing home placement because of some co-occurring physical issues but due to her psychiatric history, nursing facilities were unwilling to accept her.

While this happened several years ago, I mention it because this type of issue still arises today. We have made great strides in many areas of the state; however there is still room for improvement. The purpose of sharing this story is not to point fingers. This situation exemplifies one of the many problems older adults have in accessing appropriate mental health treatment in

595 South 20th S[redacted]

Pennsylvania. Many and varied systems of care exist to serve older individuals: home health care, behavioral health services, both private and publicly funded, Area Agencies on Aging offices, personal care homes, assisted living and nursing homes, however, older adults continue to be underserved. How can this be? Assumptions of agencies' responsibilities and misunderstanding of specific roles contribute to problems in access and service provision. Agencies, especially older adult serving agencies, feel inadequately prepared to address behavioral health issues. Needless to say, the older adult gets lost in the shuffle. If agencies knew each other's responsibilities and worked jointly in situations like this, care would have been provided more quickly and inappropriate hospitalization could have been avoided. The Pennsylvania Behavioral Health and Aging Coalition has worked since 1999 to bring older adults, family care givers, and service providers together to advocate for system resources and system change. We are a statewide Coalition of individuals concerned with the unmet behavioral health needs of older Pennsylvanians. We work together to provide education and advocacy about this very important issue.

Behavioral health problems can create formidable barriers that may prevent older adults from living healthy, productive, and independent lives in the community of their choice. A review of the literature indicates that depression, anxiety disorders and dementia are the most commonly diagnosed behavioral health disorders in persons over the age of 65.1 Substance abuse and misuse is rising quickly in the older adult population. Alcohol is the most abused substance in individuals age 65 and older, however the baby boomer generation is bringing with it illicit drug use and the system needs to be prepared.2 According to testimony delivered by aging advocates before the U.S. Senate Special Committee on Aging in September 2006, older adults accounted for one fifth of all suicides in the United States.3

Pennsylvania's need for behavioral health services for older adults is more pressing than most states, as it ranks fourth in the country in the percentage of residents aged 62 and over. Pennsylvania has the third highest percentage of people over age 60 in the United States (only

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[1] National Institutes of Mental Health (2001). *Older adults: Depression and suicide facts*. Bethesda, MD: NIH Publication No 99-4593.

[2] 2007 National Survey on Drug Use & Health: National Findings SAMHSA

[3] "Mental health crisis among aging grows: Experts tell Congress rates of illness and suicides are high in U.S." *The Baltimore Sun*, September 15, 2006.

Florida and West Virginia have higher percentages), and only four states (California, Florida, New York and Texas) have a higher number of older residents than Pennsylvania.[4] While the national rates of utilization of behavioral health services by older adults is shockingly low, older Pennsylvanians utilize behavioral health services at nearly half the national average.[5] Older adults in Pennsylvania need age-appropriate mental healthcare solutions that emphasize education, outreach, accessibility, prevention, and peer-oriented services. Despite these well documented issues and the expected population growth, direct funding for older adults continues to be difficult. Issues of stigma keep many seniors from advocating for their own services. Ageism itself, lends little impetus for funding for this population.

A survey of nursing facilities in Pennsylvania in 2011 showed that they did not feel adequately prepared to assist residents with behavioral health disorders. Reasons included lack of staff with mental health expertise, lack of mental health training for staff, all mostly tied to inadequate funding. As the nursing facilities report, they are paid a flat amount to cover all services related to a resident's care, however this amount does not come close to covering the costs of residents with behavioral health issues.

Another issue relates to the interaction between various Medicaid funding sources. An individual may only be enrolled Medicaid Managed Care through HealthChoices Behavioral Health Managed Care Organizations (BHMCOs) or for a Medicaid Waiver such as the Aging Waiver. When an older adult who had been covered under HealthChoices BHMCO becomes eligible and moves to the Aging Waiver, they lose the services they had been eligible for under the BHMCO. While the Aging Waiver is supposed to provide all needed services to those enrolled, older adults with behavioral health needs are not being met.

Behavioral health providers do not have programs specifically designed for the unique needs of older adults with behavioral health needs. Reasons for this include a lack of understanding of the needs of older adults and how they differ from individuals of other ages, and a lack of funding to

[4] United States Census, 2000.

[5] 2006 CMHS Uniform Reporting System Output Table, Pennsylvania Behavioral Health National Outcome Measures (NOMS) - CMHS Uniform Reporting System, 2006, http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/URS2006.asp.

provide these services. The assumption is made that older adults have Medicare, which will then fund all of the health care services they need. This is NOT the case. Medicare only funds a specific set of traditional mental health services, and the reimbursement is extremely low. On top of this, the Medicare requirements relating to the types of professionals approved to provide the services makes it a costly to deliver. When adding in long term care, this situation becomes even more difficult to navigate for older adults and their caregivers.

I would be remiss if I didn't discuss the impact on caregivers of all that I mentioned earlier. The Family Caregiver Alliance reports that 30 – 40 percent of caregivers suffer from depression and emotional stress.[i] According to the Alzheimer's Association and others, 1/3 of family caregivers have symptoms of depression.[ii] Training family caregivers on how to work with their loved ones when they are experiencing behavioral health issues will help to alleviate some of the stress, while programs are needed to support the family caregivers – such as respite, additional in-home services, support groups, etc. I am sure there have been many who have testified about the need of such services for family caregivers, so I won't go into this further.

I hope the information I shared today is helpful to you in understanding the great needs of older adults with behavioral health concerns who are in the long term care system. This is a problem that will only grow as baby boomers continue to age and demand services. In the past older adults have suffered in silence, afraid of the stigma of mental illness and substance use disorders and unaware of where to turn. With organizations such as ours, and the other organizations you will hear from today, we are working to ensure that all Pennsylvanians, regardless of age, have access to and receive the care and services they so deserve. We would welcome the opportunity to talk further about how we can ensure that older Pennsylvanians receive the respect and services they need.

Thank you for your time.

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[i] Family Caregiver Alliance 2003

[ii] J Gen Intern Med. 2003 December; 18(12): 1006–1014.Patient and Caregiver Characteristics Associated with Depression in Caregivers of Patients with Dementia Kenneth E Covinsky, MD, MPH,[1] Robert Newcomer, PhD,[2] Patrick Fox, PhD,[2] Joan Wood, PhD,[1] Laura Sands, PhD,[1]Kyle Dane, BS,[1] and Kristine Yaffe, MD[3]

ROSS SCHRIFTMAN INSURANCE

Presentation to the Pennsylvania Long -Term Care Commission
Presented by Ross Schriftman, RHU, LUTCF, ACBC, MSAA
June 6, 2014

"I thatched my roof when the sun was shining, and now I am not afraid of the storm." - George F. Stivers

THE ISSUE

Too few Americans plan for the high likelihood of needing long term care services until they are in a crisis. The time to start planning is not when a family first faces the devastation of Alzheimer's, a stroke or a disabling accident of a loved one.

Reliance on government programs such as Medicaid will becoming less of an option in the near future. These programs are stretched to the limit and the increasing costs and increasing numbers of Americans needing care can not be borne by these programs alone. In 2003 Medicaid expenditures for all services nationally including long term care services where $269 billion. In 2012, the cost to taxpayers was $421 billion; a 57% increase. Even more striking, in 2003 there were 43 million Americans covered by Medicaid and in 2012 there were 56 million. (1) The number of people covered by Medicaid is expected to grow by 20 million due to expansions contained within the provisions of The Patient Protection and Affordable Care Act alone. (2)

It is imperative for people to plan ahead before a crisis arises. I am very pleased that the leaders of our Pennsylvania government have convened this meeting to start the process of getting people to recognize this need and plan for it.

SUGGESTIONS

THE "IT'S NEVER TOO EARLY" CAMPAIGN

The Commonwealth should embark on a program entitled, "It's Never Too Early." The goal of this program will be to increase public awareness of the issues surrounding long term care planning, to educate people about the options and tools available and for individuals and families to take action now and not wait.

The partners to lead this effort should include government officials including the Area Agencies on Aging Directors, business leaders, insurance company executives and agents, financial planners, estate planners, accountants, bank trust officers, members of the bar association, leaders of community groups, providers of long term care, caregivers and patients. People from each of these groups bring important perspectives and experiences to this effort.

National organizations such as The American Association for Long Term Care Insurance www.aaltci.org, The Center for Long Term Care Reform centerltc.com, the 3 In 4 Need More program www.3in4needmore.com and The National Association of Health Underwriters nahu.org can provide important tools and advice to help launch our efforts. They can assist us and determining what has worked in other states around our nation as well.

Some of the areas of planning to address include the preparation of legal documents such as advanced medical directives, powers of attorney, living wills, long term care insurance and life insurance with long term care benefits, the costs of care in different regions of the Commonwealth, who pays for care if a person does not have insurance, family issues such as adult children as caregivers and managers of one's care and what types of facilities and programs are available.

The campaign should be designed to get people to have to face the tough questions such as, "how will I pay for my care, where will I live, who will care for me, how involved do I want my adult children to be in providing or managing my care and how realistic is it for me to remain at home if I need

care when I have little or no support network?" Facing these realities will make it more likely that an individual will take action. Included in this effort should be a program to encourage families to meet and talk about these issues and then list ways to develop a plan of action.

The campaign should clearly inform the public about the risk of waiting to buy long term care insurance and, not only compare the premiums of buying coverage now to buying it in the future, but also stress the fact that over time the chances of being approved for coverage or getting a good rate are diminished as a person ages.

In addition, it is very important to stress that the cost of care rises over time and the need to consider including inflation protection. For example, comparing a 40 year old purchasing a plan with a benefit of $200 per day in 2014 should not be compared to a 60 year old purchasing a benefit of $200 per day in 2034. It should be compared to purchasing $400 per day in 2034. which is 5% simple interest over that 20 year period. This is just one example of how the cost of waiting should be highlighted in the materials.

The "It's Never Too Early" campaign could sponsor presentations around the state to community and business groups. Members of the General Assembly and their staffs could help coordinate these events. Presentations should include an explanation of the Pennsylvania Long Term Care Partnership program which allows asset protection from Medicaid spend-down rules for those who purchase qualified long term care insurance. The State of Indiana has conducted these types of partnership presentations for many years and their efforts could be used as a model. The Partnership program is designed to save significant tax dollars within the Medicaid program by encouraging personal planning and private insuring for the risks associated with long term care expenses. The private insurance pays first and the government Medicaid program becomes a back stop for Pennsylvanians who have moderate income and assets and can only afford premiums 3 or 4 years of long term care insurance coverage. These programs are affected in saving Medicaid dollars by encouraging people to privately insure and preserving government financial resources for the poor.

Income Tax Credit for Long Term Care Insurance

The Commonwealth should establish a tax credit against the Pennsylvania Personal Income Tax for the premiums paid by individuals for their long term care insurance. The benefit to our state budget over the long term could be enormous.

Each policy purchased represents one more citizen who is less likely to need Medicaid to help pay for his or her care. In 2002 the daily Medicaid rate in Pennsylvania for nursing care was $208.14. (3) Each person no longer depending on help from Medicaid because they have adequate private insurance potentially reduces taxpayers costs by $75,971 per year just in today's dollars.

In addition, on the revenue side, each policy sold results in a premium tax collection of 2% of premium. In 2011, the long term care insurance industry generated $439 million in premium resulting in almost $9 million in premium tax revenue to the Commonwealth. 285,000 Pennsylvanians owned long term care insurance policies that year paying an average annual premium of $1,540. (4) Imagine the benefit of the additional revenue if another 100,000 Pennsylvanians had long term care insurance? Imagine how much better of these individuals and their families would be to own this important protection. On top of this, additional personal income tax would be realized from the additional income of insurance agents and staff hired by insurance agencies and insurance companies to handle the extra business.

Finally, the more private paying patients in long term care the more likely our vital provider organizations will thrive. After all, Medicaid reimbursements create shortfalls in the cost of providing care for these facilities and agencies. Paying care workers higher wages is vital to our success.

New Carrier Premium Tax Incentive

Another idea would be to encourage more carriers to enter the Pennsylvania market by providing a multi-year holiday from the premium tax. Currently there are about 10 insurance companies specializing with long term care insurance that are licensed to sell here. Increasing competition and choices of plans and designs would be a significant benefit to consumers. The introduction of these new carriers with this tax break will have minimal affect on current revenue from this tax but result in a much broader tax base in the long run.

State Employee Voluntary Long Term Care Insurance Offering

At no funding cost to taxpayers, the Commonwealth should establish a voluntary long term care insurance offering for its own employees. The "It's Never Too Early" campaign could provide presentations to workers and their families who would be eligible.

This type of voluntary long term care insurance is common. The Federal government has a program for its workforce, families and retirees. More than a dozen state governments including New Jersey, Maryland, Ohio and New York have established long term care insurance programs for their employees. In additional, many counties, municipal governments and state universities as well as teacher unions have established programs.

By providing this voluntary offer, Pennsylvania can take the lead and show the public that our government means business when it comes to long term care planning.

Partnership Between Apprise and Insurance Agents

Pennsylvania's Apprise program provides valuable help to consumers throughout the Commonwealth. So do insurance agents who focus on "senior" products. A cooperative effort between private citizens who sell and service insurance for our older residents and our Department of Aging's assistance program can be of great value. Agents need to be made aware of the work of Apprise. Apprise volunteers need to understand and appreciate the role of insurance agents.

Joint educational programs between agents and Aprise should be implement. Joint planning sessions around the "It's Never Too Early" campaign should be held.

Although Apprise can not refer consumers to agents, there is a lot of opportunity to work together where we can.

(1) http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf

(2) Booze and Company projection in 2012

(3) A Report on Shortfalls In Medicaid Funding for Nursing Center Care by ELJAY, LLC for The American Health Care Association, December 2012

(4) The 2012-2013 Sourcebook for Long Term Care Insurance Information published by the American Association for Long Term Care Insurance.

By Ilana Polyak

First-Hand Knowledge

An agent learns the value of long-term-care insurance when his mother needs assistance.

Ross Schriftman was no stranger to caregiving by the time his mother, Shirley, became ill with Alzheimer's in 2006. As a teenager, his grandfather, Shirley's father, moved in with him, his three brothers and mother in their Maple Glen, Penn., home. Later, he and Shirley cared for Schriftman's great-aunt in their home.

Those early caregiving experiences cemented the idea in Schriftman's mind that an elderly person's last days should be spent at home, among loved ones. "My mother would say, 'I never want to go to a nursing home,'" Schriftman, LUTCF, MSAA, ACBC, says. "She just felt that being with the family was very, very important."

A plan for the future

When he went into the insurance business as an agent, Schriftman gravitated toward disability and long-term-care insurance. In 1990 Shirley turned to her son for advice when she began to think about her later years. She and Schriftman discussed how they would pay for care should Shirley need it. Schriftman had moved back to his childhood home and taken a lead role among the four brothers in overseeing his mother's affairs. Mother and son decided Shirley needed a long-term-care insurance policy.

Shirley's small pension from Unisys, where she had been a documentation specialist for Univac, was tight, so Schriftman paid for the policy.

The importance of home

At the time, LTCI was a new product, with limited riders and benefits. Schriftman purchased a policy with an $85 a day benefit. Most importantly, the benefit could be used to hire a home-health aide and didn't require transfer to a nursing home.

"Long-term-care insurance doesn't make the pain any easier, but it does make it easier to manage."
— Ross Schriftman

The goal was to make sure Shirley could stay close to the community and the family she loved. She led a spirited life and was politically active, serving as a Democratic Committeewoman in her area. In 1972, she chauffeured Hubert Humphrey's wife, Muriel, on a visit to Philadelphia. Shirley was chosen for the task both because of her support of the former vice president's politics and because her station wagon was big enough to accommodate Muriel Humphrey's entourage.

From the beginning, Shirley was an advocate for LTCI. To show her support, she accompanied Schriftman to the 2001 Mother's Day Rally for Long-Term Care in Washington, D.C. "She went around telling people that she had the insurance, and we would have an aide at home if she needed it," he says.

LTCI to the rescue

In 2006, Schriftman began to notice Shirley's cognitive decline. It was small things at first, but they grew worse. A doctor confirmed a diagnosis of Alzheimer's. For a year he cared for Shirley while her condition worsened. Some days, Schriftman even took her with him to the office so she wouldn't be alone. Eventually it became clear that Shirley needed continual care from a professional aide. "As time went by, it was more and more difficult to care for her," he says. "I never knew what I'd come home to."

Ross Schriftman and his mother, Shirley.

Being able to hire an aide made Schriftman's workdays less anxious. "I was able to come home in the evening knowing that there was a caregiver at home with my mother and my time in the evening with her was quality time," he says.

Shirley passed away in 2009 at the age of 84. In the course of two years, Schriftman says he received more value in benefit than the amount of premiums he paid into the policy over 17 years. The benefit amount didn't cover the entire expense, but it was a significant help.

"Long-term-care insurance doesn't make the pain any easier," Schriftman says. "But it does make it easier to manage."

Ilana Polyak is a New York City-based freelance writer. The Life and Health Insurance Foundation for Education is a nonprofit organization dedicated to helping consumers make smart insurance decisions to safeguard their families' financial futures.

Good Afternoon. My name is NEIL CASSEL, and I am both a small business owner and a PRIMARY CAREGIVER. My Mother is 80 years old and suffering from the later stages of PARKINSON'S DISEASE. Over the last few years, we have exhausted her Life Savings paying the taxes on her home, maintaining her property, and providing secondary Care Giver support for her in my absence. So you see, I am the crisis we are discussing here today.

When I can't work because no one can stay with her, then no pay, no taxes paid to the COMMONWEALTH, and the state's deficit increases again. It's time to think progressively and creatively if the Commonwealth wants to keep its population, and therefore its federal dollars and congressional delegation. It's our elder citizens who have, and continue to vote, so not providing for their needs means their families will likely move them to one of the states ranked higher than **46th** on AARP's list on SUPPORT FOR LONG TERM PROGRAMS.

The ideas I am about to present to the Commission, have been well researched and are based on what other states have, or are considering implementing. And just to clarify for the members of the Commission, I have both an MBA & a BBA, and have hired CNA's, analyzed Financial Statements of both NPO's and business organizations, and have written very successful Marketing and PR campaigns for both.

1) First, about identifying services. Neither of these publications, or any list from OAAS, **completely** identifies **all providers** in this area. So many want to complain about the HEALTHCARE MARKETPLACE website, yet at least the site is complete and accurate. Isn't about time, DPW considered a LONG TERM CARE website similar to *MEDICARE.gov* listing all certified ASSISTED LIVING Centers, DAYCARE locations, and HOME HEALTH CARE Providers?

2) Second, we are highly technology savvy state, yet all LONG TERM CARE providers require their own paperwork. A simple ONE FORM mandate would ease the stress on families and applicants when requesting Long Term Care. In fact, in this area, **40%** of our citizens are served by the same HealthCare network, so practically all the information for providers could be gotten through authorized portal use.

3) Third, why does it take **3 months** for HOME CARE services and over **6 months** for a Nursing Home admission when in the states ranked below and above us, the same can be completed in less than **half the time?** Because the CAO/OAAS system is underfunded, understaffed, and burdened with rules more concerned about FRAUD than expedited care. Why not consider a USER FEE on HEALTHCARE services to improve the staffing and technology of these offices. Majority of ER visits in most suburban hospitals are for older residents, who likely will need Long Term Care support shortly after their ER visit.

4) Fourth, if Hospitals are required to provide CENSUS data for their accreditation, why not require NURSING HOME to provide their BED TURNOVER ratio and WAIT LIST size *each quarter*? And if most smart doctors will now discuss their practice with you before you are patient, why aren't NURSING HOMES required to answer questions about their Facility before Families waste their precious little free time completing 8 page applications and copying 25 pages of financial documents? Do you really want your MOM or DAD cared for in a Facility that has never ever admitted a PD patient?

5) Fifth, *expedited response* is a quality outcome and measurement for HEALTHCARE providers, yet our current Long Term Care providers would be ranked F. Why not mandate that any admission of a senior citizen to an ER requires the Hospital to provide OAAS with that patient's basic information and diagnosis? Let's be proactive and get a jump on providing services to residents who already are showing signs of physical infirmities. This is **not** a HIPPA VIOLATION since the "health & welfare" clause of the constitution trumps any law.

6) Finally, if this Commission is serious about solving the Long Term Care Crisis, then it must begin to consider looking "outside the box" for answers. Why not consider subsidizing both ASSISTED LIVING costs and expansion of NUSRING HOMES? The former will quickly reduce the WAIT LISTS at Nursing Homes at less than the cost for MEDICAL ASSISTANCE but more than WAIVER PROGRAM coverage. Floating a **$150 million** dollar BOND for NURSING HOME EXPANSION will allow our unemployment rate to continue to decline with private sector jobs, why pushing Nursing Home Administrators and executives to provide matching funds to insure their genuine interest in decreasing area WAIT LISTS.

As I stated when I began, I am the crisis. During this meeting it is estimated that one more elderly frail resident in the Commonwealth will lose their home because they no longer can afford its operational costs. Another will die prematurely from the lack of proper care options in their community. So, ladies and gentleman, with FATHER'S DAY just a week away, I ask you this simple question.

Do you really want you FATHER or UNCLE to wait 6 months for LONG TERM ASSISTANCE if he couldn't even get up to hug you ? As the old proverb states,

Honor thy FATHER & MOTHER, but bless the child.

Unfortunately, the Commonwealth has done neither as of late, and the cost of continuing on this path, is that likely, there will be no one, or no facility or provider to help you in your golden years. Thank-you.

County of Bucks

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June 6, 2014

Department of Public Welfare
P.O. Box 8025
Attn: OLTL Policy
Harrisburg, PA 17105

Subject: Notice of Public Input

Dear Pennsylvania Long-Term Care Commission:

Thank you for the opportunity to provide input regarding ways to improve the delivery of long term services and supports for Pennsylvania's older residents and those living with a disability.

Meeting the long term service and support needs for an increasing older adult population remains a challenge for states, counties, and local municipalities. The first of the nearly 78 million Baby Boomers turned age 65 as of January 2011. Pennsylvania is home to more than 3.3 million Baby Boomers, accounting for 26.6 percent of Pennsylvania's total population. The need for services and supports will continue to grow with the growth in the older adult population.

There are several factors to consider regarding the accessibility and provision of services for Pennsylvania's older adults:

1) The Older Americans Act of 1965 is the foundation for many services and supports offered today. The Act declares the U.S. government is responsible for ensuring older adults have equal opportunity to programs that promote the dignity of individuals in our society. Federal, state, and local offices assist with access to "full restorative services for those who require institutional care, and a comprehensive array of community based, long-term care services adequate to appropriately sustain older people in their communities and in their homes, including support to family members and other persons providing voluntary care to older individuals needing long-term care services." Reauthorization of the Older American's Act is crucial to preserve existing services and create new programs that support older adults.

2) The 52 Area Agencies on Aging in Pennsylvania have fulfilled our Older American's Act mandates since officially designated by our state and local officials. We support healthy older adults, those that require assistance to remain safe in the community, and those at risk for abuse, neglect, financial exploitation, and abandonment. Our consumers are typically older adults: with the greatest economic or social needs, those at risk for institutionalization, low-income minority consumers, those residing in rural areas, and those with limited English proficiency. Area Agency on Aging Care Managers complete comprehensive face to face assessments to determine the appropriate level of care, and develop care plans to meet consumers' holistic and specific needs. Our recommendations cover a continuum of care needs, with choices ranging from institutional care for those unable to reside safely in the community, to Home and Community Based Services ("HCBS") as a less restrictive and consumer preferred alternative. Preserving the Area Agency on Aging function of determining consumer level of care ensures the Commonwealth will maintain the most appropriate, unbiased, and trusted source for assessing the needs of some of our most vulnerable residents.

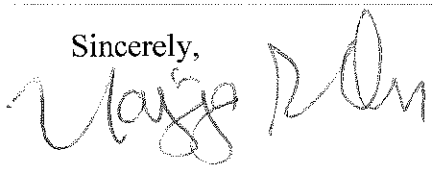
3) Older adults often experience fragile health and/or dementia that often prevent their ability to manage their own needs. Pennsylvania remains unique because the Lottery Fund addresses the service needs of older adults who do not qualify for Medical Assistance or other state entitlement programs. Lottery funded programs are responsive to consumer needs and allow for freedom of choice. Home and Community Based Services (HCBS) supported by the Pennsylvania Lottery promote older adults living in the community, provide significant relief to consumers and their caregivers, and are often an economically responsible alternative to institutionalization. Lottery funded supports also include, but are not limited to: employment assistance, volunteer recruitment and placement, health and wellness programs, legal counseling and representation, benefits and resource counseling, assistance with nutritional needs, advocacy and protection services, rent and property tax rebates, transportation services, and the PACE Program. It is important for the Pennsylvania lottery to remain dedicated to meeting the service and support needs of the Commonwealth's older adults.

4) There were a total of 47,926 nursing facility residents in fiscal year 2012-13, versus 43,900 consumers enrolled in Medical Assistance HCBS Waiver Programs. However, $309 million of Lottery revenue was budgeted to support Medical Assistance nursing facility residents, while HCBS could have delayed or prevented institutionalization for many more elderly consumers across the commonwealth. Section 301(a)(1) of the Older American's Act encourages cooperative agreements between states and Area Agencies on Aging to promote "securing and maintaining maximum independence and dignity in a home environment for older individuals capable of self care with appropriate supportive services." Consideration to rebalance Medical Assistance revenue for greater support of HCBS, and utilizing Lottery revenue for consumers not eligible for Medical Assistance or other entitlement programs, will strengthen Pennsylvania's commitment to Older American's Act mandates. The Aging Waiver Program provides community supports for persons age 60 or older, who are eligible for nursing home care, but can be safely served in the community. Additionally, the Aging Waiver Program is more economical, with the average annual nursing facility cost per consumer $60,528 versus the average annual Aging Waiver cost per consumer $23,000. Allowing consumer presumptive eligibility determinations at the local level (i.e. the pilot program "Consumer Choice"), and

completing random consumer care plans reviews, could expedite supports while allowing appropriate state oversight and monitoring. HCBS, supported by either Medical Assistance or Lottery revenue, provide the most economically feasible and least restrictive setting for our residents.

Thank you again for this opportunity to provide input regarding Pennsylvania's long-term care system.

Sincerely,



Najja R. Orr
Director

Public Comment to Committee to Create a Plan to Address Long-Term Care in Pennsylvania as Ordered by Gov. Corbett

June 5, 2014

Presented by: Sarah Floyd, Director of Care Advocacy

Bucks County Elder Law

[redacted]

Collaboration Team: Sarah Floyd [redacted]

Allan 'Chip' Teel, MD

Jim Turner

As we well know, the U.S. healthcare system is in the midst of rapidly rising demand for healthcare services to seniors. The system has been built on a model of long term care and housing that is not equipped for the growth in demand we are about to experience, nor the great desire of a majority of seniors to age in place, in their own home or residence. Continued near exclusive reliance on the existing service model of nursing homes and other assisted living options is no longer state of the art nor economically efficient.

From personal experience and observation, families are using nursing homes etc., after personal funds are exhausted and they fall back on Medicaid or other public assistance programs. Another common scenario is the family is simply overwhelmed with the process of taking care of a loved one and grasp for the straws of existing living options, without even knowing what to expect or what the best options may be.

Opportunities exist to drastically improve the status quo of senior care services through application of proven and readily available telehealth and telemed technology. In fact, if we focus on three specific goals, supported by this proven technology, we will reduce costs, improve access to care givers, and improve the quality of life of our seniors, chronically ill and their families.

Telehealth, telemedicine, telecare etc., refer to support of, or provision of care using telecommunication services of some sort. Telehealth devices can be video cameras, phones, electronic monitoring tools/sensors and now even online physician to patient "live" interactions.

Given the impressive economic and outcomes benefits of expanded access to these services, there is no reason to delay their common implementation.

Prevention and Caregiver Support, Accessibility, Provision of Services and Quality Outcomes and Measurement will all be positively impacted by implementation of telemed/telehealth services.

Strategies:

1. Help the family afford to keep loved ones at home by supplementing paid caregiver hours and family caregiver hours with certain electronic monitoring tools.
    a. The performance key here is for the people doing the electronic monitoring to be working with the caregiving company so that when hands are needed they are quickly dispatched, and that when care is provided it is provided at the most optimal times.
2. More frequent access to the doctor and other health care providers via telemedicine options.
3. Effective electronic record keeping to keep families and providers current with the consumer condition, and analysis of those records as appropriate to support/implement care decisions. This could help people avoid the hospital when they do not need it as well as send them there sooner when it is critical to do so before a real crisis. Free services such as Practice Fusion and Microsoft Health Vault are available to all healthcare consumers and physicians. Progressive homecare companies are opening their service model to provide this access to their consumer clients and their physicians.

1. Supplementing hands on care with telehealth/med monitoring/interactive services.
    a. Hourly wage "hands on" personal care and support is one of the most expensive components of the care process. By using web based monitors and communications, in concert with homecare aide support, provides a system where costly hands on care can be targeted more efficiently and assigned more effectively. The result is consumers will live more comfortably and independently at lower costs.
    b. Telehealth monitor supported chronic disease management go beyond daily vital sign capture and reporting to include daily wellness conversations with trained support persons. This service will improve overall wellness, reducing disease state exacerbation and cost of care.

2. More effective provider and caregiver access using telemed/telehealth strategies.
    a. Consumer access to healthcare providers has always been impacted by the patient's own physical, economic or family/social limitations. Limitations such as wellness, exposure to communicable infections, cash to pay for transportation and access to helpers to get to and from the provider office are all relevant issues the patient must deal with. However, today's online physician visits can mirror physician office exams – complete with live heart/body sounds and vital signs. When appropriate, an online visit can eliminate the burden of traveling to

a provider office – this improves access, reduces overall costs and can certainly, immediately improve the quality of life and care for our seniors.

b. Using telemonitors in the home, coordinated with homecare providers and a web based service host, can "open" the home to family members and care givers from virtually around the world. A web portal to the home, protected by HIPAA compliant security, can open the life of the senior up to the observation of best care options, assisting in planning use of expensive hands on care, and allowing family members to know the condition of, and assist in the care management of their loved one regularly.

3. Electronic Medical Records and Personal Health Records
   a. EMR's and PHR's are utilized to assure medical data is used and shared most effectively today. However most consumers do not use a PHR, and their physicians are often only now beginning to use such tools. By encouraging seniors to use a PHR and working with a homecare provider in sync with physician EMR's we empower a truly patient centered model where information is readily shared and care is managed on a more proactive basis. Finally, the PHR also allows us to measure and track patient status by employing Patient Reported Outcome scores that can assist in baseline wellness assessment and then ongoing progress. In this day and age, the process of aging and chronic disease progression should NOT surprise us. The more shared knowledge from the patient on up through the care continuum, the stronger our system will become.

REIMBURSEMENT ISSUES THAT DO NOT MAKE SENSE – THAT SLOW US DOWN!

Currently Medicare and Medicaid (in most states) will reimburse for telemed visits – a virtual encounter between a physician and consumer, online and "live" to the point of real time physician observation of heart/lung/GI sounds, vitals, high def visual inspection of physical issues and conversation/care discussion "face to face". Technology exists to conveniently allow this to occur from any site in the world (including consumer living rooms and bed rooms) yet CMS entities require the consumer to leave their home to visit an "approved" site to allow physicians to be paid for their services under this scenario. This care option will never replace hands on provider services; however, it can and should replace certain maintenance visits where no hands would be laid on the healthcare consumer/patient. A simple modification to update reimbursement for telemed visits permitting consumers to remain in their residence instead of traveling to a distant site to take advantage of this innovative service will immediately improve provider access and reduce costs – transportation costs alone can be drastically reduced if a consumer can access physician support without having to use public transportation or medical service transport. The associated quality of life improvements of not having to deal with such hassles are enormous as well – particularly to the consumers and their families themselves.

- Reimbursement of these hybrid human/technology supported homecare services will be critical to the quantum leap required in our healthcare service capacity if we are to successfully meet the onslaught of demand presented by our rapidly aging population.

Providers exist in Bucks County and across the state that are currently willing and waiting to provide these services and prove the concept in practice.

The key to all of this working is to have an assigned provider that monitors and makes sense of the hourly data collected by cameras and then dispatches services as needed. A camera and computer can notice that "Mr. Jones" gets up every morning at 5am. An alert can go off if "Mr. Jones" did not get up! A phone call is then made to check on him. If needed, an aide can be dispatched to check vitals and link to a doctor. That can lead to catching an issue before a crisis such as a fall occurs. So many hospitalizations can be avoided by catching routine problems sooner. The other key is to have doctors seeing the same electronic record. Duplication of medicines or harmful drug interactions are major reasons for hospital events. These hospitalizations can lead to nursing home placement. Let's work smarter and not harder at this!

Berks Encore

[redacted]

berksencore
applauding life after 50

TO: Members of the Pennsylvania Long Term Care Commission
FROM: LuAnn Oatman, President/CEO Berks Encore
DATE: June 6, 2014
RE: Provision of Service in Pennsylvania

Berks Encore, a Berks County nonprofit agency, has for the past 50 years sought to work collaboratively in meeting the daily care and support needs of older adults. We work daily with older adults and their caregivers to navigate the network of aging services. Our mantra is "Aging may not be easy, but accessing aging-related services should be!"

Our agency, as a private nonprofit agency that subcontracts with the Berks Area Agency on Aging is able to leverage and foster community partnerships, grants and private funding resources that government alone cannot do. As an active partner in the "aging network" local nonprofits can work **with** government agencies to assess the needs of older adults, identify appropriate services needed, and administer cost-effective community based programming.

For example, according to the Center for Effective Government, Meals on Wheels saves the federal taxpayers money by helping seniors live at home instead of living in comparatively expensive nursing homes. The average cost to Medicaid for nursing home care per patient is approximately $57,878 annually. According to the Administration on Aging, as many as 92% of enrollees say the Meals on Wheels program means they can continue to live in their own home.

As a community partner dedicated to the care of older adults, Berks Encore makes an average of 130 calls per month to family members and caregivers to check on their loved one. This has resulted in documented life saving measures, ensuring that the homebound senior received emergency help and intervention services to address a medical concern or issue.

A subcontractor in Berks County with the Berks Area Agency on Aging, Berks Encore actively demonstrates its ability to work with a government agency in a collaborative manner. Our staff

and volunteers are actively involved in the lives of thousands of older adults annually. Older adults who are care managed by for profit and nonprofit providers. These same adults are seen daily by our staff and volunteers, and in the majority of cases, strong personal relationships have been established. Yet consistently, our agency and others like us across the state are overlooked when it comes to serving as a resource in the care continuum of service. Overlooked, in spite of the fact that successful care coordinaton programs incorporate signficant in-person interaction with the senior, and their family caregiver.

Berks Encore strongly supports the concept of a care coordination plan that includes the nonprofit, community based agencies already in existence that serve this population of older adults. Before we duplicate what may already exist in many communities, before we look to establish yet another nonprofit agency or an additional layer of government I encourage our commission to take an inventory of what each community has in place and see how we can work together, collaboratively to improve the state of aging in Pennsylvania.

The best care coordination models are well coordinated, person/family centers, cover multiple service settings, and promote better communication and interaction across multiple disciplines involving community based, nonprofit agencies that work directly with the family.

Thank you for your time.

The system is far too complicated for most people to navigate. Caregiver support is underutilized, and it appears to the outsider that it is meant to be that way. As a family caregiver for my aging parents, I experienced first- hand the struggle of trying to keep my parents who had been married for over 72 years together in their family home. Clearly a nursing home placement was the last kind of life my parents envisioned for themselves. Their greatest pleasures came when their 7 children, 18 grandchildren, and 10 great grandchildren filled their house of almost 60 years. My siblings and I are all college educated. I work in the field of home care, and my sister is a nurse in long term care. We have the tools to be able to find resources, coordinate assignments, and communicate with my parents' doctors. Yet, it was still a struggle. My parents' only significant asset is their home. I happened to know to call Area Agency on Aging (most people think AAA is an automobile club or has something to do with alcoholism). I had to call several offices before finding the correct one for my parents' location. I had to leave a message and never got a call back. Then I learned that since Dad was a Veteran, he would have to exhaust those benefits first before being eligible for any waiver benefits. From the Veterans Affairs website, I downloaded a 12 page application form for Dad and a 12 page application for my Mom, the spouse, in order to apply for the Veteran benefit. There is a 10 page guide that is supposed to help. My brother and Sister gathered the necessary documents such as honorable discharge, financials, etc. My sister made an appointment with a designated social worker at Coatesville. Packed up Mom and Dad (oxygen, walkers, etc.) and drove them nearly an hour to be told that the social worker did not have the appointment scheduled and could not meet with them. Another dead end. My Father, the WWII U.S. Navy vet passed away this March never receiving any financial assistance.

We need to do a better job of educating families, seniors, and their physicians about options for care. The primary care physician needs to be the point person to relay options and resources to families. That grass roots approach is the most effective. Otherwise, the only people that can benefit are those that are somehow already in the system. There needs to be more multi-media Public Service Announcements. I have been seeing PSA's about the CHIP program and Healthcare.gov, but nothing about options for Seniors. They seem to be the forgotten.

I want to leave you with some questions: Why is it that Medicaid dollars are only readily accessible for the most expensive level of care, skilled nursing facilities? This eliminates the valuable contribution of the family caregiver and supplemental professional home care which is much more cost efficient and enhances quality of life. The waiting period to approve home care is exhaustive (as much as 6 months)and prevents many from being able to utilize home care. Why is it that there is more effort put into preventing fraud and abuse in government programs than making sure seniors get the help they need at the level of care they need?

Testimony Respectfully Submitted by Patricia C. Rodgers, Vice President and Director of Operations of Waverly Care Associates, Gladwyne, Pa

June 6, 2014

Good Morning:

My name is Dianna Benaknin. I am the Administrator of the York County Area Agency on Aging and have worked in the field of aging services for thirty years.

Beyond administering the valuable programs that the aging network provides, I take very seriously my responsibility to advocate on behalf of those with limited ability to advocate for themselves.

We have a network of Personal Care Homes in Pennsylvania that provide critical services to elderly and disabled adults that need daily assistance and are unable to live independently. While the great majority of Personal Care homes in Pennsylvania accept only those residents that can private pay the full cost of care, a dedicated core group of homes continue to provide care to those most in need, with a payment of only $35.00 per day.

That $35.00 covers room and board, laundry, supervision, assistance with personal care needs, medication management, coordination of physical and medical needs and appointments, and transportation.

There has been absolutely no increase in this rate since 2007.

Statewide, the number of Personal Care Homes has declined by 31 percent from 2001 to 2014. Unfortunately, most of the homes that closed were those that primarily served individuals receiving the SSI supplement as payment, the $35.00 per day. A combination of increased operating costs and more stringent regulations, with no increased funding to implement changes, left those operators with no choice but to close. The same regulations apply, whether the home receives $35.00 per day or $150.00 per day to provide care.

An Assessment and Cost Review of Personal Care Homes in Pennsylvania was conducted and completed in April 2007, at the direction of the Legislative Budget and Finance Committee.

The comprehensive study reviewed the Personal Care Home situation in Pennsylvania and compared it to practices in other states. The cost analysis validated that actual cost of service was significantly higher than the reimbursement rate, and recommended a significant increase. That increase never materialized. Today, in 2014, providers still receive $35.00 per day to provide for all of the needs of these residents.

The findings also showed that almost all other states separated the "room and board" portion from the "care " portion and supported services in personal care homes, assisted Living facilities and other residential settings through utilization of a 1915 (c) Waiver, based upon need.

In January 2014, the Centers for Medicare & Medicaid Services (CMS) published the final rule of the 1915(c) Waiver, setting standards to ensure Medicaid-funded Home and community Based

Services (HCBS) are provided in settings non-institutional in nature that have full access by the consumer to the community.

Pennsylvania has an opportunity to submit to CMS by March 17, 2015, a request for initial approval or amendment under the 1915(c) option. Upon approval, the state has 120 days to submit a transition plan, addressing all Medicaid Home and Community Based Services.

Endorsing the 1915(c) Waiver option would utilize federal match dollars to support the service portion for care of low acuity residents that are otherwise served in nursing facilities at a cost to the Medicaid system that is several thousand dollars per month higher per resident.

Service delivery within the long term care system must be re-designed to foster consumer choice in a person-centered and cost-effective care network at the least restrictive level. Personal care homes save significant money to the state Medicaid system, and have the potential to save far more.

With fewer and fewer homes and beds available for low income care dependent adults, a crisis is looming. Many more homes are on the brink of closing…and many of their residents have lived in these homes for years…this is their family.

As homes close, those with slightly higher acuity needs move into nursing facilities and those needs are more medical management and supervision are left with few alternatives. The population with Mental and Behavioral Health issues is especially affected. Personal Care Homes provide the fragile network that manages medication and medical compliance and prevents expensive and restrictive hospitalization.

There is an immediate need to provide at least a minimal increase to the Personal Care Home Supplement so that we can reduce the rate of closures. I know there is no money, but I would equate that to the family living in a flood zone that says they can't afford flood insurance.

We also have an opportunity to save the commonwealth money by initiating the process to use the 1915(c) waiver in Personal Care Homes under the guidelines of the new CMS rule. There are individuals all across the state that could be transitioned from Nursing Facilities if these services were available, and York County would be glad to serve as a pilot.

Thank you for your consideration.

Dianna Benaknin, MSW

Director, York County Area Agency on Aging

[redacted]

ACQUIRED BRAIN INJURY NETWORK OF PENNSYLVANIA, INC.
215-699-2139 or 800-516-8052 Fax: 215-699-5139
2275 Glenview Drive, Lansdale PA 19446-6082
info@abin-pa.org www.abin-pa.org

May 29, 2014

PA Department of Public Welfare
Long Term Care Commission
PO Box 2675
Attn: OLTL POLICY
Harrisburg, PA 17105.

Greetings,

The Acquired Brain Injury Network of Pennsylvania, Inc., information, education, problem solving, personal and systems advocacy, and socialization for individuals and families who are affected by brain injury. We also provide staff training for organizations in fields such as behavioral health, home health aides, intellectual disabilities, and corrections.

At this time, we have several concerns to bring to the attention of the Pennsylvania Long Term Care Commission.

1. Supports Coordination –
   a. Agencies that supply supports coordinators for the Independence, OBRA, and Commcare Waivers must be subjected to quality control to protect participants from inadequate, inefficient, and incomplete service management.
   b. Participants must be able to report lack of satisfaction to the state through an ombudsman system.
   c. At present, the only recourse for poor service is to ask the supports coordinator for a list of other agencies and ask for a transfer, but that requires dealing with the person who has been difficult – not a pleasant task. These lists should be easily available.
   d. Participants must be given a list of the services that are available under their waiver. Currently, they do not know what is available, permitting the supports coordinator to act as a parental figure and decide what will be good for them.
   e. Agencies must be required to keep their supports coordinators updated. At present, there are supports coordinators who do not know that OBRA and Commcare have reopened, cleared their waiting lists, and are now working on requests for waiver transfers to the OBRA and Commcare Waiver when necessary to meet current needs.
   f. OLTL must monitor by sampling participant satisfaction periodically to learn about those supports coordinators who cannot be reached by phone, or who went into the hospital without an assigned replacement.
   g. Supports coordinators are refusing to submit participant requests to the state without issuing denial letters with information on the right to appeal.
   h. Supports coordinators are not managing construction projects supplied through waiver funded home modifications. Participants without training in managing construction

projects must identify an approved contractor, credential the contractor, supervise construction, and hold the contractor to the construction schedule. This leads to faulty construction, incomplete modifications, unwise use of precious funds, and great frustration on the part of participants.

2. Supports Brokers –
    a. The waivers must include payment for support brokers to represent individuals or their family representatives in dealing with the supports coordinator. At present, due to the problems listed above, families are unable to manage on their own. Family members have no manual to teach them about waivers. They struggle to understand the vocabulary, the connections of persons to organizations, the responsibilities of various persons, the service plan, and the rules and regulations that apply. Without a manual and the time to be a consistent advocate for the participant, families are lost. And participants with a brain injury cannot navigate these issues on their own. As a result, families frequently have one member leaving paid employment in order to manage waiver involvement for the waiver participant. Calls come to our organization where people beg for someone to take over these responsibilities because they cannot understand and do not have the time while earning a living, raising children, caring for the children of the waiver participant, dealing with their own disability, or caring for elderly relatives. During the work day people are not free to make personal calls, send private emails, maintain files, fill out forms or attend meetings to assure appropriate services for the participant. Many are in tears as they speak.

Thank you for this opportunity to share the concerns of callers to our InfoLine.

We would be happy to partner with the Long Term Care Commission in developing solutions to these concerns.

Best regards,

Barbara A. Dively
Executive Director

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Alexander, David A

From:	Jennifer Rauscher [redacted]
Sent:	Friday, June 06, 2014 9:27 AM
To:	AI, LTC-Commission
Cc:	Thomas Earle
Subject:	Written Testimony re: Community First Choice Option
Attachments:	Adopting the Community First Choice Option- Consider the Savings.pdf; Executive Summary- CFCO.pdf

Good morning,

Attached please find the written testimony materials submitted by Liberty Resources, Inc. for Thomas H. Earle regarding the implementation of the Community First Choice Option for the expansion of Home & Community Based Services and Supports.

Thank you,

Jennifer Rauscher

Executive Assistant

Liberty Resources, Inc.

[redacted]

This email is written in Verdana 14-point font in accordance with LRI's accessible email standard.

Adopting the Community First Choice Option in PA: Consider the Savings

Pennsylvania could save $100.7 million in one year by implementing the Community First Choice option. If Pennsylvania provides 50% of its long-term care in a community based setting instead of in costly nursing homes, over the course of four years the savings would exceed $1.5 billion.

By: Leslie Allen, JD[1]

One of the single most costly expenditures in the Commonwealth's budget is its long-term care system for people with disabilities and seniors.[2] Pennsylvania has the unique opportunity to both improve live quality and save money by providing cost-effective community based care rather than expensive institution based services. The Community First Choice (CFC) option allows Medicaid recipients who need support with daily living to receive care in their homes, without first entering a nursing home and joining a waitlist for home based services. The CFC option makes home based care available to all ages and disabilities; the only requirement is that an individual meets the Medicaid criteria for institutional care.[3]

Implementing the CFC option in PA

Like many other states, Pennsylvania spends most Medicaid long-term care dollars on expensive nursing homes and other costly institutional settings instead of cost-saving home and community based care. This is both unnecessary and undesired by the majority of Medicaid eligible recipients.[4] At this current writing, there are 80,797 people with disabilities and seniors receiving long-term care in a nursing home setting.[5] Pennsylvania has the opportunity to allow people with disabilities to live in the community and achieve state savings. Implementing the CFC option will demonstrate the state's commitment to letting people decide where they want to live when they receive long-term care supports and services. This is a win-win for the care recipients and Pennsylvania's budget. The Federal Government has offered significant federal funds for implementing the CFC option and providing home based care.[6] Further, Pennsylvania saves money for every person it keeps from and transfers out of nursing home facilities. The CFC option makes home based care available for all ages. It is available for any person eligible for institutional care, including people with serious mental illness, people under 60, and folks who have Intellectual Disabilities.[7]

Savings: The other half of the Equation

The Department of Public Welfare (DPW) Office of Long-Term Living (OLTL) has focused on whether the Commonwealth can absorb the costs of implementing the CFC option rather than the savings generated by its adoption. Without disclosing their methodology, DPW estimates startup costs of $96 million due to administrative expenses.[8] Federal dollars and the overall reduction in the cost of care will offset most or all of the startup costs associated with implementing the CFC option.

- **Implementing the Community First Choice option will save an average of $31,920 per recipient by redirecting funding towards community based care from costly nursing home care.** In Pennsylvania, the average yearly cost for home based care averages $20,880 per month for a person with a physical disability in the year 2014, while nursing home care costs average about $52,800 per month.[9] Consistent with other states, Pennsylvania saves an average of $31,920 per year when it keeps an individual in the community.[10]

- **Implementing the Community First Choice option will generate $10 million to $11 million in revenue for Pennsylvania per year because the Federal Government will reimburse a greater share of the cost of home based care.** Pennsylvania currently provides home based care under waiver programs, most notably the Medicaid Attendant Care Waiver (ACW).[11] The Federal Government, who shoulders 51.82% of the ACW cost, would expand their support if the Commonwealth implemented the CFC option.[12] The Federal Medicaid Assistance Percentage (FMAP) provides an additional 6% if Pennsylvania enacts the CFC option. If the CFC option was implemented for 2015, Pennsylvania would save at least $11 million instantly from the increased Federal Government contribution.[13]

- **Increasing the number of Pennsylvanians receiving home based services will generate $9 million in 2015 Revenue because the Federal Government will provide more money if 25% of Pennsylvanians receive care in their homes.** The Federal Government has offered a financial incentive to states to provide one-quarter of their long-term care in home based settings. If states meet this goal by October 1, 2015, they receive an extra 5% FMAP to their long-term care Medicaid expenditure for two fiscal years and a 2% federal match after that. Right now, 21.9% of long-term care in Pennsylvania is delivered in a home based setting.[14] Pennsylvania

receives 52% federal match, and this incentive represents a $9 million boost in revenue in exchange for a very small increase in the number of people receiving home based care.[15]

- **Pennsylvania will be saving $747,101,620 once 50% of the population is receiving care in the community.** Pennsylvania presently has over 81,000 long-term care recipients eligible for nursing home care. Right now, 21.9% of eligible people receive home based care. For every extra person who stays out of a nursing home, Pennsylvania saves $31,920. The table below shows the increased savings as more people stay in the community and also provides the federal dollar savings.[16]

Table 1: Cost Saving For Expanded Community Based Care[17]

Balance of Nursing Home Services to Community Based Services	**2014/2015:** *75% Nursing Home Care and 25% Home Care*	**2015/2016:** *70% Nursing Care and 30% Home Care*	**2016/2017:** *60% Nursing Care and 40% Home Care*	**2017/2018:** *50% Nursing Care and 50% Home Care*
Savings with current level of community based care subtracted	$80,151,120	$209,427,120	$467,919,120	$726,471,120
FMAP Waivers 2%-5% match triggered when 25% of the long-term care recipients receive home based services	$9,377,500	$9,377,500	$3,751,000	$3,751,000
6% match for implementing community first choice option	$11,253,000	$11,253,000	$11,253,000	$11,253,000
Year Savings	$100,781,620	$230,057,620	$482,923,120	$741,475,120
Cumulative Savings	**$100,781,620**	**$330,839,240**	**$813,762,360**	**$1,555,237,480**

If in the next four years, Pennsylvania moved to 50% community based care the savings would conservatively total $1,566,237,480. This estimate keeps

the number of people receiving long-term care services constant, however the number of recipients is likely to jump in the next few years because of the aging baby boomer population.

Nursing Home Spending Will Increase Even Without the Implementation of the Community First Choice Option Because of Pennsylvania's Aging Demographic

Unlike the new savings and revenues discussed above, new nursing home costs will be incurred regardless of whether Pennsylvania adopts the CFC option. These continued escalating nursing home placement costs come from the demographic reality of the rapidly aging population of Pennsylvania. New costs come from the rapidly aging population of Pennsylvania. Right now, Pennsylvania has 2,617,959 residents over the age of 62. By 2020, this number will increase by 11.5% to 2,919,167 people.[18] The savings illustrated by Table 1 provide a solution for the Commonwealth to offset the costs anticipated by an increase in the number of people eligible and in need of nursing care.

Conclusion

Adopting the CFC option and expanding community based care by just 3% will save Pennsylvania $100 million in one year. The CFC option will almost certainly pay for itself. Even if start-up administrative costs totaled $96 million, Pennsylvania would still net a $4 million savings. Over the course of 4 years, the anticipated savings exceed $1.5 billion if Pennsylvania achieves 50% of long-term care services being delivered in the community. The savings and revenues highlighted above almost certainly offset the increased costs associated with implementation.

[1] Leslie Allen is a 2014 Juris Doctorate Graduate from Temple University's Beasley School of Law.

I would like to thank Thomas Earle, Esq., and Nancy Salandra with Liberty Resources, Inc., the Center for Independent Living for Philadelphia, for the genesis of this report, Steve Gold, Esq., Disability Rights Sole Practitioner, Laval Miller Wilson, Esq., from the Pennsylvania Health Law Project, Estelle Richman, and Jeff Iseman from the Pennsylvania Statewide Independent Living Council. All of whom provided me with information and guidance. I would also like to thank Professor Spencer Rand, Esq., for giving me the time and support necessary to complete this project.

[2] The 2014/2015 Budget allocates $841,423,000 to long-term institutional care but only $89,082 to community based services. Long-term, institutional care is the single greatest expenditure.

COMMONWEALTH OF PENNSYLVANIA: 2014-15: GOVERNOR'S EXECUTIVE BUDGET, TOM CORBETT, E.7.19, 2014.

[3] *Medicaid Program; Community First Choice Option*, FEDERAL REGISTER (May 5, 2012), available at https://www.federalregister.gov/articles/2012/05/07/2012-10294/medicaid-program-community-first-choice-option.

[4] Wendy For-Grage and Jenna Walls, *State Studies Find Home and Community-Based Services to Be Cost-Effective*, AARP PUBLIC POLICY INSTITUTE, http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/state-studies-find-hcbs-cost-effective-spotlight-AARP-ppi-ltc.pdf

[5] *Data From the Long Term Care Facilities Questionnaire*, PENNSYLVANIA DEPARTMENT OF HEALTH BUREAU OF HEALTH STATISTICS & RESEARCH, p. 16, file:///C:/Users/leslie/Downloads/Nursing_Home_Report_2012_1.pdf.

[6] *Federal Medical Assistance Percentage for Medicaid and Multiplied,* THE KAISER FAMILY FOUNDATION, last accessed April 27, 2014 at http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/.

[7] *Medicaid Program; Community First Choice Option*, FEDERAL REGISTER (May 5, 2012), available at https://www.federalregister.gov/articles/2012/05/07/2012-10294/medicaid-program-community-first-choice-option.

[8] 42 CFR § 441.

[9] COMMONWEALTH OF PENNSYLVANIA: 2009-10: GOVERNOR'S EXECUTIVE BUDGET, EDWARD G. RENDELL, E7.8, E7.9.

[10] U.S. Senator Thomas Harkin, *Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act*, THE UNITED STATES SENATE HEALTH, EDUCATION, LABOR, AND PENSIONS COMMITTEE, p. 25, Jul 18, 2013, available at http://www.harkin.senate.gov/documents/pdf/OlmsteadReport.pdf.

[11] COMMONWEALTH OF PENNSYLVANIA: 2009-10: GOVERNOR'S EXECUTIVE BUDGET, EDWARD G. RENDELL 2014-2015, E.7.19, 2014.

[12] Implementation of the CFC option triggers a 6% increase in Federal Medicaid Match for at least a five-year period.

42 CFR § 441.; *Federal Medical Assistance Percentage for Medicaid and Multiplied,* THE KAISER FAMILY FOUNDATION, last accessed April 27, 2014 at http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

[13] 11 million dollar estimate based on 2013/2014 and 2014/2015 fiscal estimates. If Pennsylvania adopts the CFC option, then the Federal Government will provide 58% matching funds for long-term care. In 2013/2014 the ACW cost $185,120,000. Right now, the Federal Government pays $99.4 million of that, if the CFC was adopted then the Federal government would have paid $110.3 million with CFC, generating $10.9 million in savings for Pennsylvania.

COMMONWEALTH OF PENNSYLVANIA: 2014-15: GOVERNOR'S EXECUTIVE BUDGET, TOM CORBETT, E.7.19, 2014.

[14] *Policy Brief: The Future of Medicaid Long term Care Services in Pennsylvania: A Wake up Call*, THE UNIVERSITY OF PITTSBURGH INSTITUTE OF POLITICS AND THE JEWISH HEALTHCARE FOUNDATION, Winter 2013, available at http://www.iop.pitt.edu/documents/Policy%20briefs/Medicaid%20Long-term%20Care%20in%20Pennsylvania.pdf.

[15] Currently, only 21.9% of Pennsylvanians receiving long-term care do so with home based services. [15] Under Section 10201 of PPACA, States that rebalance their long-term care to have 25% of services provided in the home by October 1, 2015 receive an additional 5% in Federal Medical

Assistance Percentage (FMAP) to help them offset transitional costs. Right now, Pennsylvania is receiving 52% FMAP. The 5% increase to FMAP is only guaranteed through 2015, and will likely be rolled back to 2% in 2016.

[16] There are roughly 81,000 Pennsylvanians receiving care in an institutional setting right now. According to the Governor's Blue Book, institution based care costs $4400 a month, totaling $52,800 a year per recipient. Alternatively, community based care costs $1740 a month, $31,920 a year. For each person kept out of nursing home facilities, the savings are $20,880. *Policy Brief: The Future of Medicaid Long0term Care Services in Pennsylvania: A Wake up Call*,

THE UNIVERSITY OF PITTSBURGH INSTITUTE OF POLITICS AND THE JEWISH HEALTHCARE FOUNDATION, Winter 2013, available at http://www.iop.pitt.edu/documents/Policy%20briefs/Medicaid%20Long-term%20Care%20in%20Pennsylvania.pdf.

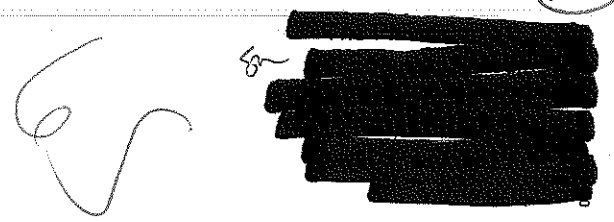
Transforming Pennsylvania's Long-Term Services and Supports System, THE PENNSYLVANIA HOMECARE ASSOCIATION, 2011, available at http://www.pahomecare.org/_files/live/Bringing_LTC_Home_Report.pdf.

Data From the Long Term Care Facilities Questionnaire, PENNSYLVANIA DEPARTMENT OF HEALTH BUREAU OF HEALTH STATISTICS & RESEARCH, p. 16; COMMONWEALTH OF PENNSYLVANIA: 2009-10: GOVERNOR'S EXECUTIVE BUDGET, EDWARD G. RENDELL 2014-2015, E.7.19, 2014.

[17] For Pennsylvania to realize the savings in Table 1, new patients need to be diverted from nursing home based care and beds must close in existing institutions. While this report does not contemplate specific hospitals where closing of wings or wards is possible, such closures are the mechanism by which the state can achieve big savings. Pennsylvania can close beds by: (1) incentivizing the closing of beds in nonprofits and private sectors, (2) implementing a plan over the next five years to close public beds, and (3) for the State to make a commitment not to open more beds in the future.

[18] *Interim Projection of the Population by Selected Age Groups for the United States and States: April 2000 to July 1, 2030*, THE US CENSUS, p. 10, available at http://www.census.gov/population/projections/files/stateproj/SummaryTabB1.pdf.

DRN
Disability Rights Network
of Pennsylvania



Long-Term Care Commission Public Hearing by the Department of Public Welfare
Testimony of the Disability Rights Network of Pennsylvania (DRN)

Presented by:

Rachel Mann, Staff Attorney
June 6, 2014, Blue Bell, PA

Thank you for the opportunity to provide testimony on Pennsylvania's long-term services and supports system. The Disability Rights Network of Pennsylvania will be submitting written testimony on a number of subjects, and I am here today to testify about children with disabilities.

Children are not often thought of in the context of Long Term Care – but unfortunately, there is a very real need to think about children. Pennsylvania boasts that it has no nursing facilities for children, but in fact there are hundreds of Pennsylvania children with developmental disabilities or complex medical conditions spending their childhoods in long term care facilities – facilities that, while not licensed as nursing facilities, are indistinguishable from them. In 2010, the Department of Public Welfare (DPW) counsel reported 30 children under the age of 3 alone, living in facilities. Some of these places, like Pediatric Specialty Care, which just opened its fourth Pennsylvania facility with 50 beds, serve only children. When these children reach age 21, they often transfer directly from these facilities to adult nursing facilities – which results in a lifetime of institutionalization. Others facilities have children living together with adults who have developmental disabilities.

Let me tell you about a couple of young women I have struggled to help. Both have severe and complex physical disabilities and medical conditions requiring constant skilled nursing supervision, and neither has intellectual disabilities. Neither have families, and both were placed in

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congregate care facilities for much of their childhoods because the child welfare system could not find any alternatives for them. No medical foster home, with rates that haven't been raised in 20 years, and very little respite available, would take them.

The older of the two – I'll call her Sue – grew up at Pediatric Specialty Care. A year before her 21st birthday, when she would age out of both the facility and the child welfare system, people who cared about her started to ask where she would go. While the Office of Long Term Living (OLTL) was well aware of her predicament, it offered her nothing. And so she moved to an acute care nursing facility with other mostly young adults who needed ventilator care. After nearly two more years of advocacy, a friend – not a case-worker – identified a provider who was willing to give her a home in the community in exchange for becoming her home health care provider in the OLTL Independence Waiver. She now lives in a community home here in Montgomery County. But many like her have not been so lucky.

The other young woman – I'll call her Lisa – benefitted from Sue's experience. After spending much of her childhood as the only verbal individual living in a 53-person facility for adults and children with Intellectual Disabilities and medical needs, Lisa came very close to being placed in a nursing facility on her 21st birthday. Nobody involved with her discharge planning even knew that the OLTL waivers existed. Even after we became involved, it required intensive advocacy, including threats of litigation, before she was able to move into the same home as Sue, under the same conditions.

Neither of these young women should have grown up in facilities. And when they aged out of the child welfare system they should have had a seamless transition to adult disability services. As part of a DPW stakeholders group on the health of children in the child welfare system, we and others have asked DPW to **bring together high level staff from the Office of Children, Youth and Families, Office of Developmental Programs (ODP) and OLTL, along with advocates, to develop policies and procedures for a seamless transition for young adults like Sue and Lisa into adult community services**. We have not yet received a response. I urge you to help make this a reality.

Just a couple of weeks ago, I was contacted by a child welfare agency about two much younger children with profound disabilities. The agency

reported to me that the families, due to poverty, do not have homes where their children can have the space needed for their medical equipment and their safe care. The families were told to give up custody to the child welfare system. Unless you do something, more children will, like Sue and Lisa, grow up in facilities, or their families will be forced to give up custody of their children in the hopes that the child welfare system will have better luck finding a medical foster home for them than they had for Sue and Lisa. There is something you can do for all of these children. You can make home and community-based waivers available to them. **You can lower the age of the OLTL Waivers, prioritize institutionalized children in the ODP Waivers, or better yet, create a new waiver for children with developmental disabilities of any kind that provides the services these children need in home and community-based settings, and includes a clear process for transitioning the children to an appropriate adult Medicaid waiver when they age-out. And in this waiver, you can provide family life-sharing – a voluntary service outside the child welfare system, where the birth or adoptive family meets and chooses an alternative family and shares responsibility for the child with this other family.** It is being done in Texas. I am providing information about this solution, provided by the PEAL Center with funding from the Developmental Disabilities Council, with my testimony. Please read it, think about it, recommend it, do it.

Contact:
Kelly Whitcraft, Policy Coordinator
[redacted]

Hello, my name is Natasha. I am a single mother of 4 children, ages ranging from 14 to 20 years of age with 2 daughters attending college and 2 sons attending high school.

I have been a CNA for over 15 years and a personal health aide with Addus Philadelphia for 9 years. I love my job. I work daily with over 40 hours a week. It is very rewarding. I have a great sense of fulfillment when I see my clients' smile as I am able to help them, spend quality time with them and even share memorable holidays with them when family members are unable to visit.

My client enjoys her independence by living at home. She treasures working in her garden.
Although I am rewarded daily, as clients appreciate me for the care I provide them, I struggle daily with balancing financial difficulty. I try to manage the rising costs of raising my children while also providing a good education for them.

With today's living costs on the rise, and recent increases in my real estate taxes, and educational tuition rates, I endure constant stress. Often I am forced to make choices on what bills to pay and what bills can I do without. I have gone without daily necessities like food or utilities to spare the expense.

Fortunately, I am blessed and grateful for my children and the support system they give me every day. I worry about their future and am determined to provide them with the education to better prepare them for tomorrow. Sometimes I feel as I am failing my children because I am not earning a wage high enough to provide for them.

I am testifying today because home care is greatly underfunded. Pennsylvania tax payers spend 3 times as much a year or more to put someone in a nursing home than it does to care for someone in their own home and the neighborhood they love.

With the appropriate funding I am more able to care for my family and provide them with a better future while also being able to care for my client, a job that I am truly blessed and love, for a long time.

Please consider my testimony to urge changes in the wage rates for home health services to make it possible for me and my fellow home health aides to be paid a dependable wage.

Thank You

(22)

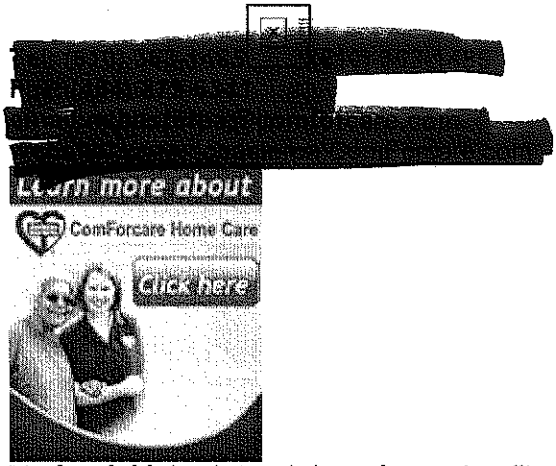
Alexander, David A

91

From: [redacted]
Sent: Thursday, April 17, 2014 5:51 PM
To: AI, LTC-Commission
Subject: verbal comments on LTC system at MCCC, Blue Bell, June

To whom it may concern,
I would like to address the need for the formation of hoarding task forces in all of our counties. As a home care agency owner and a nurse I am seeing and hearing of more people with hoarding issues. We need a collaborative approach with a multidisciplinary team to address the issues surrounding this behavioral health problem. The team should include professional organizers, AAA, physicians, emergency response team, animal rescue, home health and home care, therapists who specialize in anxiety disorders or hoarding behaviors, and perhaps recovering hoarders. How will this be funded? There is currently a task force in Bucks County and one forming in Philadelphia county. It should be replicated in every county. The need is great.
Kind regards,

Susan E. A. Mojaverian, MSN, RN
President and CEO
ComForcare Home Care
Private Duty Non-Medical Home Care Services



Member of Alzheimer's Association Early Detection Alliance
Independently Nurse Owned and Operated
ComForcare is an Equal Opportunity Employer

Alexander, David A

From: [redacted]
Sent: Tuesday, May 06, 2014 2:44 PM
To: AI, LTC-Commission
Subject: 6/6/13 Blue Bell PA LTCC forum

Hello Commissioners,
I would like to discuss the need for funding and resources in each county to provide wrap-around services from a Hoarding Task Force to address the increasing community problem of hoarding behaviors. This is a serious behavioral health and safety issue that is now listed in the DSM-5 manual. The problem is often undiagnosed until a serious incident happens as the afflicted persons isolate themselves. The task force should include animal control, psychiatric experts in hoarding and/or anxiety disorders support, professional home organizers, home health and home care providers, primary care physicians, AAA members, fire safety/ emergency response team members, family members, and others as appropriate. Hoarding task forces have begun in Philadelphia, and Bucks County, PA, and they have been in existence in Virginia since 1989. A lead is needed, perhaps with the AAA, to initiate and sustain this effort. The problems of hoarding behaviors are complex and they are challenging to solve without a comprehensive team and plan in place. The PA Behavioral Health Coalition is asking that each county develop their own special task force to tackle this growing community problem.
Kind regards,
Susan Mojaverian, MSN, RN
Owner of ComForcare Home Care,

serving Chester County, PA

Susan E. A. Mojaverian, MSN, RN
President and CEO
ComForcare Home Care
Private Duty Non-Medical Home Care Services

[redacted]

Member of Alzheimer's Association Early Detection Alliance
Independently Nurse Owned and Operated
ComForcare is an Equal Opportunity Employer

[redacted]

PHOEBE MINISTRIES

Lisa Hoffman
Resident Finance Manager
[redacted]

Testimony before the Governor's Long-Term Care Commission
June 6, 2014

Good afternoon, Secretary Mackereth, Secretary Duke, and Commissioners.

My name is Lisa Hoffman and I am the Resident Finance Manager for Phoebe Ministries, a non-profit, multi-facility organization serving seven counties and thousands of seniors specializing in health care, housing, and support services. We offer independent living, personal care, skilled nursing care, rehabilitation services, in-home care, and adult daily living services. We also have an award winning TeleHealth program and a nationally recognized program for memory support services, the Phoebe Center for Excellence in Dementia Care. Phoebe Ministries was established to be "*a community of faith, called by God, to serve the needs and to enhance the lives of our elders, their families and the broader community.*" Based on this mission, it is our practice to continue to provide care to seniors while their MA eligibility applications are pending with the County Assistance Office. This leaves the facility to carry a great financial burden, reaching over a million dollars in some cases.

We know we are not alone in bearing this financial burden. Phoebe Ministries is a member of LeadingAge PA, an association of non-profit senior service providers. We have met with other providers during the last six weeks to explore the issues related to MA application processing and as a group we have developed some proposals for change. I would like to thank Secretary Mackareth for giving us the opportunity to meet with staff at DPW next week to discuss these proposals in more detail. Here are some of the ideas our group has developed:

There are inconsistencies across CAOs related to the acceptable method for submitting applications and/or providing required documentation. In addition, there is no standard method to confirm that all documents sent to the CAO have been received. Uniform guidance from the Department to CAOs on the acceptable methods for transmitting and accepting documents (via fax, email, certified mail, etc.) would be very helpful. Also, CAOs should have methods in place to confirm that all documents sent by the consumer have been received, both in quantity and specific content.

Consumers do not receive timely notification that required documents are missing until the regulatory or court-imposed deadline is imminent. This is another area where uniform guidance from DPW can easily help improve the process. There should be procedural guidelines for providing timely written notice to consumers detailing any information that is missing from the application.

MA Applications are often pending beyond the date for a decision listed in a stipulated order. The facility should be able to bill to receive payment from the MA program if the CAO does not comply with the order, but there is currently no method in place or at least no method that providers are aware of to achieve this. Guidance from DPW on how facilities can bill for payment would help hold the CAOs accountable.

PHOEBE MINISTRIES

MA Applications can be pending for well over one year, some that we as providers suspect may have been inappropriately denied by the CAO in order to extend the time for a final decision. Some of these cases may be able to be resolved if the Department performed an audit of select CAOs to evaluate the volume of long-pending applications and address the backlog.

The Administrative Law hearing and appeal procedure is a burden on consumers, families and providers who must be available during long periods of call-in time. In addition, consumers are sometimes blindsided by amendments to a stipulated order that occur during the hearing. The Commission should explore alternatives to the current method of three-hour call-in windows for administrative law judge hearings. There should be uniform procedural rules for the amendment of the complaint and stipulated order.

Consumers and their families struggle to make reasonable efforts to collect required information and documents even after providing the CAO with authority to act on their behalf via the PA 4 form. There should be guidance from DPW regarding what authority the PA 4 form provides to the CAO to collect information on behalf of the consumer. It could save time and resources if the CAO could confirm financial information instead of asking seniors to visit their bank and gather documents.

Staffing of CAOs across the state is inconsistent and inadequate to meet the needs of consumers. Medical Assistance employees will candidly tell you that their workload is too much and they simply did not have time to get to your application in that month. The Commission should explore alternatives to the current workflow of MA eligibility determinations in the CAOs. Our recommendation is for MA application collection to occur at the CAO level as it currently does but for the application processing and eligibility determinations to occur at a separate regional office that oversees several counties. The Governor's proposed budget this year included allocations for new staff within the CAOs. This new workflow could help more efficiently use any additional staff and alleviate the burden on current CAO staff that are spread too thin.

I'd like to thank the Commission members for the work that you are doing to improve the delivery of senior services in the Commonwealth. And again, thank you to Secretary Mackareth and DPW for agreeing to meet with us next week to talk about these proposals in more detail. It is important to evaluate the current system to pinpoint simple changes that can have a large impact. We believe something must be done to improve the MA eligibility process in order to ensure the long-term financial viability of providing healthcare to seniors.

Thank you,

Lisa Hoffman

St. Ignatius
Nursing & Rehab Center
Ministry of Felician Franciscan Sisters

[redacted]

Testimony before the Governor's Long-Term Care Commission
June 6, 2014

Good afternoon, Secretary Mackereth, Secretary Duke and Commissioners.

My name is John Meacham and I am the Administrator at St. Ignatius Nursing & Rehab Center in West Philadelphia. A member of LeadingAge PA, St. Ignatius has provided skilled nursing care to thousands of low-income seniors since it was founded in 1952 by Monsignor John T. Mitchell who recognized the need for care for his elderly parishioners who were living in deplorable conditions in this Philadelphia neighborhood. We continue the mission of serving the poor as a sponsored ministry of the Felician Franciscan Sisters today as we strive to create safe and affordable housing options for seniors in the Delaware Valley.

I am here today to talk with you about the availability of Housing Tax credits for the development of new ideas relating to affordable senior housing and our efforts to develop Francis House, the first affordable personal care facility for frail elderly in Pennsylvania, to address the aging senior population facing challenges to their independence. Francis House will consist of 60 efficiency units, designed as six neighborhoods of ten units each. The proposed development will be situated on the St. Ignatius campus, which currently houses two LIHTC properties for independent seniors, a nursing & rehab center, and landscaped grounds.

The need for Francis House is evident in my work at St Ignatius. Our residents, admitted from local hospitals improve when they receive three meals a day, medications and therapy. All too often, when the residents are ready for discharge, there is no suitable, safe place for them to go. They no longer need 24 hour nursing care, but they are not able to live safely by themselves. Residents of Angela Court our LIHTC project after 10 years are facing a similar fate as they can no longer safely live independently, but they also do not need 24 hour nursing care. Francis House is an example of an innovative strategy of serving the elderly that is very consistent with LeadingAge PA Northstar vision of providing supportive community services in a 'home' environment.

As Philadelphia seniors age, the city lacks suitable affordable housing with the level of supportive services needed for this frail population. This forces many seniors into housing situations that are either too independent or too intensive for their needs. The market study we conducted for Francis House revealed that the development specific capture rate is 1.2% and its overall capture rate for low income housing is 7.8%. These findings clearly indicate that there is an extreme need for affordable housing units in the defined market area.

Let me explain the Francis House model. Overall Francis House will be one building comprised of 60 efficiency (390 sq. ft.) apartments for frail seniors, 62 years and older. We will be serving

seniors with very low income, as low as 20% of AMI in Philadelphia which is 11,040 dollars.

Each unit will feature a full, accessible bathroom, microwave, miniature refrigerator, and closet. These common areas will feature a parlor, dining room, living room, sun room, kitchen, and laundry room. In the Franciscan tradition of caring for the environment, Francis House will incorporate solar thermal energy to help with domestic hot water needs. Recycled materials will be used in construction, construction debris will be recycled or salvaged and sustainable construction materials will be used as well. So we are very green in our thinking.

Individual supportive services will be provided on-site by twelve St. Ignatius staff members twenty-four hours per day to assist residents with activities of daily living (ADLs). A personal care administrator will be on site daily to oversee service provision at Francis House. In addition to ADL services, Francis House will also provide three meals a day for all tenants, to be served in each of the six "neighborhoods." In order to make this a viable solution financially there will be operational synergy between St Ignatius and Francis House. For example St Ignatius will provide the meals and laundry services thus relieving Francis House from the cost of developing a duplicative infrastructure. Francis House's service model is to assist with the individual's activities of daily living, including eating, drinking, ambulating, transferring, toileting, personal hygiene such as bathing, dressing, managing healthcare and self-administering of medication. The residents of Francis House will not need the full 24-hour services of a nursing home; however, they are not safe to live on their own. Each resident will have an assessment to determine which services are appropriate for that resident's needs.

As for community supportive services, Francis House's location in West Philadelphia on the St. Ignatius campus makes it an ideal location for housing for frail elderly. University of Pennsylvania resources such as the hospital are located within a mile of the development and the commercial corridors of Lancaster Avenue and Market Street are within a half-mile of the development, which is easily accessible by public transportation.

The Tax Reform Act of 1986 includes Section 42 – the Low Income Housing Tax Credit (LIHTC) Program. The LIHTC provides a tax incentive to owners of affordable rental housing as a dollar for dollar reduction in the tax payer's federal taxes during the initial ten years of the available housing units. Developers engage other community investors whose financial contributions are used in the program's financial plan. Tax Credits are provided to each state to be allocated by the Governor's designated agency which is the Pennsylvania Housing Finance Agency (PHFA) here in the Commonwealth.

The LIHTC Program, though administered on behalf of the federal government, is a feasible option for affordable housing expansion in Pennsylvania. The model focuses on community development and local business investment to offer housing options to financially eligible individuals. PHFA's application process is based on the number of tax credits allocated from the federal government. It should be noted that Francis House will reside in the newly federally designated Promise Zone, the only such designation in Pennsylvania.

The increasing housing need in Pennsylvania will not be a quick fix or an inexpensive effort; however, there are successful programs available to assist the Commonwealth in providing affordable housing to seniors. The LIHTC Program is just one of these initiatives that have been

modeled wherever there is a demand. Community partnership opportunities are crucial to program success and ultimately set the groundwork for a *place* to provide long-term care and services to seniors in the community.

I would ask the Secretary of Aging and the Secretary of Public Welfare as well as the LTC Commissioners actively support innovative solutions such as Francis House in response to the very real needs of the elderly poor. The Secretary of Public Welfare and or representative has a Board seat at PHFA. This is an additional opportunity to advocate for innovate projects that are addressing the housing and care needs of Pennsylvania's low income seniors.

I would like to thank the Commission, the Department of Aging, and the Department of Public Welfare for your efforts in improving long-term care in the Commonwealth. I am hopeful that the work of the Commission will bring providers like St. Ignatius more options and opportunities to expand our services and adapt to the growing and changing needs of older Pennsylvanians in the future.

We received notification from the supports coordinator that a consumer will be discharged to home on June 9th and we are to resume services. We then receive a call on June 3rd that the consumer is home and needs services immediately. We staff the case and send an aide for the 8 hour shift. After 4 phone calls back and forth to our aide on her personal cell phone and an hour of searching, the consumer is not there and we send our aide home. The aide cannot be paid for her time as we cannot bill for that time.

We hire a new aide with a schedule of 36 hours per week. She works one week then refuses to work 14 of her 36 hours stating that with the increase in her weekly income, she will now be required to pay an additional $200 per month in rent. 14 hours a week equals $546 in the aide's pocket—way more than the $200 rent increase. She would be better off working but why work when you don't have to.

Hello, my name is Lori Michael. I am a Christian, a mother, a social worker and a nurse. I take care of people. It's what I do, what I care about. It's my passion. I own Lori's Angels, a home care agency serving the elderly and disabled in Schuylkill County. I used to feel very satisfied at the end of each day—that what my staff and I did helped people. Most days now I just want to cry. I am the executive director of my agency as well as the scheduler. I am in the trenches every day keeping my finger in the dyke hoping that tomorrow things will be better. Not only are things not getting better, they are actually getting worse.

I started my agency 10 years ago with the idea that if I took care of my employees they would take care of my consumers. Now my best hope is that we can be the best of the bad agencies providing

care to the elderly and disabled in our county. Consumer hires are no better off.

Every action taken by government—be it a new law, regulation or rate setting has adversely affected the ability of home care agencies to adequately solicit, train and supervise home care aides. Our hiring problems intensify daily while the demand for our services grows exponentially.

The cost to hire and train a new aide vs the low reimbursement rate makes it months before an agency recoups the expense to meet the supervisory requirements—most aides do not make it that long. The complexity of the medical assistance waiver participants we receive referrals for consumes enormous amounts of supervisory time for which we are not compensated at all.

A new recruitment problem that has surfaced is that applicants are giving up their vehicles as the cost of cars, gas and insurance are prohibitive on the low pay we provide especially when we expect them to run errands with their personal vehicles with no respective reimbursement for their actual expense.

Staff turn over—mostly with no notice at all, is worsening. Our good long term staff are leaving our field as they need 40 stable work hours per week with health insurance benefits—both of which are impossible in the home and community based service world. We are literally imploding.

A rate increase for personal assistance services within the home and community based services line item is essential. Without adequate reimbursements, agencies will not be able to meet the demand for services. The 5% that the Pennsylvania Homecare Association is requesting

is not adequate. Do you want to stabilize home care? Do you want a quality workforce in home care? Then rates need to be enough to pay a living wage and provide health insurance. We will never attract or keep good workers without that.

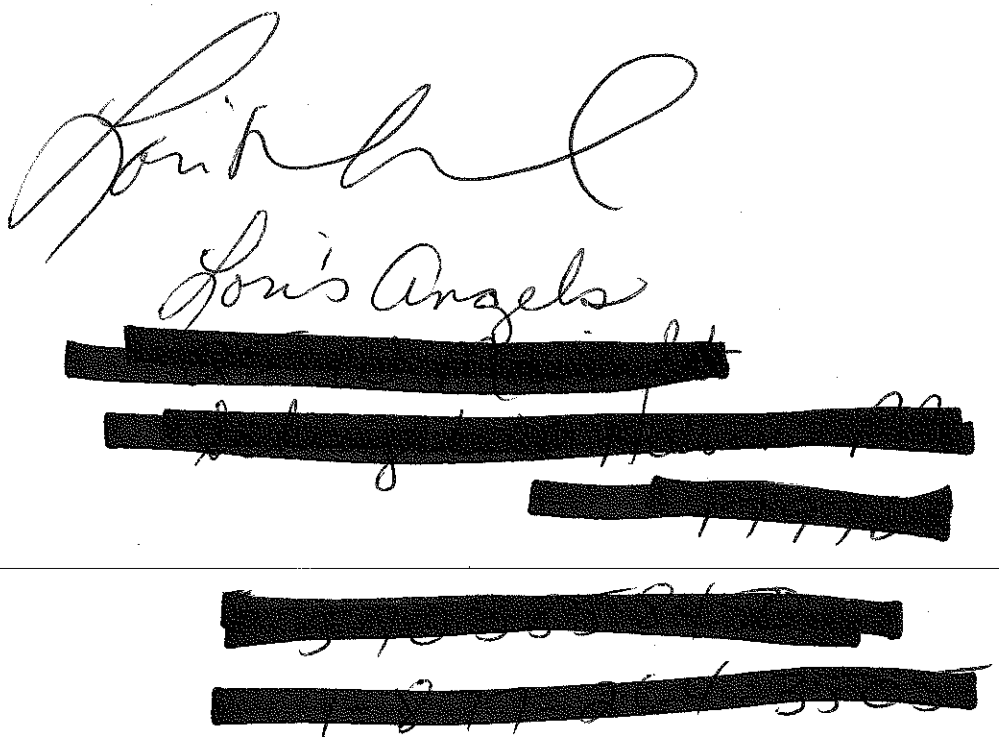
We need a rate of $30 per hour. That will allow wages of $15 per hour and health insurance to full time workers (the full $12.04 increase directly into wages and benefits!) That will stabilize home care. That will attract quality workers. That will decrease welfare payments as well. In my experience and that of many other providers, minimal cuts in hours of service to many consumers (not all but many) will not adversely affect their ability to remain at home safely should cover this increase in rates especially considering that welfare payments to 1000's of recipients will decrease or disappear!

More regulation and over site of agencies will ***not*** improve the actual quality of service. It will only make the service more expensive to provide.

Despite all we try to do to hire dedicated quality staff, in May of this year my agency had 9 aides walk off the job with no notice. Most we found out about by consumers calling stating that no one showed up. This jeopardizes the consumer's safety! My one suggestion that would help agencies actually protect consumers and improve quality is to develop a "prohibited from hire registry" of direct care workers—for agency employees and consumer hires. Employers should be required to report any direct care worker that quits with no notice or is a no call no show to this registry. Agencies and consumer's hiring direct care workers should be required to check this list of prohibited individuals to prevent them from hiring people that will jeopardize the safety and well-being of care dependent adults. We are already required to check applicants against 3

Medicare/Medicaid prohibited registries, social security and to report hires to labor and industry. What is one more check to protect our care dependent consumers? This would stop the revolving door of unreliable direct care workers that abandon care dependent consumers. This registry should prohibit hiring for 2 years.

Bottom line, stop the perception that direct care work is a throw away job. Make it a job that demands accountability and pays a fair rate for the work we do. Hold employees responsible for their actions when they accept these positions. In doing so, you will achieve quality care.



Pennsylvania Long-Term Care Commission
Public Comment Session
June 6, 2014

Delaware County Office of Services for the Aging (COSA)

Presented by Denise V. Stewart, Director

- First, I want to thank Governor Corbett for issuing the executive order to create this committee to look at the long term needs of older adults in the state of Pennsylvania.

- Next, I want to thank the Pennsylvania Long-Term Care Commission, Secretary Duke and Secretary Mackereth for this opportunity to speak before the Commission on behalf of Delaware County Council, COSA Advisory Committee, COSA consumers and the older adult residents of Delaware County.

Therefore, here are my comments I want to offer from the key discussion areas:

1. Like the other Area Agencies on Aging's (AAA), COSA is one of the 52 AAA's that supports the Pennsylvania Department of Aging and the Department of Public Welfare to assist and provide the Long-Term Care services needed to our older adults in Delaware County.

2. To prevent possible nursing home admissions, we need to be able to assist caregivers without lengthy processes and procedures. For example, we begin at the AAA and it can take up to twenty days to process a consumer's case to go to the County Assistance Office (CAO). Then the CAO has forty-five days to determine eligibility. Then OLTL makes the final decision for care plans/service plans

submitted for review taking an additional three weeks or more. The total time equals four working months. We all know that when a caregiver is coming to the AAA for help they are already in crisis. Waiting only creates more stress for the caregiver.

3. We must eliminate the operational barriers that exist. As we work to provide a person-centered system, the AAA staff along with the older adult should be able to arrange those service needs without prolonging the process. If the older adult has met the medical and financial requirements, they should not have to wait weeks most of the time months for approval of a care plan that has already been reviewed with them. Our system is creating additional stress. It is supposed to be person-centered and be easily accessible.

4. The state must recognize the consumers should always have the right to choose the setting and the services they receive.

5. We must continue to protect our at risk older adults under the Older Adults Protective Services Act. We know for a fact having an increase in public awareness and education has increased our agencies Reports of Needs (RON). Let us not forget, with that increase in RON's, the AAA's need the funding to support those older adults.

6. I am an advocate for behavioral health services for older adults. In my county, we had a consumer who participated in our AAA Aging Waiver in home behavioral health program. However, the Waiver application drastically reduced the provider rate and our one Aging Waiver provider chose to no longer provide services due to the rate decrease. After this service stopped, sad to

say, we had an Aging Waiver consumer successfully shoot and kill herself, her brother (primary caregiver) and her cat. Therefore, I ask the state to please remember the importance of behavioral health services for our older adults in this program.

In summary, I ask the state to remember consumer rights, the continued need for protecting our frail vulnerable older adults, work on eliminating service barriers as we work to provide person centered programs and remember the need for funding as we continue to provide services to this ever growing population.

Thank you.

PATF
Pennsylvania Assistive Technology Foundation

Independence is priceless...we help make it affordable

Assistive Technology (AT) for older Pennsylvanians (60+)

The federal definition of an assistive technology (AT) device is "any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities."
Technology Related Assistance to Individuals with Disabilities Act of 1988

ISSUE:
The Aging Waiver, which includes access to assistive technology (also referred to as "accessibility adaptations") should include "accessibility adaptations to vehicles" as a covered service.

BACKGROUND:
The Office of Long Term Living (within the Department of Public Welfare) administers several waivers, including the Aging Waiver (60 and older), Independence & OBRA (physical disabilities), and CommCare (traumatic brain injury).

In the Independence, OBRA, CommCare waivers **AND** in the Aging Waiver, assistive technology is defined as "any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. (*Note: the federal definition is incorporated into the waivers.*)

In Independence, OBRA, and CommCare waiver language there is an extra bullet (specific examples) that includes this service:

- Accessibility adaptations to the participant's vehicle, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the community. This service includes an evaluation of the needs of a participant, including a functional evaluation of the impact of the provision of appropriate adaptations to the participant's vehicle.

AGING WAIVER:
Page 67 of the Aging Waiver includes the same definition of Assistive Technology, but does not include the "Accessibility Adaptations to the Participant's Vehicle" bullet. The policy director (Virginia Brown) of the Office of Long Term Living says that the Aging Waiver does not include – as a service – accessibility adaptations to a vehicle! David Gingerich – Deputy Secretary of the Department of Aging – has said that he intended for "accessibility adaptations to a participant's vehicle" to be included when the Aging waiver was last amended (effective July 1, 2013).

WHY SHOULD THE AGING WAIVER BE DIFFERENT FROM ALL OTHER DISABILITY WAIVERS?

1. All of the other "disability" waivers include vehicle adaptations as a covered service. These waivers include: Independence, OBRA and Commcare (OLTL waivers) and the Consolidated and Person-Family Directed Support Waivers (home and community-based waivers for people with intellectual disabilities, Office of Developmental Programs).

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2. Why should people – who are 60 or older – be unable to obtain adaptations to a vehicle when a top priority for older Pennsylvanians is to be as independent as possible?

ACTION STEPS:

1. Work with Bonnie Rose, the Deputy Secretary of the Office of Long Term Living and ask that a Bulletin be issued that states that "accessibility adaptations" should include "accessibility adaptations to vehicles" as a covered service. An amendment to the waiver is not necessary. (Note the definition of assistive technology is inclusive!)
2. Request that the Senate Aging & Youth and the House Aging & Adult Services Committee urge the Office of Long-Term Living to establish parity and allow "accessibility adaptations to vehicles" be a covered service within the Aging Waiver.

Older Pennsylvanians (people who are 60 and older) want their independence! Having the ability to drive (or be driven) where he / she wants to go, when he / she wants to go, is key to independence, self-determination, and self-worth.

For more information:
Susan Tachau
Executive Director
[redacted]

Pennsylvania Long Term Care Commission Hearing
Montgomery County Community College
June 6, 2014

Over the last three months, Health Care Teams at the Hospital of the University of Pennsylvania in Philadelphia have cared for patients and families from Guatemala, Domenica, China, Jamaica, Ghana, Italy, Indonesia, Mali, Dominican Republic and Mexico.
The patients who arrive at the Hospital of the University of Pennsylvania for emergency care are immigrants from all parts of the world. Arriving as students, scholars, farm workers, laborers, caregivers, sailors, restaurant workers, taxi drivers, home health aides most have entered the country legally. The majority of our patients are treated and discharged back to the community. We provide medication, transportation, home medical equipment, home nursing, rehabilitative services and hospice to transition our patients to home. We have also assisted our patients with transportation to their country of origin with the participation and consent of family members. But from some, their complex medical diagnosis or traumatic injuries require long term care. The patient is unable to be cared for at their home in Pennsylvania and the patient is unable to travel to their country of origin. Due to the current restrictions on Medical Assistance for immigrants who do not meet the five year residency requirement, the patients remain in the acute hospital or in community settings supported by the hospital.

One of our current long term care patients is a 47 year old male from Sierra Leone. He was being treated for sickle cell disease when he suffered an anoxic brain injury. He is considered to be in a persistent vegetative state. His hospital stay began on April 18th, 2013. Prior to his admission, he was working as a car mechanic.

A 31 year old patient from Ghana was transferred to HUP after suffering a cardiac arrest at an outside hospital. She is a legal resident of the state of Pennsylvania but she has not been in the state for five years. Sadly, she is non-responsive and considered to be in a persistent vegetative state. Her hospital stay began on October 30th, 2013. Prior to her admission, she was working as a certified nursing assistant.

Our 50 year old patient arrived in 1999 from Egypt. He sustained traumatic injuries in 2001. As a paraplegic and bilateral amputee he has been at HUP over 50 times...many admissions for extended periods and for well over a total of 1100 days. Prior to admission, he was a taxi driver. He is currently living in the community with room, board and caregivers supported by the hospital.

Today, I am asking you to consider opening up funding and placements for immigrants to Pennsylvania who are now long term care patients residing in acute hospital settings. Please consider working with us to address funding and placement for our long term care patients who do not meet the PA residency requirements as interpreted by the Department of Public Welfare when approving long term care placements/payments.

Thank you.

Patricia E. Meehan, LSW
Director – Social Work
[redacted]

Testimony to the PA Long Term Care Commission

By: Fady Sahhar, CAO, Liberty Resources, Inc.

[redacted]

Good afternoon,

Madam Secretary, Mister Secretary, Members of the PA Long Term Care Commission. My name is Fady Sahhar, I am the Chief Administrative Officer of Liberty Resources, Inc. the Philadelphia Center for Independent Living. I am speaking to you today on behalf of LRI's 3000+ consumers, 700+ home care workers as well as voicing the position of the Coalition for Access to Care whose members are the Pennsylvania Providers Coalition (PaPCA), the Pennsylvania Association of Centers for Independent Living and the United Cerebral Palsy of Pennsylvania. Together these three associations represent over 65 agencies, serve over 10,000 consumers and employ over 13,000 individuals across the Commonwealth.

I will be talking with you today about two distinct topics which should be of great interest in the development of your recommendations for long term care in the Commonwealth of Pennsylvania. The first area I will address relates to the reimbursement rates for Homecare Agencies for the provision of Personal Attendant Services (PAS). The second area I will review will recommend the addition of the Agency with Choice option to

the waivers for individuals with disabilities and persons over 60 years of age.

Personal attendant services support 52,000 consumers in PA, providing the support these individuals need to live independently in the community. These essential services include activities of daily living and household chores without which these 52,000 individuals could be relegated to nursing homes and other institutional settings. While costs to the state are the most immediate reason to support these services, the most compelling reasons are self-determination and quality of life. PAS services are currently facing a serious crisis which you can help address by recommending an increase to the reimbursement rates to Homecare Agencies. Let me give you a short history of how we got here and the challenges that lie ahead of us.

In 2011, the Commonwealth of Pennsylvania adjusted rates for PAS services across the state as Home and Community Based Services were unbundled and rates were identified for each of the services, including service coordination, PAS and fiscal management services. Soon after these rates were established, the commonwealth implemented regulations separating these services into independent agencies to adhere to the conflict free rules. Many of the efficiencies of scale these agencies had were lost in this process. I will focus on the services of homecare agencies and would ask you to do the same because of the great economic impact this important service has in the Commonwealth of Pennsylvania.

A study conducted by Tripp Umbach for the Pennsylvania Homecare Association in October 2013 found that the Homecare and Hospice services contribute $21.7 Billion to the Pennsylvania economy, accounts for 252,500 jobs in the PA – that's 1 out of every 18 jobs. And this employment area is expected to grow

70% in the next 7 years.... at a time when jobs matter, we need to pay attention to this service area. Madam Secretary and Mister Secretary, these are jobs you will want to protect and support. As a consumer and an advocate, I am concerned about access to care; I am concerned that these rates are not adjusted consumers will not be able find agencies who will provide them services and will not be able to find workers to do the work. Access to Care is a cornerstone of why we need to have better rates.

The rates that were established in 2011 were rather arbitrary, so the commonwealth did the right thing and commissioned an independent study by Mercer. This study surveyed PAS agencies and developed a detailed recommendation to the commonwealth, with a range for each of the four regions across the state. OLTL chose the lowest end of the Mercer recommended range.

Please refer to the chart on page 3 of your handout.

Col 1	Col 2	Col 3	Col 4	Col 5
	2011	Mercer Recommended Range		July 2012 - Current
		Low	High	
Region 1	$ 18.08	$ 17.16	$ 21.36	$ 17.16
Region 2	$ 18.92	$ 19.08	$ 22.72	$ 19.08
Region 3	$ 18.08	$ 17.96	$ 22.36	$ 17.96
Region 4	$ 18.80	$ 19.12	$ 26.84	$ 19.12

In column 2, you can see the rate published in 2011, in columns 3 and 4 are the low and high ends of the Mercer recommended range, and finally in Column 5 is the rate which was adopted by OLTL in July 2012. That was two years ago. In the meantime, there have been significant pressures on the operating costs of homecare agencies. The most obvious of these costs is the

increasing cost of living, which is affecting the home care worker's life. Many of these homecare workers consider leaving this work for better paying jobs, with greater security and benefits.

And talking about benefits, the Affordable Care Act mandates healthcare coverage effective January 1, 2015. The Commonwealth has chosen NOT to pursue Medicaid expansion which could have provided coverage for many of the homecare workers. The guidelines in Healthy PA indicate that the agency employers will be responsible for providing healthcare coverage. This could represent $1.00 to $2.00 per worker hour.

In January 2014, OLTL issued a bulletin requiring substantial additional details in the documentation of PAS services, relating to the individual shifts worked and the very specific services delivered during every shift. Our primary area of concerns are about the consumer control and direction, however, we are also seeing an increase in tracking costs equal to 35 to 50 cents an hour.

The increasing costs are putting many of our consumers at risk of losing their access to services. The Coalition for Access to Care is proposing that the new rates should be established at the midpoint of the range proposed by Mercer in 2012.... Two years later. Please refer to the chart on page 5 of your handout for the recommended rates which we know can provide continuity of access to care. For an average of less than 3% per year, these essential services can be stabilized.

Col 1	Col 2	Col 4	Col 4	Col 5	Col 6
	2011	Mercer Recommended Range		July 2012 - Current	**Recommendation** Midpoint of Mercer Range
		Low	High		
Region 1	$ 18.08	$ 17.16	$ 21.36	$ 17.16	$ 19.26
Region 2	$ 18.92	$ 19.08	$ 22.72	$ 19.08	$ 20.90
Region 3	$ 18.08	$ 17.96	$ 22.36	$ 17.96	$ 20.16
Region 4	$ 18.80	$ 19.12	$ 26.84	$ 19.12	$ 22.98

There's a lot at stake if these rates are not implemented soon.

We have already seen a number of homecare agencies reduce and stop the acceptance of new waiver consumers. This limits the choice and access consumers have, especially in the more rural counties. In some instances, agencies have discontinued their waiver services and others have discontinued these operations. This is causing a significant stress on the safety net of these services. This is why the Coalition for Access to Care was formed.

Additionally, the workers are at a great deal of risk. Many of these workers have to make difficult choices about supporting the consumers with whom they work or to seek a better paying job elsewhere. Most of you on this commission are well versed and know the ramifications of turnover and the consequential expenses and reduction in the quality of care.

On behalf of the Coalition for Access to Care I ask you to recommend that the PAS reimbursement rate should be established at the midpoint of the Mercer rate range immediately.

I would also like to talk with you about the alternatives available to consumers within the waiver programs. There is a significant gap in the choices available within the waiver programs for people with disabilities and people over 60. I urge you add the Agency with Choice option to the waiver alternatives for this group of consumers.

The agency with choice option is approved by CMS and has a proven track record in PA in the waivers for individuals with intellectual disabilities and in many states across the country. This option provides the consumer with control of the services he or she receives. Why should a consumer have a prescribed schedule for waking up, bathing, eating their meals? Why should the agency providing services be able to determine what is acceptable? The Agency with Choice option is clearly one of the consumer directed options available to the states and we believe it's time to make it an integral part of the PA waivers.

Under this option, the consumer makes choices:

1. Determining how services are to be provided
2. Performing the recruiting, selecting, hiring, orientating, and training of support service workers
3. Performing the scheduling and managing of the desired home care services
4. Disciplining support service workers, when needed, up to and including termination.
5. Preparing an emergency back-up schedule for support service workers
6. Reviewing and approving timesheets

On the other hand, the agency with choice option provides the infrastructure to support this consumer in managing their services; the agency duties include

1. Assisting consumers in the scheduling and managing of their home care services.
2. Assisting consumers in disciplining or terminating support service workers.
3. Ensuring that support service workers and consumers meet the qualification criteria for Waiver Services.
4. Completing all payroll and accounts payable responsibilities
5. Collecting and maintaining all personnel and consumer files of record
6. Tracking utilization of the Agency with Choice portion of the ISP and providing monthly statements to the consumers.
7. Billing and collecting payments for services
8. Reporting Incidents to the appropriate parties

The National Center for Participant Directed Services, a premier resource for many organizations in this area states that some of the pro's of Agency with Choice are:

- "A good option for participants who want to choose and schedule their workers, but do not want other employer responsibilities like hiring, training, disciplining, or discharging
- Since the agency is the employer, it can provide ample worker-related support to participants....
- Can be easier/more cost effective to provide other benefits to workers such as health insurance, vacation and 401(k)"

These are the challenges we just discussed.

North Carolina includes Agency with Choice in its Innovations Waiver, while Connecticut describes it as

> "The... CT Agency With Choice model does more than provide consumers with a choice of workers. It allows individuals ... to experience a greater level of self-determination as they learn new skills through the sharing of

management and supervision responsibilities."

Many states across the country have adopted this model to give consumers choice in the self determination and control of their services which the waivers were designed to do. This model is essential on the continuum of options our consumers want and need to continue to live independently in the community. It works well and it does not cost more!

As the Commission will be making recommendations with truly long term impact on the services available and their delivery, the Agency with Choice option justifies writing a waiver update.

On behalf of the Coalition for Access to Care, the 52,000 consumers who receive waiver services, the 65,000 homecare workers who support them, the many employees of the 65+ agencies who work with them, I urge you to include the increased rates for PAS and the Agency with Choice options into the recommendation of the Long Term Care Commission.

Thank you

MEALS ON WHEELS
OF LEHIGH COUNTY, INC

Pennsylvania Long-Term Care Commission
Montgomery County
June 6, 2014

Testimony

Pamela S. Bechtel
Executive Director
Meals on Wheels of Lehigh County

Thank you for allowing me to speak on behalf of my agency, Meals on Wheels of Lehigh County.

We send a survey each year to our clients:

96% of them said Meals on Wheels is helping them live independently

94% say that Meals on Wheels provides them with their main source of food each day.

92% said they feel better, physically, mentally, they feel better that someone is checking on them, feel less lonely,

69% say they worry less about how they will get food.

17% say they would skip meals if they didn't have Meals on Wheels.

These are a few statistics, but I always think our stories give you the best picture.

A couple weeks ago, one of our Wednesday volunteers went into the home of a client who was a regular on her route. He was in his chair as always, but wasn't responding. He opened his eyes but then closed them. She called to him and tried to rouse him, but all he did was open his eyes and close them. She called her partner in to come in to see him. They decided to call 911 because this was not his normal behavior. Afterward they called our office and we called his son who was listed as his first emergency contact. This is our protocol. He lived in Saylorsburg, 30 miles away. We told him how his father was acting and that we had called 911, that the EMTs has arrived and that they were taking him to the hospital. He said I wish you hadn't done that, I talked to him last night, he was fine. He has sleep apnea. I am sure he was just sleepy. Later that afternoon, the son called back and said, "I owe you an apology. I drove down to the hospital. My father had a stroke. Thank you for calling 911. Thank you for doing what you do."

One of our volunteers named Alice Schaeffer, who is 85 years old herself, said the reason she was hooked on volunteering and continues to volunteer 38 years later, is because on one of her very first delivery days, a Friday, one of the clients on her route said, "You can lock the door as you leave because I won't see anyone else until the Meals on Wheels volunteer comes on Monday."

Neal Bell, the son of Edna M. Bell, told us that Meals on Wheels has improved his mother's life tremendously. Edna is 88, frail and uses a cane or walker because she's been physically challenged for the last ten years suffering from scoliosis and sciatica.

Neal works out of state during the week and is only in Pennsylvania from Friday-Sunday so even though he shops for her, to make sure she had good food, by the time Edna put a meal together, she'd be too tired to eat it. She became dismayed and depressed by this so she wouldn't bother and her health declined.

Neal told us that Meals on Wheels has been a God-send. The nutritious, already prepared meals are helping her physically and the wonderful volunteers give her a chance to visit with someone daily which brightens her spirits. She gets to know everyone by name and will tell him "Oh Gracie was here today. I love her!"

Neal also likes that we'll call if anything is awry. He said "It is much more than food that is brought to her home by Meals on Wheels!"

85 year old Margaret wrote to us, and said "I'm partially disabled and live alone. Thank you for your caring and happy stop at my apartment. It's good there are things to help us to live independent as best we can. It's important to a better life and peace of mind."

The daily visit is one of the most valuable services that Meals on Wheels provides, that cannot be counted in a statistic or quantified in dollars. How can you measure the reduction in isolation? How can you calculate the brightening of a spirit? Can you place a value on a visit that results in a life being saved? All of these things are priceless really, and they occur at every Meals on Wheels program across the State.

With the support of thousands of volunteers, Meals on Wheels is one of most cost effective ways to nourish our homebound seniors both body and spirit, and give them autonomy and dignity so they can live where they most want to be, their own homes.

We took part in a national campaign last year. We sent a paper plate to our clients and asked them to tell us what Meals on Wheels means to them. These are

your copies of their 178 messages to read and hopefully heed. Many wrote paragraphs…others are beautiful and profound in their simplicity like this one:

"Glad for the company and food. Without you would be lonely."

Thank you.

Thank you for allowing me to speak on behalf of my agency, Meals on Wheels of Lehigh County. Since 1971 we've delivered 6 million meals to homebound When we set up our service we act as a liaison to other seniors and adults w/ disabilities services.
We send a survey each year to our clients:

96% of them said Meals on Wheels is helping them live independently

94% say that Meals on Wheels provides them with their main source of food each day.

92% said they feel better, physically, mentally, they feel better that someone is checking on them, feel less lonely,

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