

PENNSYLVANIA LONG TERM CARE COMMISSION FINAL REPORT



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EXECUTIVE SUMMARY

The Pennsylvania Long-Term Care Commission (Commission) was established by Governor Tom Corbett's Executive Order 2014-01. Governor Corbett directed the Commission to submit a report by December 31, 2014 with its "recommendations [to] ensure Pennsylvania's long-term care services and support delivery system is person-centered, efficient, effective and fiscally accountable." Consistent with the Executive Order, this report provides recommendations along with proposed strategies and implementation activities to achieve the objectives outlined in the Executive Order. The report is the culmination of nine months' work by Commission members, private individuals who volunteered to serve as advisors to the Commission, and Department staff who helped to facilitate the Commission's activities. During this time, the Commission examined Pennsylvania's current long term services and supports (LTSS) system, gathered information about LTSS innovative programs and practices in Pennsylvania and other states, reviewed various literature and reports, traveled across the Commonwealth to solicit input from interested Pennsylvanians, and engaged in frank and open dialogue in assessing where and how the LTSS system could be improved.

The LTSS system serves a diverse population with a wide range of service and care needs. Consumers, providers and public officials involved in the system are dedicated to making it work effectively and efficiently. Nonetheless, the Commission found that despite this dedication, and the current \$5 billion annual expenditures on publically funded LTSS, the LTSS delivery system has many challenges: LTSS sometimes lack coordination; the eligibility process is lengthy and complicated; inefficiencies in service delivery can result in unnecessary costs; provider reimbursement methodologies are inconsistent and may need updating; funding and service silos may hinder maximization of existing resources; and lack of technology coupled with inadequate or outmoded data, metrics and tools, hamper efforts to assess and ensure quality services. Recognizing that demand for public LTSS programs is likely to grow even more, given the demographics of Pennsylvania's population, the Commission also concluded that additional support and services must be afforded to family caregivers, and that efforts to promote preventive services and personal planning for LTSS needs, including private insurance coverage options, must be increased if the LTSS system is to be sustainable in the long term. To address these and other challenges confronting Pennsylvania's LTSS system, the Commission developed the following four broad recommendations along with multiple proposed strategies to enhance Pennsylvania's LTSS system:

RECOMMENDATIONS:

1. IMPROVE CARE COORDINATION IN THE LTSS SYSTEM

- Develop and implement a LTSS coordinated integrated demonstration program.
- Conduct a gap analysis to identify and address service gaps and barriers that prevent the LTSS system from operating in a person-centered, efficient, effective and fiscally accountable manner.

2. IMPROVE SERVICE DELIVERY IN THE LTSS SYSTEM.

- Streamline, standardize and expedite the Medical Assistance LTSS eligibility process.
- Increase education to promote personal planning for LTSS needs.
- Expand access to evidence-based health and wellness programs.
- Take appropriate measures to increase affordable, accessible housing options for individuals needing LTSS, and include home modifications as a covered service in waiver and state-funded programs.
- Provide increased support and assistance to unpaid caregivers to improve their well-being and relieve the stresses of caregiving.
- Elevate the profession of direct care workers (DCWs).

3. IMPROVE QUALITY AND OUTCOMES IN THE LTSS SYSTEM

- Adopt a uniform assessment for all LTSS levels of care.
- Expand Health Information Exchange and Electronic Health Record initiatives to LTSS providers.

4. MAKE THE LTSS SYSTEM MORE FISCALLY SUSTAINABLE

- Serve the greatest number of individuals in the safest, most appropriate, least restrictive, and cost effective setting possible with limited available state and federal resources.
- Provide the Department of Human Services budget flexibility to maximize use of appropriated LTSS funds.
- Review the LTSS rate setting and reimbursement systems for all LTSS providers.

INTRODUCTION

The Long-Term Care Commission

Governor Corbett created the Long-Term Care Commission (Commission) on January 31, 2014 through Executive Order 2014-01. He charged the Commission with developing “recommendations [to] ensure Pennsylvania’s long-term care services and support delivery system is person-centered, efficient, effective and fiscally accountable.” Governor Corbett directed the Commission to submit a final report detailing its recommendations by December 31, 2014.¹ Along with the Secretaries of Aging and Public Welfare,² who were designated as co-chairpersons, individuals appointed to serve on the Commission included those with broad-based knowledge, varied expertise, and first-hand experience with different aspects of Pennsylvania’s long-term services and supports (LTSS) delivery system.³

In issuing his Executive Order, Governor Corbett noted the significant demographic challenges confronting Pennsylvania’s LTSS system:

- Pennsylvania has the 16th largest population of non-institutionalized people with disabilities in the country; and there are 1.7 million Pennsylvanians living with physical disabilities in their communities who need assistance with self-care, mobility and independent living; and with changing demographics and developments in technology and medical treatment, this number is expected to increase in coming years.
- Pennsylvania has the fourth-largest percentage of residents age 60 years and over; and during the next decade, Pennsylvania’s age 85 years and over population is expected to grow by 42 percent while its total population is expected to grow by only 2 percent; and research shows that nearly 70 percent of individuals reaching age 60 in 2012 are expected to need long-term care services at some point during their lifetime.

With these statistics in mind, the Commissioners gathered in Harrisburg on March 7, 2014 to begin the Commission’s work. Thereafter, the Commission held monthly meetings culminating in its final meeting on December 15, 2014, at which the Commission voted to approve this report. Along with its monthly meetings during the summer, the Commission held seven regional public input sessions in Allegheny, Dauphin, Lycoming, Mercer, Montgomery, Philadelphia and Pike Counties, with over 200 stakeholders, consumers and other interested persons in attendance. These sessions offered Commissioners first-hand insight into the critical issues surrounding consumers, caretakers, stakeholders, providers and other entities involved

¹ A copy of the Executive Order is located in Appendix 1.

² After the Executive Order was issued, legislation was enacted to change the name of the Department of Public Welfare. This report refers to the Department by its current name and acronym – the Department of Human Services or DHS.

³ Additional information about the composition and activities of the Commission can be found in Appendices 2, 3 and 4 and on the Commission’s website at <http://www.dhs.state.pa.us/dhsorganization/officeoflongtermliving/ltcc/index.htm>.

with Pennsylvania’s LTSS system. The Commission provided individuals who were unable to attend the public sessions with the opportunity to submit written comments. Over 150 comments were received through this public input process and considered by the Commission.

The Commission also received information through presentations and panel discussions by local and national experts on LTSS, as well as staff from the different Commonwealth agencies involved in Pennsylvania’s LTSS system. As a result of the process, the Commission was able to obtain a comprehensive understanding of the current LTSS delivery system and its many challenges.⁴

Pennsylvania’s Long Term Services and Support System

The Commission focused its review on LTSS received by older adults and adults with physical disabilities.⁵ In Pennsylvania, these LTSS are provided in private homes, non-residential and residential settings, and licensed facilities. LTSS span a continuum ranging from periodic in-home services and supports to round-the-clock care provided by professional nurses and trained staff in 800 licensed nursing facilities throughout the Commonwealth. Most LTSS are uncompensated, provided by caregivers to their family members and loved ones. Other LTSS are funded through private insurance coverage or through a range of government programs using a combination of state and federal funding. At least four different Commonwealth agencies (the Departments of Aging, Health, Human Services, and Military and Veterans Affairs) are responsible for various aspects of the LTSS system.

Government funded LTSS are delivered through multiple programs. Most are provided through the Medicaid Program, a joint state and federal program established by Title XIX of the Social Security Act through which low income individuals who meet certain categorical requirements obtain coverage for physical and behavioral health care services and LTSS. In Pennsylvania, the Medicaid Program is known as the Medical Assistance (MA) Program.

MA LTSS include nursing facility services, which are an entitlement under the Commonwealth’s Medicaid State Plan,⁶ and an array of home and community based (HCB) services, which are provided to a limited number of individuals under six different Medicaid 1915(c) waivers. Currently, MA nursing facility services and MA HCB waiver services are reimbursed on a fee-for-

⁴ A copy of a presentation summarizing the public comments received by the Commission is included in Appendix 5.

⁵ In reviewing the LTSS system for older adults and adults with physical disabilities, the Commission considered both MA and state-funded LTSS. The Commission did not examine LTSS received by children or LTSS administered by the DHS Office of Developmental Programs, which are received by individuals with intellectual or developmental disabilities. Further, except for recommending better coordination of behavioral health services for older adults and adults with physical disabilities, who also receive LTSS, the Commission did not examine LTSS administered by the DHS Office of Mental Health and Substance Abuse Services.

⁶ Under federal law, a state Medicaid Program must provide nursing facility services to any Medicaid recipient who chooses to receive those services as long as the recipient requires the level of care provided in a nursing facility. In contrast to services provided under a Medicaid waiver, a state may not cap the number of recipients receiving Medicaid funded nursing facility services.

service basis. However, MA LTSS are also provided to individuals age 55 and over through the Commonwealth's Living Independence for the Elderly (LIFE) program, an all-inclusive capitated MA LTSS program for individuals who are dually eligible for Medicare and MA benefits. LIFE is only available in 30 counties and the approximately 5,000 current enrollees represent a small fraction of the MA LTSS consumers in Pennsylvania.

To receive LTSS under the Pennsylvania MA Program, an individual must be both financially and categorically eligible⁷ for MA coverage. In addition, the individual must be functionally eligible—i.e., require the level of services provided in a nursing facility or other specified institutional setting.⁸ For individuals who do not meet MA financial or functional eligibility requirements, Pennsylvania offers HCB LTSS through state-funded programs, such as the Act 150 program and the Lottery funded Options and Family Caregiver Support programs. Like the HCB services provided under the MA waiver programs, however, these state funded services are not entitlements, but rather are provided to a limited number of individuals depending on available state funding.

Pennsylvania also provides LTSS through six State Veterans' Homes operated by the Department of Military and Veterans Affairs (DMVA). The Homes, which are located across the Commonwealth, offer nursing home care and domiciliary/personal care to honorably discharged Pennsylvania veterans and their spouses on a first-come, first-served basis. In addition to state general funds, the Homes receive funding through the MA Program and the US Department of Veterans Affairs.⁹

In some instances, LTSS are provided locally by counties. The type of LTSS vary by county. Some counties operate AAAs, provide waiver services, administer the MA transportation program in their locality, and provide housing, and behavioral health services in the long term care continuum. In addition, 25 counties operated county nursing facilities that serve as critical safety net providers for MA recipients. In using local funds to support these county facilities, the counties are able to certify public expenditures which draw down federal matching funds under the MA Program.

Pennsylvania currently spends over \$5 billion each year on LTSS: \$4.7 billion on MA LTSS and an additional \$381 million on state funded LTSS.¹⁰ Approximately 25% of the \$4.7 billion is used

⁷ Generally, to be eligible for MA coverage, an individual must fall within one of the following categories: be age 65 or older; have a permanent disability as that term is defined by the Social Security Administration; be blind; be a pregnant woman; be a child, or the parent or caretaker of a child.

⁸ Individuals enrolled in the OBRA waiver are required to need the level of care provided by an Intermediate Care Facility/Other Related Conditions (ICF/ORC). All other MA LTSS consumers must need the level of care of a nursing facility. In addition to meeting applicable level of care requirements, the waivers may require participants to have certain diagnoses or functional limitations. For example, the Independence and OBRA waivers require that participants have substantial functional limitations in three or more specified major life activities.

⁹ In addition to the State Veterans Homes, there is one other state nursing facility – South Mountain Restoration Center, a 159-bed facility located in Fulton County, which is operated by DHS.

¹⁰ These amounts do not include expenditures for LTSS by DMVA or expenditures for South Mountain Restoration Center.

for MA LTSS to support individuals in their homes and communities.¹¹ Funding for LTSS programs is provided through line item appropriations, which currently do not permit any reallocation of funding absent a supplemental appropriations act. In the 2012-2013 fiscal year:

- The Pennsylvania Options program had an average spend of \$1,880 per unduplicated recipient.¹²
- The average spend for HCB services in MA and state funded programs was just over \$22,500 per user.¹³
- The LIFE program had an average spend of \$32,500 per unduplicated recipient per year.¹⁴
- The average cost to the MA Program for a year-long nursing facility was just under \$43,500 per recipient.¹⁵

When reviewing the cost data above, it is important to note that the services provided in each LTSS program can be very different and the acuity levels of individuals receiving LTSS also vary. For example, nursing facilities are required to provide care around the clock, whereas the LIFE program and HCB programs typically do not provide 24 hour a day care. There may also be variations in the types of medical services provided based upon individual acuity and need.

In addition to the public funding of LTSS, the AARP Public Policy Institute estimates that family caregivers provided an estimated \$19.9 billion in uncompensated care in Pennsylvania.¹⁶

Additional information regarding the current Pennsylvania LTSS system is included in Appendices 6 and 7. A crosswalk to LTSS data provided to the Commission and available on the Commission website is included in Appendix 8. A listing of, and links to, other studies and reports considered by the Commission in the course of developing this report are included in Appendix 9.

¹¹ Eiken S, Sredel K, Gold L et al, "Medicaid Expenditures for Long-Term Services and Supports in FFY 2012", CMS, Truven Health Analytics (April 28, 2014), Table AL, available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/LTSS-Expenditures-2012.pdf>.

¹² Source: Department of Aging, SAMS System as of 6/30/2014.

¹³ Source: PROMISe Data Warehouse; Date of Extraction: 6/01/2014; Information includes both paid Claims and Supplemental Payments.

¹⁴ *Ibid.*

¹⁵ *Ibid.*

¹⁶ Houser A, Fox-Grage W, Ujari K, "Across the States 2012: Profiles of Long Term Services and Supports," AARP, 9th Ed (2012), p. 271, available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf.

RECOMMENDATIONS

Despite significant levels of public funding and the vast investment of private, human, and financial capital, including significant investment by Governor Corbett over the last 4 years in acknowledgement of the importance of the LTSS system, the Commission found multiple areas of concern in Pennsylvania's LTSS delivery system. The Commission's concerns included: a lack of coordination, inefficiencies, inconsistencies and delays in both eligibility and service delivery processes, funding and service silos, and inadequate or outmoded data, metrics and tools to assess and ensure quality services. Recognizing that the system's problems are long standing and that addressing them will not only take time, but will require the cooperation and concerted effort of both public and private resources, the Commission identified and is recommending multiple ways in which Pennsylvania's LTSS could be enhanced.

In keeping with the charge of the Governor's Executive Order, the Commission's recommendations are grouped around four themes that are listed below but are not in any priority order.

Recommendation 1 – Improve Care Coordination in the LTSS System

Recommendation 2 – Improve Service Delivery in the LTSS System

Recommendation 3 – Improve Quality and Outcomes in the LTSS System

Recommendation 4 – Make the LTSS System More Fiscally Sustainable

Information on each recommendation, including a description of the proposed strategies and implementation activities needed to achieve the recommendations, along with a fiscal impact estimate developed by the Commonwealth for each proposed strategy is provided below.¹⁷ It is important to understand that while a proposed strategy may be grouped under a particular recommendation, it may support multiple recommendations. (e.g., Proposed Strategy 1.1, "Develop and Implement a LTSS Coordinated Integrated Demonstration Program," not only supports the Commission's recommendation to improve care coordination, but also supports other recommendations to improve LTSS service delivery, quality and outcomes, and system sustainability.)

For purposes of this report, the Commission adopted the following terminology in describing the estimated fiscal impact of a proposed strategy:¹⁸

- Low – estimated impact of \$5 million or less in state funds

¹⁷ More detailed information regarding the recommendations, proposed strategies and recommended implementation activities is contained in Appendix 10.

¹⁸ The fiscal impact estimates included in this report are preliminary and were based solely on the information available to the Commonwealth at the time the recommendations in this report were developed. As proposed strategies are implemented, the Commission expects that the fiscal impact estimates will be revised based on actual experience and more up-to-date expenditure and utilization data.

- Medium – estimated impact of between \$5 and \$25 million in state funds
- High – estimated impact of greater than \$25 million in state funds.

RECOMMENDATION 1 – IMPROVE CARE COORDINATION IN THE LTSS SYSTEM

Background

As described in the public comments submitted to the Commission, Pennsylvania’s current LTSS system has limited coordination among the physical health, mental health, substance abuse, and LTSS systems:

- Most LTSS consumers access physical health care services through the Medicaid and Medicare fee-for-service (FFS) systems. Others may receive physical health services through a Medicaid HealthChoices physical health managed care plan or a Medicare Advantage managed care plan.
- Most LTSS consumers receive mental health and substance abuse services through a Medicaid HealthChoices behavioral health managed care plan. Others may receive mental health and substance abuse services through the MA FFS program, county mental health resources or through a very limited Medicare benefit.
- Most LTSS consumers receive their LTSS in a nursing facility, which is able to assist residents in obtaining necessary physical and behavioral health care because of the 24-hour care setting. Consumers receiving LTSS in a home or community based setting have their services coordinated through an Area Agency on Aging (AAA) or other Service Coordination Entities (SCE). Service coordination for these individuals generally does not include physical or behavioral health care services.
- A small number of LTSS consumers are enrolled in the LIFE Program and have their physical health, mental health, substance abuse, and LTSS services coordinated through a Medicare and Medicaid capitation payment model. The program, which is dedicated to helping frail older people continue to live in their own homes, offers all services typically covered by Medicare and MA, plus an extensive array of in-home care, as well as meals, recreation, transportation and rehabilitation services.

Commissioners discussed the challenges consumers and providers face under these varied delivery and financing systems. They learned about different delivery and financing demonstrations and pilots, and had robust discussions around topics such as the type of model (e.g. capitated vs. FFS), population and services covered (e.g. Medicare, Medicaid, physical health, mental health, substance abuse, LTSS), and enrollment options (e.g., voluntary, mandatory, automatic enrollment with ability to opt out).

The Commissioners also heard concerns from stakeholders regarding gaps and barriers in the current LTSS system that could directly or indirectly impact care coordination. For example,

Commissioners received public comments urging the Commonwealth to adopt the Community First Choice Option (CFC Option), which would include personal care services as an entitlement service under Pennsylvania’s Medicaid State Plan and enable the Commonwealth to qualify for additional federal matching funds. The Commissioners were also told by stakeholders that the inability to obtain home modifications prevented individuals from remaining in or returning to their homes and that Pennsylvania’s current estate recovery policies may deter individuals from applying for MA HCB waiver services.

Based on these comments and related discussions, the Commissioners identified a number of changes to the LTSS system which, in their view, would make it operate in a more person-centered, effective, efficient and sustainable manner. However, the Commissioners understand and agree that the Commonwealth must assess the legal, operational and financial implications before any of these changes can be implemented. The Commissioners also agree that a further top-to-bottom review of the system could identify additional gaps and barriers that should be considered both in determining whether to modify the existing LTSS system and in designing future service delivery models.

The Commissioners developed the proposed strategies and goals outlined below to address these challenges.

Proposed Strategy 1.1: Develop and Implement a LTSS Coordinated Integrated Demonstration Program.

Develop and implement one or more demonstration programs (demonstration) in designated geographic areas to pilot service delivery and financing models that provide coordinated, integrated, person-centered physical health, mental health, substance abuse, and LTSS services.

- Each demonstration should be developed within the following parameters:
 - Is voluntary.
 - Is person-centered.
 - Is available for adults who are:
 - Eligible for MA only, or
 - Dually eligible for Medicare and MA, or
 - Eligible for the Options or Act 150 Program and meet the current functional eligibility for MA LTSS programs, or
 - A small population who are eligible for the Options or Act 150 Program and do not meet the current functional eligibility for MA LTSS programs.

- Integrates services and funding from Medicare, MA (LTSS, FFS, HealthChoices and MA waivers), and state funded LTSS programs for applicable demonstration enrollees.
- Is coordinated with, but not dependent on other state initiatives.
- Is expanded statewide through a phased process, with the option of using passive enrollment, if the demonstration's outcome, satisfaction and sustainability goals are achieved; and is discontinued if the demonstration's goals are not met.

Goals:

1. Enable older adults and adults living with physical disabilities to remain in their homes and live independently as long as possible.
2. Improve coordination of an individual's physical health, mental health, substance abuse, social and housing services, and LTSS, if the individual so chooses.
3. Enhance coordination and integration of services during care transitions from more to less intensive settings, to ensure necessary follow up care and prevent unplanned re-admissions.
4. Test models that improve care coordination, outcomes, and consumer satisfaction and that make the LTSS system more fiscally sustainable with better aligned financial incentives.
5. Determine which model(s) best supports obtaining better outcomes, consumer satisfaction and the long-term financial sustainability of Pennsylvania's LTSS system.

Proposed Implementation Activities:

1. Identify the appropriate funding mechanism (e.g., 1115 demonstration) and request and obtain approval from the Centers for Medicare and Medicaid Services (CMS) to ensure federal matching funds.
2. Have ongoing stakeholder involvement in the development, implementation and evaluation of the demonstration.

Convene an existing or newly formed broad-based stakeholder group to assist the Commonwealth throughout all phases of the demonstration program. The stakeholder group should provide input, consistent with the parameters of this recommendation, on the demonstration populations, specific geographic demonstration areas, comprehensive benefit design, service delivery and care management, and financial

arrangements (e.g. capitated, managed fee-for-service, partial capitation, episodes of care bundled payments) to be tested.

3. Include strong consumer protections in the demonstration.

Design the demonstration to allow consumers sufficient time (e.g., 60 days) to choose their demonstration plan option and safely transition from the FFS program or their present managed care plan into the demonstration program. Conversely, allow consumers opting to leave the demonstration plan sufficient time to safely transition into FFS or a managed care plan. Develop quality measures to assure access, timely service delivery, person-centered services and outcomes in the demonstration program, and establish provider network requirements to ensure appropriate access to services.

4. Continue to support the existing networks of local, non-profit, public, and small business providers, including Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs), during the development and implementation of the demonstration.

Give providers ongoing technical assistance, training, and incentives to maximize their ability to keep up with the demands for high quality, cost effective services, and the use of technology systems. Consider the results of the LTSS rate setting and reimbursement review as part of developing the demonstration. (See also Proposed Strategy 4.2.)

5. Enhance coordination and integration of mental health and substance abuse services for LTSS consumers.

Design the demonstration to promote and support the growth of person-centered mental health and substance abuse services within the Commonwealth while coordinating with LTSS, if the individual so chooses. Among other things, consider the use of telepsychiatry and telemedicine; MA reimbursement for advanced practice professionals (e.g., psychiatric nurses); and MA reimbursement for appropriately trained and experienced workers to expand the availability of mental health and substance abuse services. (See also Proposed Strategy 1.2.) Allow budget flexibility to breakdown the funding silos between the Office of Long-Term Living (OLTL), Office of Medical Assistance Programs, Office of Mental Health and Substance Abuse Services, and the Pennsylvania Department of Aging (PDA).

6. In preparation for the demonstration, develop and implement comprehensive educational programs to assist participating consumers understand the demonstration and evaluate their options; help providers make necessary changes in current practices to prepare for new business models; and inform managed care organizations of current LTSS programs to facilitate the development of partnerships between the plans and current LTSS providers.

7. Work with legislative leaders to inform them about and obtain their support for the demonstration, including securing the necessary budget flexibility to successfully implement the demonstration. (See also Proposed Strategy 4.2.)
8. Establish data and reporting requirements and make appropriate system modifications to obtain necessary data to monitor, measure, and evaluate the demonstration and its impact on consumers and the existing FFS program. (See also Proposed Strategies 3.1 and 3.2.)

The estimated fiscal impact of this proposed strategy is Low (estimated impact of \$5 million or less in state funds) due to long term state and federal savings.

Further detail on this Proposed Strategy, is contained in Appendix 10, pp. 78-83.

Proposed Strategy 1.2: Conduct a Gap Analysis.

Conduct analyses of the existing LTSS system to identify and eliminate gaps and barriers in care coordination and service delivery. Coordinate the results of these analyses with the design and implementation of the demonstration.

Goals:

1. Enable older adults and adults living with physical disabilities to remain in their homes and live independently as long as possible.
2. Improve coordination of the services between an individual's physical health, mental health, substance abuse, LTSS, social and housing services, if the individual so chooses.
3. Ensure that LTSS services are coordinated and delivered in a manner that reflects and respects the racial and ethnic values and preferences of Pennsylvania's ethnically diverse populations.

Proposed Implementation Activities:

1. Conduct a feasibility study of the following:
 - Adding coverage of home modifications (including modifications to a rental property), activities of daily living (ADL) technology, and remote service technology in all Medicaid waivers and the Act 150 program;
 - Permitting nurse delegation, or other alternatives to nurse delegation, to enable direct care workers to provide additional services for LTSS consumers;
 - Providing MA reimbursement for advanced practice professionals (e.g., psychiatric nurses);

- Providing MA reimbursement for appropriately trained and experienced workers to expand the availability of mental health and substance abuse services;
- Eliminating restrictions that limit housing options in domiciliary care for LIFE consumers;
- Allowing interim care plan approvals;
- Removing limitations on paying family members to provide personal care;
- Permitting reimbursement for costs related to the use of service animals;
- Modifying estate recovery policies to exempt MA HCB services; and,
- Permitting MA HCB services to be provided in personal care homes and assisted living residences.

The study should examine the legal, operational and financial implication of each proposed modification to the system and identify the action steps required for any modification determined to be operationally, legally and financially feasible. Feasible changes should be implemented as soon as possible and should not be delayed or contingent on implementation of the demonstration.

2. Convene a study group to evaluate the policy, operational and financial implications to the Commonwealth of adopting the CFC Option, or other financing options, in order to offer personal care services under the Medicaid State Plan.
 - The study group should include adults with disabilities and adults who are 60 years old or older and their representatives/caregivers, LTSS and other service providers and their representatives, and staff from the Commonwealth agencies.
 - The study group should: (i) consult with CMS and those states that have implemented the CFC Option and those states that withdrew CFC Option State Plan Amendments; (ii) analyze and report on CFC Option feasibility; and (iii) consider innovative proposals that push the boundaries of the CFC Option regulations in order to better fit the needs of Pennsylvania.
 - The study group should complete its analysis and report in sufficient time to enable the Commonwealth to make a final determination on whether to pursue the CFC Option, or some other alternative, so that, if appropriate, the necessary funding authority may be included in the 2015-2016 state budget.
 - If the study group finds adoption is not recommended in the current policy/regulatory environment, then the study group should recommend the

policy and regulatory changes that would be required to make adoption preferable.

3. Conduct a longer term gap analysis to identify:

- Additional services that should be covered to strengthen the LTSS system, empower its users with choices, enable them to receive person-centered care and to age in place;
- Aspects of the LTSS system that limit choice, hinder the ability to provide person-centered care or to age in place, or hamper the flexibility needed to adapt to changing long-term care needs and opportunities;
- Any waiver, State Plan, legislative, or regulatory amendments or other options needed to address service gaps and barriers (e.g., standardization of benefit packages and provider reimbursement rates and methodologies); and,
- Alternative and innovative funding streams being used in other states, as well as innovative models being offered at the federal level for use by states to address identified service gaps.

This gap analysis should also assess the policy and fiscal implications and feasibility of addressing identified service gaps, and whether any legal or regulatory barriers exist that limit or prevent changes necessary to address the gaps. Where feasible, identified gaps and barriers should be addressed immediately. Changes should not be delayed or contingent on implementation of the demonstration.

4. Consider and coordinate results of these analyses in the design and piloting of the demonstration.

The estimated fiscal impact of this proposed strategy is Low (estimated impact of \$5 million or less in state funds). This estimate does not include any costs related to changes recommended as a result of the feasibility study, the adoption of the CFC Option, or any changes made to eliminate gaps and barriers identified in the gap analysis.

Further detail on this Proposed Strategy, is contained in Appendix 10, pp. 84-87.

RECOMMENDATION 2 – IMPROVE SERVICE DELIVERY IN THE LTSS SYSTEM

Background

In addition to care coordination challenges in the LTSS system, the Commissioners also examined issues related to access and delivery of services. The Commissioners considered whether current policies relating to MA HCB services may inadvertently prompt individuals, who could be safely and appropriately served in their homes, to choose more expensive care

settings. They were told that the application process for MA LTSS is long, tedious and difficult for applicants and their families to navigate. They learned that individuals seeking HCB services through MA waivers face different financial eligibility standards and, as a result, may experience more difficulty initiating HCB services than they would in initiating MA nursing facility services.

The Commissioners heard concerns that disparities in payment policies for HCB services and nursing facility services may affect the ability of LTSS consumers to remain in or return to their homes. Specifically, unlike MA nursing facility service payments, which can be retroactive, MA payments for HCB services are only authorized prospectively after the entire eligibility process is completed, including service plan approval. Because the process to obtain HCB services can be lengthy, some individuals who have immediate service needs may have no choice but to seek admission to a nursing facility.

The Commissioners also heard concerns about the adequacy of the State Supplementary Payment provided to residents of personal care homes who are eligible for Supplemental Security Income and its impact on personal care home providers. The Commissioners learned that this state payment, which is applied to defray the cost of personal care home services, has not been increased since 2001. They heard from commenters that the number of personal care homes willing to admit and serve Supplemental Security Income (SSI) recipients is declining and an increasing number of homes are closing for financial reasons.

The Commissioners received comments and information suggesting that limited preventive health and wellness programs, lack of awareness of the availability of private LTSS coverage, and scarce affordable housing options may also limit service options for Pennsylvanians in need of LTSS.

In addition to these concerns, the Commission received considerable feedback regarding the challenges faced by paid and unpaid caregivers¹⁹ in the LTSS system. Both public comments and the Commission's own discussions underscored the importance of caregivers and direct care workers (DCWs). The Commissioners explored ways to attract and retain caregivers and DCWs to better assure the sustainability and effective administration of the LTSS system.

As noted above, the bulk of LTSS in Pennsylvania is uncompensated care provided by caregivers to their family members and loved ones. Given caregivers' significant role in the LTSS delivery system, the Commission agreed that appropriate steps must be taken to support caregivers, improve their health-related quality of life, and delay, mitigate or prevent the adverse health effects of caregiving.

Public comments and Commission discussion also focused on the impact of DCW shortages, high turnover rate, insufficient training, and inadequate wages and benefits in Pennsylvania's

¹⁹ This report uses the term "caregiver" to refer to unpaid caregivers and the term "direct care worker" or DCW to refer to paid caregivers, including aides and attendants.

LTSS delivery system. While there have been various initiatives over the last decade relating to these issues,²⁰ the problems are longstanding and difficult to resolve.

Commissioners considered all of these challenges in developing the following proposals to improve service delivery in the LTSS system.

Proposed Strategy 2.1: Streamline, standardize and expedite the MA LTSS Eligibility Process.

Streamline, standardize and expedite eligibility and re-eligibility determinations for all MA LTSS programs across all levels of care.

Goal:

Provide older adults and adults with disabilities timely access to cost effective and quality LTSS in the safest, most appropriate, least restrictive, and cost effective setting possible.

Proposed Implementation Activities:

1. Streamline the process:

- In coordination with current Balancing Incentive Program initiatives, modify the Compass system to expand capacity to accept applications and supporting documentation for all LTSS programs.
- Increase the use of technology to facilitate more timely exchange of information and eliminate duplication of effort.

2. Standardize the process:

- Adopt consistent elements in assessment tools for all programs.
- Apply the same eligibility standards and requirements, including allowing “spend down” to the same income levels, regardless of whether individuals seek LTSS in nursing facilities or in HCB settings.²¹ (See also Proposed Strategy 4.1.)

3. Expedite the process:

- Develop and use a preliminary financial screening tool to determine whether an applicant for LTSS is likely to be determined MA eligible. Use Lottery funds to

²⁰ Initiatives include the Department of Aging’s DCW Incentive Funds, the Department of Labor and Industry’s Center for Health Careers, and the Robert Wood Johnson Foundation’s Better Jobs Better Care State Grant program. There have also been studies conducted by Penn State and the University of Pittsburgh quantifying the vacancies and turnover rates of LTSS provider organizations.

²¹ Individuals whose incomes exceed the income limit for Medicaid coverage may qualify for Medicaid if they have medical bills that equal or are greater than their "excess" income. The process of subtracting those medical bills from the individual’s income over a six month period is referred to as “spend-down.”

advance payment for services on an interim basis for individuals over age 60 who are determined likely MA eligible pending a final determination of their eligibility. Identify an alternate funding source to pay for services on an interim basis for individuals under age 60 who are determined likely MA eligible.

- Take appropriate measures to enable HCB services to commence pending eligibility determinations by permitting the development of an interim service plan for HCB services, including submitting waiver amendments and revising 55 PA Code Chapter 52 regulations — Long Term Living Home and Community Based Services.

The estimated fiscal impact of this proposed strategy is High (estimated impact of greater than \$25 million in state funds) due to the “spend down” eligibility changes that could increase HCB program enrollment. Some offsetting cost savings may be realized as the result of decreased use of institutional care.

Further detail on this Proposed Strategy, including recommended implementation activities and the anticipated costs or budget impact, is contained in Appendix 10, pp. 88-89.

Proposed Strategy 2.2: Increase education to promote personal planning for LTSS needs.

Pursue a multi-dimensional approach to increase education to promote personal planning for and awareness of LTSS needs.

Goal:

Delay the need for more costly and restrictive levels of care by providing additional education on preventive services and private insurance coverage for LTSS.

Proposed Implementation Activities:

1. Build on existing programs (both public and private) to educate the public on the necessity for planning for their long-term needs. Simplify access to information and support.
2. Promote education surrounding long-term care insurance and the Long-Term Care Partnership Program.²² (See also Proposed Strategy 4.1.)

²² The Long-Term Care Partnership Program in Pennsylvania was established by Act 40 of 2007. It offers Pennsylvanians the opportunity to provide for their own needs while helping to conserve taxpayer resources. It encourages an individual to purchase long-term care insurance by providing asset coverage equal to the benefits paid by a qualifying policy in the event that the individual becomes eligible for MA nursing facility services. For example, a person whose qualifying policy paid for \$100,000 of care would be entitled to keep \$100,000 in assets if person applied for and received Medical Assistance in the future.

The estimated fiscal impact of this proposed strategy is Low (estimated impact of \$5 million or less in state funds) and accounts for staff time related to supporting education efforts.

Further detail on this Proposed Strategy, including recommended implementation activities and the anticipated costs or budget impact, is contained in Appendix 10, pp. 89-90.

Proposed Strategy 2.3: Expand access to evidence-based health and wellness programs.

Expand access to evidence-based health and wellness programs, including both physical health and behavioral health.

Goal:

Delay the need for more costly and restrictive levels of care by building preventive services into a more coordinated, person-centered model of LTSS.

Proposed Implementation Activities:

1. Collaborate with primary care physicians, AAAs, CILs, county and private LTSS providers in order to maintain or enhance health and wellness.
2. Continue to involve the AAAs and CILs as essential components of the LTSS system in their roles as stakeholders, advocates and service providers.
3. Develop and integrate a voluntary health and wellness evaluation for participants in all programs and services offered through PDA, MA waiver programs, senior centers, respite centers, personal care homes, domiciliary care, and assisted living facilities.
4. Develop a voluntary longitudinal database, or Residential History File (RHF), to track a person's health and wellness and use of LTSS throughout the continuum. (See also Proposed Strategies 3.1 and 3.2.)
5. Promote the development of partnerships (among state agencies, HCB service providers, county government, and private partners) that encourage the evolution of communities in which to age and live well.
6. Support consumers' participation in sports and other recreational activities.
7. Facilitate the exchange of information on innovative solutions in housing and transportation that support independent living.

The estimated fiscal impact of this proposed strategy is Medium (estimated impact of between \$5 and \$25 million in state funds) due to the cost of developing the longitudinal database and related activities.

Further detail on this Proposed Strategy, including recommended implementation activities and the anticipated costs or budget impact, is contained in Appendix 10, pp. 90-92.

Proposed Strategy 2.4: Increase affordable, accessible housing options and expand home modifications for individuals needing LTSS.

Increase affordable, accessible housing options and expand home modifications to enable individuals who need LTSS to remain in or return to their homes.

Goal:

Enable individuals needing LTSS to maximize their level of independence and live as safely and independently as possible.

Proposed Implementation Activities:

1. Improve the home modification program by taking the following actions:
 - Include home modifications as a covered service in all MA HCB service waivers and under Act 150. (See also Proposed Strategy 1.2.)
 - Re-establish regional Construction Officers to monitor and assure home modification projects paid for with MA and Commonwealth funding are designed and completed appropriately.
 - Create mechanisms to allow progress payments for home modifications, work, and materials while projects are completed, and to reimburse for home modifications prior to an individual's discharge from a post-acute setting.
 - Improve the timeliness of the MA waiver home modification approval process.
 - Establish linkages with programs, such as Habitat for Humanity, to assist with home modifications in order to allow more individuals to "age in place." (See also Proposed Strategies 1.2 and 4.1.)
2. Make MA HCB services available in additional settings to the extent permissible under state and federal law and regulations:
 - Allow for MA HCB services to be provided in Assisted Living Residences and other allowable settings.
 - Add and promote the use of Family Group (Shared) Living as a covered service in MA HCB programs.

3. Identify mechanisms and sources to provide increased financial support of \$10 per day to personal care homes²³ and to expand the Housing Trust Fund. (See also Proposed Strategy 4.3.)
4. Charge the Pennsylvania Housing Finance Agency (PHFA), the Pennsylvania Department of Aging or other appropriate state agency with evaluating the cost/benefits of emerging housing options, such as “Green Houses,” “naturally occurring retirement communities,” single family and multi-family limited equity partnerships, cooperatives, safe havens, and Fairweather Lodges, and assess each setting for access to available funding streams.
5. Take appropriate measures to promote increased collaboration among PHFA, the Department of Community and Economic Development, public housing, and private developers/landlords to maximize the availability of and access to low income accessible housing options for individuals transitioning out of long-term care facilities, including expanding the use of “targeted transitional housing priorities” and the Keystone Renovate and Repair program.

The estimated fiscal impact of this proposed strategy is High (estimated impact of greater than \$25 million in state funds) due to the cost of increasing reimbursement to personal care homes and increased funding to the Housing Trust Fund.

Further detail on this Proposed Strategy, including recommended implementation activities and the anticipated costs or budget impact, is contained in Appendix 10, pp. 92-94.

Proposed Strategy 2.5: Enhance services provided to unpaid caregivers.

Take appropriate actions to ensure unpaid caregivers’ good health and well-being by tailoring interventions to prevent the adverse health effects of caregiving.

Goal:

Enhance services provided to unpaid caregivers to enable them to support LTSS clients in the community.

Proposed Implementation Activities:

1. Develop and utilize a risk assessment tool to identify caregivers at highest risk for adverse health outcomes.
2. Encourage unpaid caregivers to take advantage of Medicare/Medicaid wellness checks already available.

²³ Personal care homes are reimbursed through a combination of resident income and a Personal Care Supplement of \$35 per day paid by DHS. The personal care supplement is available for individuals age 18 or over who reside in a personal care home and who meet financial and clinical eligibility criteria.

3. Encourage coverage for respite care under LTC insurance plans, and integrate education regarding respite care insurance benefits into the APPRISE Program.²⁴
4. Address safety issues with home assessments and alterations as well as patient monitoring devices and assistive technology.
5. Address self-care and preventive health behaviors of unpaid caregivers via education, monitoring, personal health records, and facilitating access to primary health care services.
6. Provide support to assist unpaid caregivers navigate needed resources and connect with support groups through the PA LINK.²⁵ Such resources may provide instrumental assistance, information, and peer support.
7. Help with depression and distress by providing assistance with care coordination and counseling offered through the Family Caregiver Support Program. Explore and implement, where feasible, alternative approaches including: teaching relaxation techniques, scheduling pleasant events for caregivers to attend, treatment of prolonged grief, and coaching on transitioning to new and from previous roles.
8. Provide respite, voluntary education and counseling opportunities, and other supportive services to caregivers.

The estimated fiscal impact of this proposed strategy is Low (estimated impact of \$5 million or less in state funds) and attributable to staff time to develop an assessment tool and assist with educational efforts.

Further detail on this Proposed Strategy, including additional recommended implementation activities and the anticipated costs or budget impact, is contained in Appendix 10, pp. 94-96.

Proposed Strategy 2.6: Elevate the profession of Direct Care Workers.²⁶

Pursue a multi-step strategy to eliminate DCW shortages and turnover, beginning with the enactment of legislation establishing a voluntary statewide DCW certification program for DCWs in all long-term service settings.

²⁴ APPRISE is a free health insurance counseling program provided by PDA. It helps older Pennsylvanians with Medicare obtain objective, easy-to-understand information about Medicare, Medicare Supplemental Insurance, Medicaid, and Long-Term Care Insurance.

²⁵ PA LINK is Pennsylvania's Aging and Disability Resource Center. The ADRCs are a nationwide effort to take a seamless approach in assisting older adults and adults with disabilities who need help with ADLs.

²⁶ In this report, "direct care worker" or DCW refers to paid caregivers, including aides and attendants hired by consumers through the self-directed service model.

Goal:

Elevate the profession of DCWs by facilitating a career ladder for DCWs in all long-term service settings.

Proposed Implementation Activities:

1. Establish a Curriculum Steering Committee composed of trainers, providers and DCW advocates to review current DCW training, including past efforts such as the Robert Wood Johnson Foundation's Better Jobs Better Care initiative, and develop a state core curriculum.
2. Introduce legislation to adopt the Pennsylvania Direct Care Worker Certification Program.
3. Ensure training is consumer-centered and financially feasible to provider organizations and affordable to DCWs.
4. Develop an incentive for high volume MA providers and DCWs to have DCWs certified by offering a higher MA reimbursement for those agencies with 60% or more certified DCWs.
5. Investigate how DCW wages and benefits could be improved. (See also Proposed Strategy 4.3.)
6. Investigate other ways to address the DCW shortage, including technology use, shared living arrangements, changes to the scope of practice to permit nurse delegation or other alternatives to nurse delegation, and expansion of the DHS medication administration program. (See also Proposed Strategy 1.2.)

The estimated fiscal impact of this proposed strategy is High (estimated impact of greater than \$25 million in state funds) due to incentives and wage costs.

Further detail on this Proposed Strategy, including recommended implementation activities and the anticipated costs or budget impact, is contained in Appendix 10, pp. 96-98.

RECOMMENDATION 3 – IMPROVE QUALITY AND OUTCOMES IN THE LTSS SYSTEM**Background**

Both public comments and Commission discussions stressed the need to improve the use of technology and to develop tools to capture and analyze uniform data among all LTSS providers and care settings. The Commissioners examined measures that could be undertaken to increase the use of Health Information Technology (HIT) such as the Health Information Exchange (HIE) and Electronic Health Records (EHR), and explored how these technologies

could improve service delivery and care coordination processes in terms of system sustainability.

As the Commissioners were informed about the state's current HIE and EHR initiatives, they considered the unique aspects surrounding LTSS and HIT, including the existence of multiple LTSS provider types, limited financial resources, and the importance of consumer choice and privacy concerns. The Commissioners recognized that using technology could help consumers receive LTSS more quickly and help providers obtain timely access to information.

To promote the use of technology and data in the LTSS system, the Commissioners developed the proposed strategies outlined below.

Proposed Strategy 3.1: Adopt a uniform assessment for all LTSS levels of care.

Adopt an existing or develop a new single uniform assessment tool by September 30, 2015 that collects comparable data elements at specified intervals for all LTSS consumers in all Commonwealth-funded LTSS settings.

Goal:

Enable the ongoing comparison of consumers' health and functional status, service needs, costs, and other related data elements to ensure economic efficiency, consistency, and improvement across all LTSS programs.

Proposed Implementation Activities:

1. Review changes to Pennsylvania's assessment and monitoring tools made in connection with the Balancing Incentive Program (BIP).
2. Designate an existing advisory committee (or form a new advisory group, if necessary) to obtain stakeholder input and ensure that LTSS participants are included as an integral focus in tool development.
3. Research federal data requirements and existing LTSS metrics used in other states.
4. Develop and validate a tool to collect valuable LTSS metrics on outcomes and person-centered experience, employing data driven decisions to ensure the best use of available resources.
5. Once the tool is validated, require its use upon initiation of services, and at comparable intervals while the consumer is receiving services, including any time that there is a change in the consumer's care needs (e.g., as currently specified by the MA program for nursing facilities).
6. Pilot the tool in designated geographic areas before implementing statewide.

7. Use the data gathered from the tool to review LTSS program efficacy and economic sustainability, both periodically and over an extended period of time. Integrate information into the RHF. (See also Proposed Strategy 2.2.)
8. Monitor and modify the tool as necessary to address any problems or issues and to ensure consistency with federal requirements, including changes made as a result of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which requires the recording and use of standardized data for post-acute providers in order to improve payment methodologies, improve care delivery, and base care planning on measurable data.

The estimated fiscal impact of this proposed strategy is Medium (estimated impact of between \$5 and \$25 million in state funds) due to costs associated with developing the tool, training, oversight, and quality assurance. Any increased costs may be covered, in part, under the BIP.

Further detail on this Proposed Strategy, including recommended implementation activities and the anticipated costs or budget impact, is contained in Appendix 10, pp. 98-99.

Proposed Strategy 3.2: Expand Health Information Exchange and Electronic Health Record initiatives to LTSS providers.

Promote and incentivize the adoption of HIE, EHR and other care management systems to enable the electronic transfer of consumer health and service data among individuals, family caregivers, and providers in the LTSS delivery system.

Goal:

Establish a complete and appropriately accessible single source of information for all LTSS consumer health status, treatment, and assessment information in order to support improved provider and participant monitoring based on outcomes, process, utilization of services, and participant/family experience.

Proposed Implementation Activities:

1. Include LTSS providers in HIE and EHR initiatives in order to help providers use technology more effectively, to connect and integrate providers at all levels within the healthcare and LTSS delivery systems, and to share information among providers, individuals and family caregivers across care settings (with hierarchical levels of access as necessary to meet applicable privacy and security requirements).
2. Ensure that LTSS EHR initiatives allow consumers to “opt out” and that the initiatives comply with all applicable federal and state privacy and security requirements, including consumers’ rights to request corrections to and restrict the use of his or her protected health information.

3. Adopt systems which make health assessment and care planning information, including discharge plan information, accessible electronically and in a timely manner to providers and service agencies in order to facilitate access to care and enable the creation of reports to track quality, access, and satisfaction with LTSS, telemedicine, and care coordination services.
4. Explore the possibility of using an existing Pennsylvania entity (e.g., the data warehouse or the Pennsylvania Health Care Cost Containment Council²⁷) to collect data from different sources, and make them accessible to different levels of providers using a single portal.
5. Coordinate, align with and leverage resources of existing technology initiatives, including BIP level 1 screening, the state’s Coordinated HIT Plan, and the E-Health Partnership Authority, to include and target LTSS providers as recipients of EHR incentives.
6. Work with the US Department of Veterans Affairs (VA) and DMVA to integrate data in order to coordinate and enhance services to Pennsylvania’s veterans, to incorporate VA and DMVA LTSS utilization into Pennsylvania’s longitudinal RHF, and to share and incorporate Pennsylvania service and assessment data on enrolled veterans in the Veterans Health Administration into VA’s RHF.

The estimated fiscal impact of this proposed strategy is High (estimated impact of greater than \$25 million in state funds). The cost to acquire EHR technology is not included in the estimated fiscal impact of this proposed strategy.

Further detail on this Proposed Strategy, including recommended implementation activities and the anticipated costs or budget impact, is contained in Appendix 10, pp. 100-101.

RECOMMENDATION 4.0 – MAKE THE LTSS SYSTEM MORE FISCALLY SUSTAINABLE

Background

Both public comment and Commission discussions highlighted the many fiscal challenges confronting Pennsylvania’s current LTSS system, including challenges related to Pennsylvania’s growing aging and physically disabled populations. The Commissioners considered how the current system could be changed to make it more fiscally sustainable and what considerations

²⁷ The Pennsylvania Health Care Cost Containment Council (PHC4) is an independent state agency that was established to address the problem of escalating health costs. Its primary responsibilities are to: collect, analyze and make available to the public data about the cost and quality of health care in Pennsylvania, ensuring the quality of health care, and increasing access for all citizens regardless of ability to pay; study, upon request, the issue of access to care for those Pennsylvanians who are uninsured; and, review and make recommendations about proposed or existing mandated health insurance benefits upon request of the legislative or executive branches of the Commonwealth.

should be included in any new delivery system to ensure that it is fiscally sustainable into the future.

During the public input process, the Commissioners heard providers' concerns regarding their reimbursement. The Commissioners discussed the need to both evaluate the reimbursement for all LTSS providers and to better align incentives among consumers, providers, and payors.

The Commissioners discussed how to balance consumer choice, fiscal accountability, and consumer safety in light of the growing number of individuals needing LTSS, the US Supreme Court's Olmstead decision, and the Commonwealth's limited fiscal resources. They also considered public comments regarding the need for greater choice in the location of services in order to help address Pennsylvania's reliance on nursing facility care, as well as the social isolation and high costs for some HCB services consumers.

The Commissioners discussed the benefits of obtaining greater budget flexibility and how unspent funds in one program area could be leveraged to serve individuals in the overall system.

To address these challenges, the Commissioners developed the proposed strategies and goals outlined below.

Proposed Strategy 4.1: Serve the greatest number of individuals in the safest, most appropriate, least restrictive, and cost effective setting possible with the limited available state and federal resources.

Adopt policies to assure that the greatest number of individuals eligible for publicly funded LTSS receive needed services in the safest, most appropriate, least restrictive, and cost effective setting possible. These policies should take into account consumer choice, federal health and welfare assurance requirements, service costs, the US Supreme Court's Olmstead decision, and the limited amount of available MA and other state and federal resources.

As part of this effort, review the current Nursing Home Transition (NHT) and Money Follows the Person (MFP) programs and implement changes, if necessary, to make them more person-centered and timely to support the long-term sustainability of the LTSS program.

Goals:

1. Serve the greatest number of adults in need of LTSS in the safest, most appropriate, least restrictive, and cost effective setting possible.
2. Increase consumer choice among LTSS services.
3. Apply best practices (both in-state and out-of-state) to the NHT and MFP programs.
4. Improve identification of individuals for NHT.

Proposed Implementation Activities:

1. Establish a broad stakeholder group to assist in developing guidelines that incorporate consumer choice, fiscal accountability, and consumer safety in determining appropriate care settings.
2. Consider both costs and consumer choice in determining the most appropriate care setting.
3. Develop a common assessment tool(s) that facilitates the development of an initial service plan and identifies the most cost effective setting. (See also Proposed Strategy 3.1.)
4. Develop programs and resources to identify individuals at risk who are or should be utilizing LTSS. This effort should not be limited to existing programs, but should include gathering information/data from individuals currently receiving services through senior centers, those ineligible for Options or HCB services, or those receiving services through the Healthy PA Private Coverage Option.
5. Assess consumer ability to access home modifications necessary to remain at or return home (See also Proposed Strategy 2.3)
6. Improve the NHT and MFP program.
 - Review other states' programs that have resulted in higher transition rates and identify best practices.
 - Do a barrier/gap analysis of the current NHT and MFP programs.
 - Determine necessary program and operational changes.
 - Make necessary modifications to waivers.
 - Create greater incentives and disincentives for NHT providers and nursing facility providers.
 - Review the current NHT identification tool, compare it with other tools, and make necessary revisions that result in better identification of the potential NHT population.
 - Collaborate with consumers, NHT partners, and nursing facilities and coordinate with the efforts of the BIP.
7. Incorporate this proposed strategy and related implementation activities in the development of the demonstration, but do not delay implementation based on the demonstration. (See also Proposed Strategy 1.1.)

8. Consolidate, review, modify as necessary, and routinely evaluate and update Pennsylvania's Olmstead Plan for LTSS services.
9. Streamline eligibility for all care settings and assure that all individuals applying for or receiving LTSS are treated the same under the MA Program with respect to financial eligibility, spend down, and retroactive payment of providers. (See also Proposed Strategy 1.2.)
10. Implement education on the existing Long-Term Care Partnership Program to increase understanding of LTSS costs and promote the purchase of private long-term care insurance to help prevent individuals from entering the MA program. (See also Proposed Strategy 2.2.)

The estimated fiscal impact of this proposed strategy is Low (estimated impact of \$5 million or less in state funds) and attributable to resources to develop assessment tools and staff time to support other activities. While costs may be incurred to address NHT barriers or implementing best practices, it is assumed that those costs will be offset from reduced expenditures.

Further detail on this Proposed Strategy, including recommended implementation activities and the anticipated costs or budget impact, is contained in Appendix 10, pp. 102-104.

Proposed Strategy 4.2: Provide DHS budget flexibility to maximize use of appropriated LTSS funds.

Seek legislative authority to allow DHS, subject to appropriate parameters, to more easily and quickly transfer funding among the five LTSS line items—Long-Term Care, Home and Community Based Services, Long-Term Care Managed Care, Services to Persons with Disabilities and Attendant Care—when unspent funds are projected within a fiscal year.

Goal:

Use the Commonwealth's limited financial resources in an economically responsible manner by providing greater flexibility so that funds do not go unspent within a fiscal year due to the silo funding that occurs by having five separate line items in the annual Appropriations Act.

Proposed Implementation Activities:

1. Draft appropriation act language, similar to the Children's Health Insurance Program (CHIP) language, HB 2328 of 2014, (i.e. Act 1A), that allows funding to be transferred from the Department of Insurance to DHS for CHIP enrollees.
2. Obtain the necessary support from the Administration, stakeholders and the Legislature.
3. Ensure that related laws/regulations governing particular funds would be strictly followed (e.g., Lottery funds would only be used to provide services to older

Pennsylvanians; nursing facility assessment funds would only be used for payments to nursing facilities).

This proposed strategy is budget neutral, and, therefore, has no fiscal impact.

Further detail on this Proposed Strategy, including recommended implementation activities and the anticipated costs or budget impact, is contained in Appendix 10, pp. 104-106.

Proposed Strategy 4.3: Review the LTSS rate setting and reimbursement systems for all LTSS providers.

Undertake a comprehensive review of the current LTSS rate setting and reimbursement systems for all LTSS providers, including personal care homes and DCWs. Make modifications, as necessary, to ensure that: (i) providers receive payments and appropriate incentives that are sufficient to assure adequate access to quality LTSS; and (ii) LTSS rate setting and reimbursement systems are market-driven, efficient, economically sound, fiscally accountable and sustainable over time. The recommendations should be considered in the development of the demonstration. (See also Proposed Strategy 1.1.)

Goal:

1. Ensure that there is adequate LTSS provider capacity in Pennsylvania.
2. Support and enhance the ability of consumers to choose how and where they receive LTSS as well as ensure that they are served in the safest, most appropriate, least restrictive, and cost effective setting possible.
3. Ensure payments and reimbursement methodologies comply with applicable federal and state requirements.
4. Develop market driven reimbursement systems that address the full range of consumer and person-centered needs, and provide incentives for providers who exceed regulations and/or policy directives.
5. Collate quality data used to calculate reimbursement incentives and develop a publically available consumer report card that includes information on available services, satisfaction, and health outcomes.

Proposed Implementation Activities:

1. Undertake a comprehensive review of current LTSS reimbursement and incentive methodologies, including existing managed care organization (MCO) methodologies.
 - Review other appropriate risk adjusted pay for performance criteria, and LTSS payment methodologies and rate setting processes across the nation.

- Review current access to LTSS providers and services across the state.
- Review and compare like services in other states and Commonwealth funded programs.
- Use an independent agency to assess adequacy of wages, benefits and rate reimbursement for DCWs, and implement increases which are consistent across all provider groups. (See also Proposed Strategy 2.2.)
- Utilize the LTC Subcommittee²⁸ and other stakeholder groups to review and make recommendations on methodologies.
- Work with rate setting vendors to determine the impact of proposed changes.
- Initiate any necessary regulatory changes.
- Work with legislative leaders.

2. Develop quality measurement tools to help oversee LTSS programs.

- Implement a standardized measurement tool to facilitate provider accreditations and certification standards as appropriate.
- Develop a report card format to deliver information to the public and consumers in cases where they do not currently exist.

The fiscal impact of this proposed strategy is Low (estimated impact of \$5 million or less in state funds) and related to staff and vendor costs associated with research, evaluating and recommending changes. If recommended changes are not designed to be budget neutral, there will be additional costs.

Further detail on this Proposed Strategy, including recommended implementation activities and the anticipated costs or budget impact, is contained in Appendix 10, pp. 106-108.

²⁸ The LTC Subcommittee is a subcommittee of Pennsylvania’s Medical Assistance Advisory Committee (MAAC). The MAAC, which was established to comply with federal Medicaid requirements, advises the Department of Human Services on issues of Medical Assistance policy development and program administration.

Appendix 1 – Executive Order 2014 - 01

EXECUTIVE ORDER Commonwealth of Pennsylvania Governor's Office	
Subject: Pennsylvania Long-Term Care Commission	Number: 2014-01
Date: 01/31/2014	By Direction of: Tom Corbett, Governor

WHEREAS, Pennsylvania's long-term care system encompasses a diverse array of options through facility-based care and home-based care, which empowers older adults and persons with physical disabilities to remain active participants in their communities; and

WHEREAS, older adults and persons with physical disabilities could benefit from a more coordinated, person-centered approach to delivering services and supports; and

WHEREAS, Pennsylvania has the 16th largest population of non-institutionalized people with disabilities in the country; and there are 1.7 million Pennsylvanians living with physical disabilities in their communities who need assistance with self-care, mobility and independent living; and with changing demographics and developments in technology and medical treatment, this number is expected to increase in coming years; and

WHEREAS, Pennsylvania has the fourth-largest percentage of residents age 60 years and over; and during the next decade, Pennsylvania's age 85 years and over population is expected to grow by 42 percent while its total population is expected to grow by only 2 percent; and research shows that nearly 70 percent of individuals reaching age 60 in 2012 are expected to need long-term care services at some point during their lifetime; and

WHEREAS, Pennsylvania currently spends over \$4.7 billion each year on Medicaid long-term care services and an additional \$381 million on preventive services for individuals not yet eligible for Medicaid long-term care, with the demand for long-term care services growing annually; and

WHEREAS, in order to achieve better health and life outcomes, the long-term care system in Pennsylvania needs to ensure access to the right level of services, at the right time, that are coordinated with other types of care that address identified medical and social needs; and

WHEREAS, development of recommendations and supporting care delivery models that focus on creating a sustainable, person-centered approach while

increasing quality outcomes and supporting independence, regardless of an individual's physical disability or age, remains a priority of this administration; and

WHEREAS, it will benefit the commonwealth to identify opportunities and services, which if appropriately delivered, may eliminate, through prevention or delay, the need for more costly care later in life; and

WHEREAS, it will benefit the commonwealth to comprehensively study Pennsylvania's long-term care services and supports delivery system and review access to the long-term care services and supports necessary to meet the needs of these communities in order to improve the lives of all Pennsylvanians.

NOW, THEREFORE, I, Tom Corbett, Governor of the Commonwealth of Pennsylvania, by virtue of the authority vested in me by the Constitution of the Commonwealth of Pennsylvania and other laws, do hereby establish the Pennsylvania Long-Term Care Commission (hereinafter referred to as "Commission").

1. Purpose. The purpose of the Commission shall be to provide a forum through which an open, forthright and constructive dialogue will be fostered among a diverse group of stakeholders, representing individuals involved in the delivery and financing of long-term care services and supports, families of individuals in need of such services and supports, consumers, representatives of local area agencies on aging and the physical disabilities community, legislators and state government agencies responsible for oversight, funding and regulation of such services and supports, in order to provide the Governor with recommendations that ensure Pennsylvania's long-term care services and support delivery system is person-centered, efficient, effective and fiscally accountable.

2. Responsibilities. The powers and duties of the Commission shall be to:

- a. Identify and examine the critical issues and trends in Pennsylvania's long-term care services and supports delivery system;
- b. Study existing long-term care resources available for individuals with physical disabilities, older adults, their families and caregivers;
- c. Consult with various commonwealth departments and agencies, including, but not limited to the Department of Aging, the Office of the Budget, the Department of Health, the Department of Insurance and the Department of Public Welfare, on regulations, licensure, financing or any other responsibilities of those departments or agencies relating to long-term care;
- d. Review current and proposed state and federal legislation relating to long-term care;
- e. Review current and proposed state and federal regulations relating to long-term care; and
- f. Make written recommendations to the Governor on findings.

3. Composition.

- a. The Secretaries of Aging and Public Welfare or their designees shall serve as Co-chairpersons and their Departments shall provide administrative support and other resources as necessary to fulfill the requirements of this Executive Order.
- b. The Commission shall consist of no more than 26 members, to be appointed by the Governor. In addition to the Co-chairpersons, members of the Commission shall consist of:
 - (1) two members of the Senate, one recommended by the President pro tempore of the Senate and one recommended by the Minority Leader of the Senate, and two members of the House of Representatives, one recommended by the Speaker of the House of Representatives and one recommended by the Minority Leader of the House of Representatives; and
 - (2) other members involved in long-term care services and supports, including, but not limited to, consumers, families of individuals in need of such services and supports, representatives of local area agencies on aging and the physical disabilities community, the medical community, providers from the long-term care continuum and managed care organizations with experience in long-term care.
- c. The Commission may establish advisory workgroups, as the Co-chairpersons may determine are needed, and membership of the workgroups may be extended beyond members of the Commission, as necessary to perform its functions.

4. Terms of Membership.

- a. Members shall be appointed for terms of one year. All members appointed by the Governor shall serve at the pleasure of the Governor;
- b. Commission vacancies that may occur shall be appointed in accordance with Section 3 of this Executive Order. Successors shall be appointed for the remainder of the original one-year term; and
- c. A member who is absent from two consecutive meetings of the Commission, without excuse, shall forfeit membership on the Commission, and a replacement member shall be appointed for the remainder of the original one-year term in accordance with Section 3 of this Executive Order.

5. Compensation. Members of the Commission shall receive no compensation for their service, except that members may be reimbursed for travel expenses in accordance with commonwealth policy.

6. Relationship with Other Agencies. All agencies under the Governor's jurisdiction shall cooperate with and provide assistance and support as needed by the Commission to carry out its functions effectively.

7. Reports. The Commission shall submit a report to the Governor by December 31, 2014.

8. Effective Date. This Executive Order shall take effect on January 31, 2014.

9. Termination Date. This Executive Order shall expire on December 31, 2014.

Appendix 2 – Commissioners and Advisors

Commissioners:

Carl W. Bailey

Carl W. Bailey is the retired President and CEO of CWB Consulting Services, where he worked to set up small businesses, giving workshops in business planning, marketing, finance, and problem solving. He has served for 12 years as an AARP volunteer in various capacities including on the Pennsylvania Executive Council, Consumer Protection Committee, Predatory Lending Task Force, Legislative Liaison, Tax Aide Consultant, and President of Chapter 280. Mr. Bailey has a Bachelor of Business Administration from Alameda College and University and completed the Wharton Executive Education Program at The Wharton School of the University of Pennsylvania. He also attended Bryn Mawr College - Graduate School of Social Work and Social Research where he received a Certificate in Mediation in Social Work Practice. He attended the Henry George School of Social Science and Economics, Chartered by the University of the State of New York – Economics. He is a veteran of the Korean War, a Captain in the Third Regiment Infantry, N.G.P. Veteran Guard, and is a member of the Alpha Phi Alpha Fraternity, Inc., Zeta Omicron Lambda Chapter. Mr. Bailey has also served on a number of boards including the NAACP Philadelphia Executive Board, the Salvation Army Advisory Board, the Greater Philadelphia Chamber of Commerce, the United Way of Southeastern Pennsylvania, the USO of Pennsylvania & Southeastern New Jersey, Inc., the Better Business Bureau, the American Heart Association, and is a Past President of Rotary International Eastwick Chapter.

Francis J. Byrne

Francis Byrne is currently the President and CEO of the Pennsylvania LIFE Provider Alliance (PALPA), a position he has held since 2012. PALPA is the statewide association representing the Programs for All-Inclusive Care for the Elderly (PACE) as they are known nationally and called Living Independence for the Elderly (LIFE) in Pennsylvania. In this position, he serves as the principle representative for the association and its membership in all policy, advocacy, education and business related matters. Prior to joining PALPA, he was a Vice President at LeadingAge New Jersey for 18 years representing non-profit nursing homes, assisted living residences, continuing care retirement communities, subsidized senior housing and home and community based programs for the elderly. During this time Mr. Byrne was appointed to and served on various state aging related councils and committees including the Medicaid Long-Term Care Funding Advisory Council. Before this he served as Legislative Director of the Eastern Paralyzed Veterans Association directing the legislative and regulatory initiatives for the association at both the state and federal levels impacting spinal cord injured veterans residing in Connecticut, New York, New Jersey and Pennsylvania. He has over 25 years' experience in the health and long term care field representing and advancing the public policy interests of facility and home and community based providers, senior citizens and individuals with disabilities. Mr. Byrne has a Bachelor of Arts from Villanova University.

Scott Crane

A licensed insurance agent since 1994, Scott Crane specializes in employee benefits and individual products. He was the State Legislative Chair from 2006 to 2012 at the Pennsylvania Association of Health Underwriters, where he is currently the Special Projects Coordinator and Board Member. He is a past Legislative Chair and Board Member of the Greater Philadelphia Association of Health Underwriters, and member of the former Long-Term Care Guild. Scott is certified in Long – Term Care holding a CLTC designation and holds a Bachelor of Science in Business Administration from Philadelphia University.

Angela Dohrman

Angela Dohrman is the Board Chair for LeadingAge PA. She attained a Bachelor's Degree in Social Work (Shippensburg University, Shippensburg, PA) and a Master's degree in Health Services Administration (College of St. Francis, Joliet, Il.). Ms. Dohrman's career encompasses over thirty years' experience in long term care and senior services and she has also worked for the Alzheimer's Association. A licensed nursing home administrator in Pennsylvania, Ms. Dohrman currently is the Vice President for Senior Living at Lutheran Social Services of South Central Pennsylvania, York, PA. In that role, she oversees the operations of six senior living communities and three Section 202 housing units. Ms. Dohrman also serves on the Embracing Aging advisory committee of the York County Community Foundation, the Healthy York County Coalition leadership council, and the Your Life, Your Wishes task force in York County.

The Honorable Brian M. Duke

Brian Duke was nominated by Governor Tom Corbett to be the Secretary of Aging on February 3, 2011, and confirmed by the Pennsylvania Senate on May 3, 2011. Secretary Duke has a wide background in aging issues as well as hospital administration. Prior to his nomination, he served as Director of the Bucks County Area Agency on Aging. Before that he served as Executive Director of the New Jersey Foundation for Aging, a statewide public charity dedicated to improving the quality of life of older persons. Most recently, Secretary Duke, on behalf of the Pennsylvania Alzheimer's Disease Planning Committee, presented the Pennsylvania State Plan for Alzheimer's Disease and Related Disorders to Governor Tom Corbett. The plan provides recommendations to the Governor on addressing the epidemic of Alzheimer's disease and related disorders in the commonwealth. Secretary Duke holds a B.S. in Business Administration from the University of Scranton, an MHA (Health Administration) from George Washington University and an MBE (Bioethics) from the University of Pennsylvania, and is an Associate Fellow of the Institute on Aging of the University of Pennsylvania.

Vicki M. Hoak

Vicki Hoak is currently the Chief Executive Officer of the Pennsylvania Homecare Association, a position she has held since 2000. Prior to that, she was the Corporate Communications Director of Northwestern Human Services where she developed marketing and communications strategies for external and internal audiences throughout Pennsylvania, Virginia, New Jersey, and Washington, DC. Vicki was also the Public Affairs Director of the Pennsylvania Bar Association and the Communications Director for the Pennsylvania

Department of Public Welfare. She has also worked at the Pennsylvania Department of Transportation and the Pennsylvania Division of the American Cancer Society. Vicki holds a Bachelor of Arts in Communications from Shippensburg University.

Anne E. Holladay

Anne Holladay is currently Administrator with Susquehanna Health Skilled Nursing and Rehabilitation Center, a position she has held since 2001. Prior to that, she was Administrator at both Williamsport-North, MCHS and ManorCare Health Services. Anne was also Assistant Administrator and Admissions Director with Leader Nursing and Rehabilitation Center, and Director and Owner of Building Blocks Child Care and Learning Center. She holds a Master of Health Administration from the University of Scranton, a Bachelor of Science in Education from The Pennsylvania State University, and a Health Care Disaster and Emergency Certificate from the Federal Emergency Management Agency. Anne obtained Certified Nursing Home Administrator status from the American College of Health Care Administrators and has been a fellow with the American College of Health Care Administrators since 2006.

Sharon Alexander Keilly

Sharon Alexander Keilly is Vice President, Business Integration, Medicare Plans, with AmeriHealth Caritas Family of Companies in Philadelphia, PA, where she directs operations integration for the organization's Medicare Advantage business line. Additionally in this role, she is working with several states and the Centers for Medicare & Medicaid Services (CMS) to test innovative models that better integrate primary, acute, behavioral health and long-term services and supports for Medicare-Medicaid enrollees. She came to AmeriHealth after previously serving as Secretary of Aging for the Commonwealth of Pennsylvania, where she was the State's chief advocate for the health, economic and social needs of 2.5 million older people and their families. She brings Medicare expertise from Universal American Corp., where she was instrumental in launching and managing a full array of Medicare Advantage products including Special Needs Plans and managed long term care initiatives in multiple states. She was chief product development officer for a nationwide geriatric care management company and helped diversify Genesis Health Ventures' portfolio of facility and community-based long term care services. Sharon holds a Master of Public Management, with a Health Care Management Concentration, from The H. John Heinz III School of Public Policy and Management, Carnegie Mellon University, and a Bachelor of Science, Health Planning and Administration, from The Pennsylvania State University.

Bruce Kinosian, MD

Bruce Kinosian is currently Associate Director, Geriatric and Extended Care Data Analysis Center. He is also Senior Investigator with the Center for Health Equity Research and Promotion, Staff Physician with home Based Primary Care of the Philadelphia Veterans Affairs Medical Center, and Staff Physician with NewCourtland LIFE program. In addition, Bruce is Associate Professor of Medicine at the University of Pennsylvania. Before holding these positions, Bruce was Medical Director at various agencies in Philadelphia. He is a member of many local and national societies and committees including the American Geriatric Society, the

Society for General Internal Medicine, the American Academy of Home Care Physicians, Pennsylvania Medical Assistance Long Term Care Advisory Committee, and Philadelphia Nursing Home Advisory Board. He has provided editorial review for a variety of publications such as the American Journal of Medicine, Journal of Gerontology, and the New England Journal of Medicine. Bruce is board certified by the American Board of Internal Medicine and holds a Certificate in Geriatrics. He is also certified in Advanced Cardiac Life Support and Advanced Trauma Life Support.

Kathleen Kleinmann

Kathleen Kleinmann is the Chief Executive Officer with Tri-County Patriots for Independent Living (TRIPIL) a position she has held since 1990. Her former employment includes Three Rivers Center for Independent Living as program Director of the accessible Housing Data and Referral Service and Housing Consortium. Kathleen was also a Social Work Member of the Periodic Medical Review Team for Long Term Care with the New Jersey Department of Medical Assistance. Her educational background includes a Master's Degree in Public Health from the University of Pittsburgh, a Master's Degree in Social Work from Florida State University, and a Bachelor's Degree in Rehabilitation Education and Social Welfare from The Pennsylvania State University.

The Honorable Christian Y. Leinbach

Commissioner Christian Leinbach was elected in 2007 to serve on the Berks County Board of Commissioners. When he was re-elected in 2011, he was selected to serve as Chairman of the Board. Christian is a member of the Election Board, the Prison Board, and the 4-H Development Board. He chairs the Salary Board and the Retirement Board. In addition, Christian is a director on the Berks County Conservation Board and the Berks Community Television Board. He is the Chairman of the Board of the County Commissioners Association of Pennsylvania, serves on the Board of Directors of The National Association of Counties where he is also a member of the Executive Committee. Prior to becoming a Commissioner, Christian was the vice president of agency services of a local marketing firm.

M. Crystal Lowe

Crystal Lowe is currently the Executive Director of the Pennsylvania Association of Area Agencies on Aging (P4A), a position she has held since 2005. Prior to her work with P4A, she was the Director of the York County Area Agency on Aging for 10 years. Crystal was also the Planning Coordinator and Assistant Director of the York County Human Services Department. Her professional experience also includes Director of Social Services with Williamsport Home, and the Medical Social Work and Director of Social Services at Williamsport Hospital. Crystal holds a Bachelor of Science in Special Education from Bloomsburg State University and a Master of Science in Social Work from Marywood University. She serves on numerous statewide coalitions, is an appointed member of the Office of Mental Health and Substance Abuse Older Adult Committee and just completed a term on the Long Term Care Sub-Committee of the Medical Assistance Advisory Committee, and appointed member of the Pennsylvania Supreme

Court's Task Force on Elder Abuse, and a Board Member of the Pennsylvania Society of Association Executives.

The Honorable Beverly Mackereth

Beverley Mackereth is currently the Secretary of the Pennsylvania Department of Human Services (DHS) (formerly Department of Public Welfare or DPW), a position she has held since June 2013. Prior to that, in November 2011, Mackereth was appointed by Governor Corbett as the Deputy Secretary of the Office of Children, Youth and Families in DPW. Her previous professional experience includes four years as the mayor of Spring Grove, PA, four terms as a member of the Pennsylvania House of Representatives serving the 196th district, and Executive Director of the York County Human Services Department. Mackereth also served as a statewide consultant for Pennsylvania's Office of Attorney General, was appointed by Pennsylvania Governor Tom Ridge as deputy director of the Governor's Community Partnership for Safe Children, and served as Executive Director of the Healthy York County Coalition.

Kyle Merbach

Kyle Merbach is a consumer in Pittsburgh who also serves on Pennsylvania's Department of Public Welfare Subcommittee. Professionally, he recently completed Post Master's Degree work in Counseling and holds a Licensed Professional Counselor status. Kyle has served persons with disabilities over the last fifteen years as a vocational rehabilitation counselor and case manager.

Matthew E. Perkins

Matthew Perkins is Chief Executive Officer of Service Coordination Unlimited, Inc. Prior to that, he was with UCP-CLASS as Attendant Care Director, CSPPPD Program Director, and Administrative Entity Project Director. Matthew was also Waiver Specialist for CSPPPD Administrative Entity and Supports Coordinator for the Attendant Care Program with UCP-CLASS. His professional experience also includes Therapeutic Support Staff with Mental Health Alternatives and PrimeTime Health Assistant with the Butler County Area Agency on Aging. Matthew is also the Pastor of New Beginnings Free Methodist Church, Vice President of Pennsylvania Provider Coalition Association, and President of the Kiski Valley Family Camp Board of Administration. Matthew holds a Master of Science in Health Education and a Bachelor of Science in Health Services Administration, both from Slippery Rock University.

Lisa M. Perugino

Lisa Perugino is currently a Home Health Nurse with Erwine's Home Health Agency. She is also an Adjunct Instructor at Bucks and Luzerne County Community Colleges where she teaches all aspects in pre-hospital care. Prior to her position as a home health nurse, Lisa was Clinical Coordinator/Infection Control Nurse at Mercy Center Nursing Unit in Dallas, PA. She has a Bachelor of Science in Nursing from Misericordia University and is a member of the Sigma Theta Tao National Nursing Honor Society. She also has a Certificate from Wilkes-Barre Area Vocational Technical School of Practical Nursing and is a Licensed Practical Nurse with intense

training in direct nursing care. Lisa is also a volunteer with the Emergency Management Agency and is a CPR and First Aid Instructor trainer with the American Heart Association.

Donald E. Rea

Donald Rea has over 25 years' experience as an investor, developer and manager of various enterprises including hydropower and waste recyclers solid waste facilities. He is a founder and has served as president and director since Liberty Tire Recycling's inception, where he is currently the Vice Chairman. Donald is also one of the principals of Laurel Mountain Partners, a merchant banking firm located in Pittsburgh, which has been in business since 1986. He was principal with Russell, Rea, & Zapalla, Inc., a regional investment bank, where he was lead underwriter of bonds, leveraged buyouts, venture capital, institutional money management and special project development. He has also served as an officer and director of Chester Solid Waste Associates and National Waste Industries. Donald received his Master of Business Administration from the University of Chicago and his Bachelor of Arts degree from Penn State University.

Charles F. Reynolds III, MD

Charles F. Reynolds III, MD, is the University of Pittsburgh Medical Center (UPMC) Endowed Professor in Geriatric Psychiatry at UPMC and Professor of Behavioral and Community Health Sciences at the Graduate School of Public Health. He directs the Aging Institute of the UPMC and the NIMH sponsored Center of Excellence in the Prevention and Treatment of Late Life Mood Disorders. Dr. Reynolds is internationally renowned as the recipient of a National Institute of Mental Health (NIMH) Research Scientist Award and a MERIT award for Maintenance Therapies in Late-Life Depression. He has been named several times as one of The Best Doctors in America and is the 2012 recipient of the APA Jack Weinberg Award for lifetime contributions to geriatric psychiatry. Dr. Reynolds graduated magna cum laude from the University of Virginia before earning his medical degree from Yale University School of Medicine in 1973. His writings include 625 publications in peer-reviewed journals such as JAMA, the New England Journal of Medicine, and The Lancet. Associate Editor of American Journal of Geriatric Psychiatry, Dr. Reynolds has also served on the board, American Journal of Psychiatry and Archives of General Psychiatry.

The Honorable Steve Samuelson

Representative Steve Samuelson is the Democratic Chair of the House Aging and Older Adult Services Committee, a committee he has served on since first becoming the state representative for the 135th Legislative District in 1999. Serving the state's senior citizens has always been a priority, as exemplified by the fact that his constituent service office assisted more than 800 senior households with the property tax and rent rebate program last year, and may surpass that figure this year. Before his election, Representative Samuelson was a legislative aide and clerk to the board for the Lehigh County Commissioners from 1989 to 1998, an experience that gives him a great understanding of the challenges facing local governments. A Bethlehem resident, Representative Samuelson earned a bachelor's degree in government from Lehigh University and is a graduate of Leadership Lehigh Valley. He has always been active

in his community having served as a PTA Board member at Spring Garden Elementary School, president of the Bethlehem Area Jaycees and a board member of Habitat for Humanity of the Lehigh Valley.

Karen Squarrell Shablin

Karen Squarrell Shablin is Executive Client Manager with UnitedHealth Group—Optum, in Langhorne, Pennsylvania, where she is liaison to the state government clients in New Jersey, Pennsylvania, Delaware, West Virginia, and the District of Columbia. She is also an Adjunct Professor in the School of Global Business and Health Administration at Arcadia University. Karen's other professional experience includes work at Strategies for Health Care Excellence, LLC, as Managing Director, AMERIGROUP Corporation as Vice President of Government Markets, AmeriHealth Mercy Health Plan as Associate Vice President of National Strategy, and Health Management Systems as Vice President Client Services. She was also Principal at Health Management Associates, Deputy and Acting Medicaid Director at New Jersey Division of Medical Assistance and Health Services, Vice President of Policy and Program Development at Health Partners of Philadelphia, and Director Business Development/Health Services Administrator at Lomax Health Systems. Karen holds a Master of Health Services Administration from University of Michigan School of Public Health, a Bachelor of Arts from Johns Hopkins University, and is a Certified Specialist in Aging from University of Michigan Institute of Gerontology.

Stuart H. Shapiro, MD

Dr. Shapiro has a Medical Degree with honors from the State University of New York at Buffalo and a Master's Degree in Public Health from Harvard University and is Board Certified in Radiology, Nuclear Medicine, and Public Health. He has authored numerous articles on management and healthcare. Dr. Shapiro has enjoyed a successful and diversified career as a businessman and entrepreneur, a top government official and a physician. In both the public and private sectors, he has had extensive experience in public policy development, fund raising, and in media/crisis management. Since mid-2006, Dr. Shapiro has been the President and CEO of the Pennsylvania Health Care Association (PCHA), a statewide advocacy organization representing the elderly and disabled as well as their providers of care. He has been on the faculty of Harvard Medical School, Harvard School of Public Health, the Wharton School at the University of Pennsylvania, and Georgetown University School of Medicine. Dr. Shapiro is currently a member of the Board of Visitors of the Temple University College of Health Professions and Social Work.

The Honorable RoseMarie Swanger

Representative RoseMarie Swanger is in her fourth term as the representative for the 102nd District in the Pennsylvania House of Representatives. She is also a board member of the South Central Assembly for Effective Governance. Representative Swanger also serves on the Allocations and Review Committee of the United Way of Lebanon County and is a senior member and past president of the Kiwanis Club of Lebanon. Representative Swanger currently serves on the House of Representatives Aging, Gaming, Local Government and Veterans Affairs

committees. A graduate of South Lebanon High School, she attended Thompson Institute in Harrisburg and Lebanon Valley College. Prior to her election to the Pennsylvania House, Representative Swanger served as Lebanon County Commissioner from 1984 to 2004. She also served as a city clerk-personnel officer in the City of Lebanon mayor's office.

Ralph Trainer

Ralph Trainer is presently Executive Director of Abilities in Motion (AIM), a position he has held since 1997. Prior to his work at AIM, he was Civil Rights Specialist with Berks County Center for Independent Living where he also served as Peer Advocate and Americans with Disabilities Act Coordinator. Ralph's community service includes membership with Amity Township Vision 2000 committee, American Syringomyelia Alliance Project, Berks Area Regional Transportation Authority, Office of Vocational Rehabilitation, and Metropolitan Planning Organization. He is also a member of the Transportation Alliance Project, Pennsylvania Council for Independent Living, and co-founder of Provider Coalition Association. Ralph was also Vice Chair of the Department of Public Welfare's Community Living Advisory Committee, Co-Chair of the Department of Labor and Industry's Direct Care Worker Committee, and Board Member of the Statewide Independent Living Council.

Advisors

Ms. Kelly Andrisano
Ms. Jennifer Barnhart
Mr. Ron Barth
Ms. Sandy Cornelius
Ms. Patricia Darnley
Mr. Russell McDaid
Ms. Rachel Delevan
Ms. Carol Irvine

Ms. Diane E. Marciano
Mr. Tim Moran
Mr. Matthew Lockwood Mullaney
Mr. Ray Prushnock
Ms. Ann Torregrossa
Ms. Mary Turnbaugh
Ms. Gail Weidman
Ms. Anita Weinberg

Appendix 3 – Commission Overview and Activities

Creation and Composition of the Long-Term Care Commission

Governor Corbett created the Long-Term Care Commission (Commission) on January 31, 2014 through Executive Order 2014-01. Governor Corbett charged the Commission to develop “recommendations that ensure Pennsylvania’s long-term care services and support delivery system is person-centered, efficient, effective and fiscally accountable” and to submit a final report on its recommendations on or before December 31, 2014.

The Secretaries of Aging and Human Services were appointed as members and co-chairpersons of the Commission along with the following additional members:

- Two members of the Senate, one recommended by the President pro tempore of the Senate and one recommended by the Minority Leader of the Senate, and two members of the House of Representatives, one recommended by the Speaker of the House of Representatives and one recommended by the Minority Leader of the House of Representatives; and
- Other members involved in long-term care services and supports, including, but not limited to, consumers, families of individuals in need of such services and supports, representatives of local Area Agencies on Aging (AAA) and the physical disabilities community, the medical community, providers from the long-term care continuum and MCOs with experience in long-term care.

A copy of the Executive Order is located in Appendix 1 and a list of Commission members is located in Appendix 2.

Vision Statement

To meet the Executive Order’s charge, and to provide a broad, inspirational, and dynamic picture of the future of long-term care in Pennsylvania, the Commission adopted the following vision statement to guide Commissioners through their deliberations:

Older Pennsylvanians and individuals with disabilities will have access to quality long-term care while living with dignity, safety and respect through a system that is fiscally responsible and person centered while achieving better health and life outcomes.

Commission Meetings

On March 7, 2014, the Commission gathered in Harrisburg to launch its efforts to develop recommendations focused on improving the current LTSS system. Thereafter, the Commission held monthly meetings, many in tandem with regional public input sessions.

Initial meetings focused on enhancing Commissioners' knowledge through presentations and panel discussions by local and national experts in the various aspects of LTSS. Topics ranged from rebalancing initiatives in other states, innovative and alternative care models and delivery systems, and overviews of current Pennsylvania initiatives affecting LTSS, such as the BIP and SIM. In addition, staff from the Pennsylvania Departments of Aging, Health, Human Services and Insurance provided the Commission with an overview of the Commonwealth's existing LTSS system, including services, eligibility requirements, and demographics of current LTSS consumers. The Commissioners also reviewed an analysis of recommendations and accomplishments of LTSS-related state and national commission reports and initiatives, such as the Pennsylvania State Plan for ADRD and US Senate Commission on Long Term Care. Of equal importance were the valuable contributions by Commissioners based on their own expertise and experience.

Although education and information sharing continued throughout the year, the focus in later meetings turned toward refining and reframing goals, proposed strategies and recommended implementation activities. This effort aligned with the core objectives outlined in Governor Corbett's Executive Order: to make recommendations which assure that the Commonwealth's LTSS system is person-centered, efficient, effective and fiscally accountable.

The Commission co-chairs established four work groups (described below) to assist the Commission in developing recommendations. The work groups presented their proposed recommendations to the Commission for consideration. The Commissioners fine-tuned the work groups' recommendations via on-line communications, supplemental meetings and webcasts.

The Commission approved this report at its final meeting on December 15, 2014.

The date, time and location of commission meetings and materials presented are available at:

<http://www.dhs.state.pa.us/dhsorganization/officeoflongtermliving/ltcc/index.htm>

Public Input Sessions

Over the summer months, the Commission traveled throughout the Commonwealth to gather public input. Seven regional meetings were held in Allegheny, Dauphin, Lycoming, Mercer, Montgomery, Philadelphia and Pike Counties with over 200 stakeholders, consumers and other

interested persons in attendance. These sessions offered Commissioners first-hand insight into the critical issues surrounding consumers, caretakers, stakeholders, providers and other entities involved with Pennsylvania’s LTSS system. Over 150 comments were received through the public input process.

The date, time and location of public input sessions, testimony and other public input, including comments submitted via email, postal mail and received at public input sessions, may be viewed by visiting the Long-Term Care Commission website at:

<http://www.dhs.state.pa.us/dhsorganization/officeoflongtermliving/ltcc/index.htm>

Comments were summarized, categorized into common themes and distributed to the work groups. A presentation to the Commission summarizing the public comments is included in Appendix 5, and can also be viewed on the Commission website.

Work Groups

As noted above, work groups were established to assist the Commission. Work groups consisted of 5 to 7 commissioners, advisors, and Department staff who provided administrative support and facilitated meetings. One commissioner served as the lead of each work group. The work groups met independently. After considering the comments, data and other information presented to the Commission, the work groups were tasked with vetting the common themes heard from public comments and with framing proposed recommendations in the following areas:

WORK GROUP NUMBER AND TITLE	THEMES
1 – Prevention and Caregiver Support	<ul style="list-style-type: none"> ● Caregiver Support ● Education ● Insurance ● Services
2 – Accessibility	<ul style="list-style-type: none"> ● Access to Services ● Timeliness of Services ● Workforce
3 – Provision of Service	<ul style="list-style-type: none"> ● Coordination ● Rates ● Service Models
4 – Quality Outcomes and Measurement	<ul style="list-style-type: none"> ● Oversight ● Quality ● Reporting ● Technology

A work group steering committee was established to share information among the Departments, work group leads, and Department facilitators. The steering committee met at least monthly to provide guidance to the work groups. Work group leads also gave updates, as needed, at the monthly Commission meetings. A list of work group members, advisors and other participants is included in Appendix 4.

Appendix 4 – Work group Members, Advisors and Other Participants

WORK GROUP	<u>WORK GROUP 1</u> Prevention and Caregiver Support	<u>WORK GROUP 2</u> Accessibility	<u>WORK GROUP 3</u> Provision of Service	<u>WORK GROUP 4</u> Quality Outcomes and Measurement
COMMISSION MEMBERS	<ul style="list-style-type: none"> • Scott Crane • Chip Reynolds (Lead) • RoseMarie Swanger • Randy Vulakovich • Secretary Brian Duke 	<ul style="list-style-type: none"> • Vicki Hoak (Lead) • Crystal Lowe • Matthew Perkins • Steve Samuelson • Karen Shablin • Stuart Shapiro 	<ul style="list-style-type: none"> • Frank Byrne (Lead) • Anne Holladay • Sharon Alexander Keilly • Bruce Kinosian • Kyle Merbach • Christian Leinbach • Ralph Trainer 	<ul style="list-style-type: none"> • Carl Bailey • Angela Dohrman • Kathleen Kleinmann • Lisa Perugino • Don Rea • Secretary Bev Mackereth • Bonnie Rose (Lead)
COMMISSION ADVISORS	<ul style="list-style-type: none"> • Jennifer Barnhart • Carol Irvine • Ray Prushnock • Gail Weidman 	<ul style="list-style-type: none"> • Diane E. Marciano • Matthew Lockwood • Mullaney • Ann Torregrossa 	<ul style="list-style-type: none"> • Kelly Andrisano • Russ McDaid • Tim Moran • Mary Turnbaugh 	<ul style="list-style-type: none"> • Sandy Cornelius • Patricia Darnley • Rachel Delevan • Anita Weinberg
PARTICIPANTS ON BEHALF OF COMMISSIONERS AND ADVISORS	<ul style="list-style-type: none"> • Sharon Schwartz for RoseMarie Swanger • Nate Silcox for Randy Vulakovich • Vince Phillips for Scott Crane 	<ul style="list-style-type: none"> • Jennifer Crosbie for Matt Lockwood Mullaney • Melissa Myers for Steve Samuelson 	<ul style="list-style-type: none"> • Kelly Andrisano for Christian Leinbach • Beth Hennigan for Ralph Trainer • Sue Ellen Stefevich for Tim Moran • Laval Miller-Wilson for Kyle Merbach • Jen Kotesich for Sharon Alexander Keilly 	<ul style="list-style-type: none"> • Jim Hahn and Elliot Simon on behalf of Sandy Cornelius • Tracy Lawless as advisor to Patricia Darnley • Janel Gleeson

Public Input

- The public input we received has been placed on the LTCC website.
- The input has been summarized and categorized into 11 themes.
- In some instances, the subcategories have been identified.
- Recommendations received via the public input process were then placed into the applicable category/subcategory.
- Policy papers are being developed for the 11 themes.
- The policy papers provide background information.



Overview of the Public Comments

- Consists of submitted testimony via email, mail and public input sessions.
- Seven regional meetings were held (Harrisburg, Mercer, Allison Park, Williamsport, Blue Bell, Pike, Philadelphia).
- Over 130 individuals testified.
- Submitted testimony may be viewed by visiting the Long – Term Care Commission website at:
 - <http://www.dpw.state.pa.us/dpworganization/officeoflongtermliving/toc>
- Comments are summarized and distributed to the workgroups.



Common Themes

Work Group	Theme
Work Group #1 – Prevention and Caregiver Support	<ul style="list-style-type: none"> • Caregiver Support • Education • Insurance • Services
Work Group #2 – Accessibility	<ul style="list-style-type: none"> • Access to Services • Timeliness of Services • Workforce
Work Group #3 – Provision of Service	<ul style="list-style-type: none"> • Coordination • Rates • Service Models
Work Group #4 – Quality Outcomes and Measurement	<ul style="list-style-type: none"> • Oversight • Quality • Reporting • Technology



Workgroup 1 – Prevention and Caregiver Support

Common Themes

Caregiver Support

Education

Insurance

Services

Caregiver Support

- Provide more money for caregivers
- Consider ideas to support caregivers in continuing to work

Education

- Provide information to families
- Expand public engagement and marketing
- Campaigns to help individuals plan for long-term care
- Simplify the access to information and support



Workgroup 1 – Prevention and Caregiver Support

Insurance

- Create a tax credit for individuals that purchase long-term care insurance
- Provide a tax incentive for families and other unpaid caregivers
- Encourage a better partnership between APPRISE counselors and insurance brokers
- Create a voluntary program for public/state employees to purchase long-term care insurance

Services

- Continue to support the role of the AAA
- Preserve Lottery funding for preventive Aging services
- Invest in services for individuals who are not nursing facility clinically eligible
- Invest in the home delivered meals program



▶ Workgroup 2 – Accessibility

Common Themes

Access to Services

Timeliness of Service

Workforce

Access to Services

- Streamline waiver programs
- Improve access to care
- Address the closing of personal care homes
- Adopt Community First Choice Option
- Support Medicaid Expansion
- Expand Home and Community Based Services



Workgroup 2 – Accessibility

Timeliness of Service

- Inability for the system to provide adequate home modifications
- Access to affordable care in congregate settings – same day eligibility and service packages
- Shorten timeframe to access services
- Improve and shorten the service plan approval process

Workforce

- Increase pay and affordable healthcare
- Address the shortage of able, educated, and experienced care coordinators
- Promote the ability to control hires and manage care
- High quality services to participants can only be accomplished with qualified, trained and stable workforce with a dedicated system of supervision and support



Workgroup 3 – Provision of Service

Common Themes

Coordination

Rates

Service Models

Transitions

Coordination

- Improve care coordination
- Improve support to help navigate the continuum
- Improve coordination between behavioral health and aging services
- Create sample agreements to allow voluntary coordination – exchange regular data plans to allow access to waiver participants data and identify service coordination entities

Rates

- Increase pay for home care workers
- Increase payments to personal care homes



Workgroup 3 – Provision of Service

Service Models

- Provide funding to expand assisted living facilities and nursing facilities
- Fund support broker services
- Include vehicle modifications in the Aging waiver
- Implement the agency with choice model of service

Transitions

- Provide funding to expand assisted living facilities and nursing facilities
- Fund support broker services
- Include vehicle modifications in the Aging waiver
- Implement the agency with choice model of service



Workgroup 4 – Quality Outcomes and Measurement

Common Themes

Oversight
Quality
Reporting
Technology

Oversight

- Improve oversight of service coordination services
- Expand the role of long-term care Ombudsman to HCBS
- Decrease regulatory burdens

Quality

- Improve quality of services



Workgroup 4 – Quality Outcomes and Measurement

Reporting

- Require nursing facilities to provide quarterly reports on waiting lists and turnover of staff
- Require hospitals to notify the AAA for all admission of older adults

Technology

- Use Health information technology to improve efficiency
- Expand the use of technology and access to electronic health records



Appendix 6 – Pennsylvania LTSS Overview and Administration

Pennsylvania Long Term Services and Supports Overview and Administration

Administration and oversight of Pennsylvania’s Long-Term Services and Supports (LTSS) system are divided among the Departments of Aging, Health, Human Services, Insurance, and Military and Veterans Affairs.

Department of Aging

The Department of Aging is responsible for overseeing the Long-Term Care Ombudsman (LTCO) program, Options program, PA Caregiver Support program, care transitions programs, pre-admission assessment, the Older Adult Protective Services program, the PACE and PACENET prescription assistance programs, licensing Older Adult Daily Living Centers and certifying domiciliary care homes.

- The LTCO program helps investigate and resolve complaints on behalf over 150,000 residents in 2,900 long-term care settings.
- The Options program provides services such as personal care, home delivered meals, transportation and adult day care services to support over 45,000 older adults who are not eligible for LTSS under Pennsylvania’s MA Program.
- The PA Caregiver Support program provides respite services, home modifications and education to over 7,000 caregivers.
- The care transitions programs are focused on reducing hospital re-admissions within health systems and to improve access to community based services. The Department has helped expand the program to 26 AAAs.
- Through pre-admission assessment, the Department oversees the clinical evaluation of over 115,000 individuals seeking to access LTSS in either state or MA-funded programs.
- The Older Adult Protective Services program investigates and supports over 16,500 individuals who are alleged to be the victim of abuse (physical, emotional, or sexual), neglect (by self or others) or financial exploitation.
- The PACE and PACENET programs serve over 300,000 individuals.
- There are 255 licensed adult daily living centers that support over 13, 000 individuals.
- There are 553 certified domiciliary care home supporting over 1,000 individuals.
- Over 360,000 individuals received preventive services through the Department’s various programs.

Department of Health

The Department of Health is responsible for licensing health care facilities such as nursing facilities, home health care agencies, home care agencies and hospice agencies. The

Department is also responsible for surveying health care facilities to determine if they meet the conditions for participation in the Medicare and MA Programs.

Department of Human Services

The Department of Human Services administers Pennsylvania's MA Program, including the different programs that provide LTSS to MA eligible older adults and adults with physical disabilities. MA LTSS are provided through home and community based (HCB) service waivers, nursing facilities and managed care services.

The Department operates six MA LTSS waiver programs:

- The Aging Waiver that supports over 27,000 older adults,
- The AIDS waiver that supports adults with symptomatic HIV or AIDS,
- The Attendant Care Waiver that supports over 9,400 adults ages 18-59 with physical disabilities who are capable of managing their services,
- The CommCare Waiver that supports over 600 adults with traumatic brain injuries,
- The Independence Waiver that supports over 7,000 adults ages 18-59 with physical disabilities, and
- The OBRA Waiver that that supports over 1,500 adults age 18-59 with a physical developmental disability.

In addition to the waiver programs, the Department operates the state funded Act 150 program that supports over 1,200 individuals not financially eligible for the Attendant Care Waiver program. The Department provides an all-inclusive LTSS program known as the Living Independence for the Elderly (LIFE) program, which is modeled after the national Program for All-Inclusive Care for the Elderly (PACE) program.²⁹ The Department makes payments and oversees the rate-setting process, and provides financial monitoring and regulations for MA nursing facility providers. On average, approximately 57,000 MA consumers receive MA nursing facility services per day.

The Department also operates South Mountain Restoration Center, a 159 bed licensed nursing facility located in Franklin County, Pennsylvania.

Department of Insurance

The Department of Insurance is responsible for licensing the over 120 Continuing Care Retirement Communities and regulating long-term care insurance products.

²⁹ The Department chose the name, Living Independence for the Elderly (LIFE), to avoid confusion with Pennsylvania's Pharmaceutical Assistance Contract for the Elderly Program, which is also known as PACE. Pennsylvania's PACE program offers low-cost prescription medication to qualified residents age 65 and older.

Department of Military and Veterans Affairs

The Department of Military and Veterans Affairs operates six State Veterans' Homes located across the Commonwealth. The Homes offer nursing home care and domiciliary/personal care to honorably discharged Pennsylvania veterans and their spouses on a first-come, first-served basis. Nursing care occurs at all levels including dementia and skilled care.

Domiciliary/personal care consists of shelter, sustenance and incidental medical care to assist eligible veterans who are disabled by age or disease, but who are not in need of hospitalization or nursing care services, to attain physical, mental and social well-being. The Homes currently have a combined capacity of 1,554 beds: 1,160 licensed nursing facility beds and 394 licensed domiciliary/personal care beds. In 2009, the Homes became certified nursing facility providers in the MA Program in order to provide MA nursing facility services to eligible residents through a veteran-specific program known as Enhanced Veterans Reimbursement (EVR).³⁰ The Homes also receive federal funding from the US Department of Veterans Affairs (VA). The Department provides outreach, education and assistance to veterans in coordinating health and LTSS programs offered through VA.

Counties

LTSS are also provided locally by counties in some instances. While it varies by county, some counties operate AAAs, provide waiver services, administer the MA transportation program in their locality, provide housing, and behavioral health services in the long term care continuum. In addition, 25 counties operated county nursing facilities that service as critical safety net providers for MA recipients. In contributing local funds to support these county facilities, the counties certify public expenditures which draw down federal matching funds under the MA Program.

Recent Long-Term Services and Supports Initiatives

In addition to the Long-Term Care Commission, the Corbett Administration implemented several other initiatives to improve LTSS in Pennsylvania.

The state fiscal year 2013-2014 budget included an investment of \$50 million to support older adults in their homes and communities. The investment helped reduce the waiting list for the Options program by over 6,900 individuals and served an additional 1,100 individuals in the Aging Waiver. In fiscal year 2014-2015, an additional \$25.3 million was added to support over 3,200 older adults and persons with disabilities in the LIFE and HCB services waiver programs

³⁰ DMVA chose the name Enhanced Veterans Reimbursement; the program enrolls MA eligible state veteran home residents in Medicaid.

and an additional \$7.2 million was added to serve individuals on the waiting list for the Act 150 program.

The Departments of Aging and Human Services applied for the Balancing Incentive Program (BIP) to receive enhanced federal funds for community based LTSS through September 2015. The Commonwealth is projected to receive approximately \$94 million under BIP to develop a no wrong door / single entry process, a core standardized assessment and conflict-free case management.

In February 2013, Governor Corbett signed an Executive Order calling for the creation of the Pennsylvania Alzheimer's Disease State Planning Committee. The Secretary of Aging, members of the General Assembly, leaders in research and advocacy, and those living with the disease and their families developed an action plan for Pennsylvania to address the growing crisis of Alzheimer's disease and related dementias (ADRD). The plan was finalized in February 2014 and approved by the Governor in June 2014. The Department of Aging, in collaboration with the Committee and key stakeholders, is beginning to implement the plan, which started with an ADRD Forum in September 2014.

Appendix 7 – Services and Statistics by LTSS Program

Program	SERVICES:	Housing	Home Modifications	Respite Care	DME/Assist. Tech.	Medications	Supplies	Home Health	Behavioral Health	Tele Medicine	Meals	Personal Care	Med Administration	Care Coordination	Transportation	Adult Day Care	Benefits Counseling	Education/Rec/Social/Health	Aging (A)/Under 60 (U)/Both (B)	Payment Source	FFS/MLTSS/MFFS	Unduplicated Consumers Enrolled	Average Monthly Cost per Unduplicated Consumer*
Personal Care Homes		X									X	X	X	X				X	B	Private Pay, SSI, State Supplement, LTC Insurance	FFS	8,173	
Assisted Living		X									X	X	X	X	X			X	B	Private Pay, SSI, LTC Insurance	FFS		
Domiciliary Care		X									X	X		X	X				B	Private Pay, Medicare, SSI, State Supplement for LTC Insurance	FFS	1,260	
Care Transitions			X	X	X		X	X	X	X	X	X	X	X	X	X			B	CMS Grant	FFS, MLTSS, MFFS		
PACE/PACENET						X							X						A	Lottery	FFS	310,932	\$74.68
APPRISE																	X	X	A	Medicare, OAA, Lottery	--	109,543	\$1.71
Prime Time Health																		X	A	OAA, Lottery	--	4,387	\$26.82

Program	SERVICES:	Housing	Home Modifications	Respite Care	DME/Assist. Tech.	Medications	Supplies	Home Health	Behavioral Health	Tele Medicine	Meals	Personal Care	Med Administration	Care Coordination	Transportation	Adult Day Care	Benefits Counseling	Education/Rec/Social/Health	Aging (A)/Under 60 (U)/Both (B)	Payment Source	FFS/MLTSS/MFFS	Unduplicated Consumers Enrolled	Average Monthly Cost per Unduplicated Consumer*
Senior Center Services & Activities																	X	X	A	PA Lottery	FFS	93,393	\$28.69
Nutrition Services											X							X	A	PA Lottery, OAA	FFS	156,686	\$2.79
Medical Assistance Transportation Program (MATP)															X				B	Medicaid	FFS		
Shared Ride															X				B	Lottery, Patient Pay, Pa DOT	FFS		
Family Caregiver Support			X	X	X		X	X	X		X			X	X		X	X	A	OAA, Lottery	FFS	7,101	\$193.66
OPTIONS			X	X	X	X	X	X	X	X	X	X	X	X	X	X			A	PA Lottery	FFS	30,082	\$750.73
Protective Services			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	B	OAA, Lottery, Medicaid Admin	FFS-(Client Based)	9,647	\$13.54
Aging Waiver			X	X	X		X	X		X	X	X		X	X	X			A	Medicaid	FFS	29,576	\$1,441.52
Attendant Care Waiver (Over 60)							X					X		X					A	Medicaid, Lottery	FFS	1,739	\$1,737.09
Attendant Care Waiver (Under 60)							X					X		X					U	Medicaid, State Funds	FFS	8,544	\$1,667.09
Act 150 (Over 60)												X		X					B	Lottery	FFS	904	\$2,009.52

Program	SERVICES:	Housing	Home Modifications	Respite Care	DME/Assist. Tech.	Medications	Supplies	Home Health	Behavioral Health	Tele Medicine	Meals	Personal Care	Med Administration	Care Coordination	Transportation	Adult Day Care	Benefits Counseling	Education/Rec/Social/Health	Aging (A)/Under 60 (U)/Both (B)	Payment Source	FFS/MLTSS/MFFS	Unduplicated Consumers Enrolled	Average Monthly Cost per Unduplicated Consumer*	
Act 150 (Under 60)												X		X					B	State Funds	FFS	1,332	\$1,990.82	
Independence Waiver			X	X	X			X	X			X		X	X	X			U	Medicaid	FFS	8,621	\$2,851.71	
COMMCARE Waiver			X	X	X			X	X			X		X	X	X			U	Medicaid	FFS	607	\$6,349.78	
OBRA Waiver			X	X	X			X	X			X		X	X	X			U	Medicaid	FFS	1,494	\$4,408.53	
AIDS Waiver												X		X					U	MA Outpatient Appropriation	MLTSS FFS			
LIFE Program			X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	B	Medicare, Medicaid	MLTSS	5,037	\$2,715.37	
Nursing Facility Care		X		X	X	X	X	X	X	X	X	X	X	X	X			X	B	Medicaid, LTC Insurance, Medicare, Private Pay, Insurance, VA	FFS	83,738	\$3,622.40	
Nursing Home Transition														X					B	Medicaid, State	FFS			
VA-PACE			X	X	X	X	X	X	X	X	X	X	X	X	X	X		X					23	\$3,675.00
Veteran Directed Care		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X					26	\$2,762.00

Program	SERVICES:	Housing	Home Modifications	Respite Care	DME/Assist. Tech.	Medications	Supplies	Home Health	Behavioral Health	Tele Medicine	Meals	Personal Care	Med Administration	Care Coordination	Transportation	Adult Day Care	Benefits Counseling	Education/Rec/Social/Health	Aging (A)/Under 60 (U)/Both (B)	Payment Source	FFS/MLTSS/MFFS	Unduplicated Consumers Enrolled	Average Monthly Cost per Unduplicated Consumer*
VA-Home-maker/Home Health Aide												X	X									4,162	\$576.00
VA In Home Respite				X								X										704	\$317.00
VA-Skilled Services								X		X													
VA-Adult Day Care						X			X					X	X							477	\$885.00
VA-Home Based Primary Care					X	X		X	X	X		X	X	X								3,624	\$1,338.00
VA-based Adult Day Health Care																X						932	\$501.00
VA-waiver equivalent (ADHC, CADHC, Homemaker/HHA, skilled care, in-home respite)				X	X	X	X	X	X	X		X	X		X	X						5,324	\$632.00
VA- PACE equivalent (HBPC/IDT + HHA &/or ADHC)		*	*	X	X	X	X	X	X	X		X	X	X	X	X						1,015	\$2,129.00

Source: PROMISe Data Warehouse

Date of Extraction: 6/1/2014

Information includes both paid Claims and Supplemental Payments.

FY12-13 Information was summarized based on actual service end dates within the reporting period and may not be complete.

Information for Dollar Amounts:

*The Average Monthly cost per unduplicated users is calculated as the total expenditures for the fiscal year divided by the total unduplicated users for the year. Since the number of unduplicated users reflects the fiscal year level, the average monthly cost may not be representative of 12 months of expenditures per user.

** Medical Foster Home provides Housing with Home Based Primary Care.

*** Not all expenditure data were available at the time this chart was compiled. Some services were included on this chart because they are received by LTSS consumers but expenditures relating to those services are not considered LTSS expenditures.

LTSS Program, Agency and Regulations

Program	State Agency	Regulations	
Personal Care Homes	DHS	55 Pa Code Chapter 2600	http://www.pacode.com/secure/data/055/chapter2600/chap2600toc.html
Assisted Living	DHS	55 Pa Code Chapter 2800	http://www.pacode.com/secure/data/055/chapter2800/chap2800toc.html
Domiciliary Care	PDA	6 Pa Code Chapter 21	http://www.pacode.com/secure/data/006/chapter21/chap21toc.html
Care Transitions	PDA (Adult Day Care Component), AAAs	6 Pa Code Chapter 11	http://www.pacode.com/secure/data/006/chapter11/chap11toc.html
PACE / PACENET	PDA	6 Pa Code Chapter 22	http://www.pacode.com/secure/data/006/chapter22/chap22toc.html
APPRISE	PDA		
Prime Time Health	PDA		
Senior Center Services & Activities	PDA		
Nutrition Services	PDA		
Medical Assistance Transportation Program (MATP)	65+-Lottery, Pa DOT, MA Under 65- Medicaid		
Shared Ride	65+-Lottery, AAA/Consumers 60-64- AAA/Consumers Under 60-Pa DOT, Co-insurance		
Family Caregiver Support	PDA	6 Pa. Code Chapter 20	http://www.pacode.com/secure/data/006/chapter20/chap20toc.html

Program	State Agency	Regulations	
OPTIONS	PDA	6 Pa Code Chapter 11	http://www.pacode.com/secure/data/006/chapter11/chap11toc.html
Protective Services	PDA (Older Adults)	6 Pa Code Chapter 15	http://www.pacode.com/secure/data/006/chapter15/chap15toc.html
	DHS		-
Aging Waiver	DHS OLTL	55 Pa. Code Chapter 52	http://www.pacode.com/secure/data/055/chapter52/chap52toc.html
	DOH for Home Health and Home Care component	28 Pa Code Chapters 601 and 611.	http://www.pacode.com/secure/data/028/chapter601/chap601toc.html
			http://www.pacode.com/secure/data/028/chapter611/chap611toc.html
PDA for Adult Day Care component	6 Pa Code Chapter 11	http://www.pacode.com/secure/data/006/chapter11/chap11toc.html	
Attendant Care Waiver (Over 60)	OLTL	55 Pa. Code Chapter 52	http://www.pacode.com/secure/data/055/chapter52/chap52toc.html
	DOH for Home Health and Home Care component	28 Pa Code	http://www.pacode.com/secure/data/028/subpartIVGtoc.html , http://www.pacode.com/secure/data/028/subpartIVHtoc.html
Attendant Care Waiver (Under 60)	OLTL	55 Pa. Code Chapter 52	http://www.pacode.com/secure/data/055/chapter52/chap52toc.html
	DOH for Home Health and Home Care component	28 Pa Code	http://www.pacode.com/secure/data/028/subpartIVGtoc.html , http://www.pacode.com/secure/data/028/subpartIVHtoc.html

Program	State Agency	Regulations	
Act 150 (Over 60)	DOH for Home Health and Home Care component	28 Pa Code	http://www.pacode.com/secure/data/028/subpartIVGtoc.html , http://www.pacode.com/secure/data/028/subpartIVHtoc.html
Act 150 (Under 60)	OLTL	55 Pa. Code Chapter 52	http://www.pacode.com/secure/data/055/chapter52/chap52toc.html
	DOH for Home Health and Home Care component	28 Pa Code	http://www.pacode.com/secure/data/028/subpartIVGtoc.html , http://www.pacode.com/secure/data/028/subpartIVHtoc.html
Independence Waiver	OLTL	55 Pa. Code Chapter 52	http://www.pacode.com/secure/data/055/chapter52/chap52toc.html
	DOH for Home Health and Home Care component	28 Pa Code Chapters 601 and 611.	http://www.pacode.com/secure/data/028/chapter601/chap601toc.html
			http://www.pacode.com/secure/data/028/chapter611/chap611toc.html
PDA for Adult Day Care component	6 Pa Code Chapter 11	http://www.pacode.com/secure/data/006/chapter11/chap11toc.html	

Program	State Agency	Regulations	
COMMCARE Waiver	OLTL	55 Pa. Code Chapter 52	http://www.pacode.com/secure/data/055/chapter52/chap52toc.html
	DOH for Home Health and Home Care component	28 Pa Code Chapters 601 and 611.	http://www.pacode.com/secure/data/028/chapter601/chap601toc.html
			http://www.pacode.com/secure/data/028/chapter611/chap611toc.html
PDA for Adult Day Care component	6 Pa Code Chapter 11	http://www.pacode.com/secure/data/006/chapter11/chap11toc.html	
AIDS Waiver	OLTL	55 Pa. Code Chapter 52	http://www.pacode.com/secure/data/055/chapter52/chap52toc.html
	DOH for Home Health and Home Care component	28 Pa Code Chapters 601 and 611.	http://www.pacode.com/secure/data/028/chapter601/chap601toc.html http://www.pacode.com/secure/data/028/chapter611/chap611toc.html

Program	State Agency	Regulations	
LIFE Program	OLTL,	55 Pa. Code Chapters 1187, 1189	http://www.pacode.com/secure/data/055/055toc.html
	PDA - (for Adult Day Care)	6 Pa Code Chapter 11	http://www.pacode.com/secure/data/006/chapter11/chap11toc.html
	DOH - (for Home Health Care, Hospitals, and Nursing Homes)	28 Pa. Code Part IV	http://www.pacode.com/secure/data/028/028toc.html
	Dept. of State (for Doctors & Licensed Professionals)	49 Pa Code	http://www.pacode.com/secure/data/049/049toc.html
Nursing Facility Care	OLTL	55 Pa. Code Chapters 1187, 1189	http://www.pacode.com/secure/data/055/055toc.html
	DOH	28 Pa. Code Part IV	http://www.pacode.com/secure/data/028/028toc.html
Nursing Home Transition	OLTL		

Appendix 8 – LTSS Data Crosswalk

Data Report Name	Subject
<u>Dual Eligible Participants: 101 Presentation</u> from May 9, 2014 LTCC meeting	National and State Dual Eligible Information
<u>PA Dual Eligible Presentation</u> from June 6, 2014 LTCC meeting	State Dual Eligible Information
<u>LTSS Data Presentation</u> from July 11, 2014 LTCC meeting	National and State LTSS Data
<u>Long-Term Care Services and Supports Data</u> – updated data from August 8, 2014 LTCC meeting	Updated National and State LTSS Data
<u>Comparison Data: Nursing Facility to Waiver Spend</u> - referenced at November 14, 2014 LTCC meeting	Updated State LTSS Data

Appendix 9 – LTCC Reports Crosswalk

Report/Presentation Name	Link	Subject
Adapt Action Report (2010)	http://www.adapt.org/freeourpeople/harrisburg/demand_s12a.php#header	Recommendation for Improving LTSS
ADAPT of Western PA, "Bill of Rights of Disabled Pennsylvanians" (2011)	http://www.doninc.org/adapt/docs/Bill_of_Rights-8%205x11.pdf	Educational Material
Avalere Health LLC, "Skilled Nursing Facilities in Pennsylvania: Analysis of Total Profit Margins for Freestanding Facilities," The Pennsylvania Health Care Association (February 2014)	http://www.phca.org/docs/financial-crisis-studies-avalere-report.pdf	Funding
Bachrach D, Pfister H, Wallis K and Lipson M, "Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment," The Commonwealth Fund (May 2014)	http://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs?omnicid=EALERT480081&mid=sarah@collaborativeconsulting.net	Recommendation for Improving LTSS
Commonwealth of Pennsylvania, "Balancing Incentive Program Application" (April 18, 2014)	http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_081062.pdf	Funding
DeJonge KE, Janshed N, Gilden D et al, "Effects of Home-Based Primary Care on Medicare Costs in High-Risk Elders" <i>Journal of American Geriatrics Society</i> (July 18, 2014)	http://onlinelibrary.wiley.com/enhanced/doi/10.1111/jgs.12974/	Models of Care
Eiken S, Sredel K, Gold L et al, "Medicaid Expenditures for Long-Term Services and Supports in FFY 2012", CMS, Truven Health Analytics (April 28, 2014)	http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/LTSS-Expenditures-2012.pdf	LTSS Data (Expenditures)
ElderPAC Education presentation (2014)	http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_096844.pdf	Models of Care
ELJAY LLC, "A Report on Shortfalls in Medicaid Funding for Nursing Center Care," The American Health Care Association (January 2014)	http://www.ahcancal.org/research_data/funding/Documents/FINAL%202013%20Medicaid%20Underfunding%20for%20Nursing%20Center%20Care.pdf	Funding

Report/Presentation Name	Link	Subject
Genworth, "2014 Cost of Care Survey" (March 25, 2014)	https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032514_CostofCare_FINAL_non_secure.pdf	Funding
Governor's Office of Health Care Reform: Long - Term Living Project, "Addressing Pennsylvania's Direct Care Workforce Capacity Primary Recommendations for Quality Jobs and Quality Care" (December 7, 2007)	http://www.portal.state.pa.us/portal/server.pt?open=18&objID=490272&mode=2&_ga=1.76284949.1627312484.1413215552	Workforce
HealthInsight New Mexico External Quality Review Organization (EQRO), "Independent Assessment of New Mexico's Medicaid Managed Care Program- Physical Health Salud!" (June 28, 2013)	http://www.hsd.state.nm.us/uploads/FileLinks/8087bfcd31b14dfe8b92a6206b890b19/PH_IA_Report_FY_12_FINAL.pdf	Managed LTSS
Houser A, Fox-Grage W, Ujari K, "Across the States 2012: Profiles of Long Term Services and Supports," AARP, 9th Ed (2012)	http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf	LTSS Data
Joint State Government Commission, General Assembly, Commonwealth of Pennsylvania, "Report of the Advisory Committee on Long Term Care Services and Supports for Older Pennsylvanians" (August 2014)	http://jsg.legis.state.pa.us/publications.cfm?JSPU_PUBLN_ID=374&_ga=1.252726665.1627312484.1413215552	Recommendation for Improving LTSS
Kaye HS, LaPlante M, Harrington C, "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?" <i>Health Affairs</i> , Vol. 28, No. 1 (January/February 2009)	http://www.wvdhhr.org/oig/olmstead/what%20is%20the%20olmstead%20decision/do%20noninstitutional%20services%20reduce%20medicaid%20spending.pdf	Funding
Moses S, "Long - Term Care Reform: More Access to Better Care at Lower Costs," The Commonwealth Foundation (January 2011)	http://www.commonwealthfoundation.org/docLib/20110110_LTCReport.pdf	Funding

Report/Presentation Name	Link	Subject
National Council on Disability, "Medicaid Managed Care for People with Disabilities: Policy Implementation Considerations for State and Federal Policymakers" (March 18, 2013)	http://www.ncd.gov/rawmedia_repository/20ca8222_42d6_45a5_9e85_6bd57788d726?document.pdf	Managed LTSS
National Governor's Association, "NGA Health Care Sustainability Task Force Report" (Approved February 22, 2014)	http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1402HCSTFReport.pdf	Recommendations for Improving LTSS
National PACE Association, "Memorandum, Guidance for PACE - Eligibility and Penalties for the EHR Incentive Programs" (July 16, 2014)	http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_094052.pdf	Health Information Technology
<i>Olmstead, Commissioner, Georgia Department of Human Resources, et al. v. L. C.</i> , 527 U.S. 581 (1999) PA Coalition of Medical Assistance MCOs, "Briefing Paper, A Road Map for Implementing Medicaid Managed Long-Term Services and Supports (MLTSS) in Pennsylvania" (October 2013 (Revised))	http://www.hhs.gov/ocr/civilrights/resources/specialtopics/community/olmstead_decision.pdf http://www.pamco.org/publication_files/mltss-program-recommendations---10-11-13.pdf	Educational Material Recommendation for Improving LTSS
PA Senior Care and Service Study Commission (2009)	http://www.dhs.state.pa.us/cs/groups/webcontent/documents/report/d_006882.pdf	Recommendation for Improving LTSS
PACE/EMR Survey Presentation, "State of Electronic Health Records Systems in PACE 2012 Member Survey Analysis"	http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_096846.pdf	Health Information Technology
PACE/LIFE Cost-Benefit and Quality Outcome Study Abstracts, 2014	http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_096847.pdf	Managed LTSS
Pennsylvania Alzheimer's Disease Planning Committee, "State Plan for Alzheimer's Disease and Related Diseases" (February 2014)	http://www.portal.state.pa.us/portal/server.pt/document/1395692/pennsylvania_state_plan_for_alzheimer's_disease_and_related_disorders_pdf?_ga=1.110234629.1627312484.1413215552	Recommendation for Improving LTSS
Pennsylvania Department of Aging, "2012 - 2016 State Plan on Aging"	http://www.portal.state.pa.us/portal/server.pt/document/1288810/2012-2016_pa_state_plan_on_aging_w_pdf	Recommendation for Improving LTSS

Report/Presentation Name	Link	Subject
Pennsylvania Health Law Project, "Home and Community Based Services (HCBS) Waiver Programs: A Manual for Consumers and Advocates in Southwestern PA" (July 2012)	http://www.phlp.org/wp-content/uploads/2012/08/SW-Waiver-Manual-Formatted.pdf	Educational Material
Pennsylvania Intra-Governmental Council on Long-Term Care, "PA Transition to Home (PATH), Final Report Nursing Home Transition 2000 Grant) (March 1, 2004)	http://www.portal.state.pa.us/portal/server.pt/document/389414/040301_path_final_report_pdf	Recommendation for Improving LTSS
Pennsylvania State Health Care Innovation Plan (December 2013)	http://www.portal.state.pa.us/portal/server.pt?open=18&objID=1386300&mode=2&ga=1.90442906.1627312484.1413215552	Health Information Technology
The Kaiser Family Foundation, "Medicaid Home and Community-Based Services Programs: 2010 Data Update" (March 27, 2014)	http://kff.org/medicaid/report/medicaid-home-and-community-based-service-programs/	LTSS Data (Users and Expenditures)
The National Advisory Board on Improving Health Care Services for Seniors and People with Disabilities (NAB), "Managed Care: Doing It Right, Applying the Independent Living Philosophy, A Toolkit for Legislators, Advocates, and Consumers" (2012)	http://www.amerigroup.com/sites/amerigroup.com/files/files/NAB%20Toolkit_10-2-12ack(1).pdf	Managed LTSS
Thomson Medstat. "Home and Community Based Services Reform and Rebalancing Feasibility Analysis" (2006)	http://www.paproviders.org/Pages/MR_Archive/HCBS_Feasibility_Study_MedStat.pdf	Recommendation for Improving LTSS
Truven Health Analytics, "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update" (2012)	http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf	Managed LTSS
University of Pittsburgh, Institute of Politics and the Jewish Healthcare Foundation "Policy Brief: The Future of Medicaid Long-term Care Services in Pennsylvania: A Wake-up Call" (2013)	http://www.iop.pitt.edu/documents/Policy%20briefs/Medicaid%20Long-term%20Care%20in%20Pennsylvania.pdf	Recommendation for Improving LTSS

Report/Presentation Name	Link	Subject
US Department of Justice, "Statement of the Department of Justice on Enforcement of the Integration mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C." (June 22, 2011)	http://www.ada.gov/olmstead/q&a_olmstead.htm	Educational Material
US Senate, Commission on Long-Term Care, Report to Congress, September 30, 2013 Alternative Report, A Comprehensive Approach to Long-Term Services and Supports, Long-Term Care Commission, September 23, 2013	http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf http://www.aapd.com/resources/press-room/ltss-alternative-report.pdf	Recommendations for Improving LTSS
Woodcock CH, The Hilltop Institute, A technical report commissioned by the National Governors Association, "Long-Term Services and Supports: Challenges and Opportunities for States in Difficult Budget Times" (2011),	http://www.hilltopinstitute.org/publications/ltSSChallengesandopportunitiesforStatesindifficultBudgettimes-December2011.pdf	Recommendation for Improving LTSS

Appendix 10 – Recommendation Worksheets

RECOMMENDATION 1 – IMPROVE CARE COORDINATION IN THE LTSS SYSTEM

PROPOSED STRATEGY 1.1:

Develop and implement one or more demonstration programs (demonstration) in designated geographic areas to pilot service delivery and financing models (e.g. capitated, managed fee-for-service, partial capitation, episodes of care bundled payments) that provide coordinated, integrated, person-centered physical health, mental health, substance abuse, and long-term services and supports (LTSS) services. Each demonstration should be developed within the following parameters:

1. Is voluntary.
2. Is person-centered.
3. Is available for adults who are:
 - Eligible for medical assistance (MA) only, or
 - Dually eligible for Medicare and MA, or
 - Eligible for the Options or Act 150 Program and meet the current functional eligibility for MA LTSS programs, or
 - A small population who are eligible for the Options or Act 150 Program and do not meet the current functional eligibility for MA LTSS programs.
4. Integrates services and funding from Medicare, MA (LTSS, fee-for-service (FFS), and HealthChoices and MA waivers), and state funded LTSS programs for applicable demonstration enrollees.
5. Is coordinated with, but not dependent on other state initiatives.
6. Is expanded statewide through a phased process, with the option of using passive enrollment, if the demonstration's outcome, satisfaction and sustainability goals are achieved; and is discontinued if the demonstration's goals are not met.

GOAL:

1. Enable older adults and adults living with physical disabilities to remain in their homes and live independently as long as possible.
2. Improve coordination of an individual's services, physical health, mental health, substance abuse, social and housing services, and LTSS, if the individual so chooses.
3. Enhance coordination and integration of services during care transitions from more to less intensive settings, to ensure necessary follow up care and prevent unplanned re-admissions.
4. Test models that improve care coordination, outcomes, and consumer satisfaction and that make the LTSS system more fiscally sustainable with better aligned financial incentives.
5. Determine which model(s) best supports obtaining better outcomes, consumer satisfaction and the long-term financial sustainability of Pennsylvania's LTSS system.

PROPOSED IMPLEMENTATION ACTIVITIES:

9. Identify the appropriate funding mechanism (e.g., 1115 demonstration) and request and obtain approval from the Centers for Medicare and Medicaid Services (CMS) to ensure federal matching funds.
10. Have ongoing stakeholder involvement in the development, implementation and evaluation of the demonstration.

Convene an existing or newly formed broad-based stakeholder group to assist the Commonwealth throughout all phases of the demonstration program. The stakeholder group should provide input, consistent with the parameters of this recommendation, on the demonstration populations, specific geographic demonstration areas, comprehensive benefit design, service delivery and care management, (see examples in notes) and financial arrangements (e.g. capitated, managed fee-for-service, partial capitation, episodes of care bundled payments) to be tested.

11. Include strong consumer protections in the demonstration.

Design the demonstration to allow consumers sufficient time (e.g., 60 days) to choose their demonstration plan option and safely transition from their present FFS plan into the demonstration program. Conversely, allow consumers opting to leave the demonstration plan sufficient time to safely transition into FFS. Develop quality measures to assure access, timely service delivery, person-centered services and outcomes in the demonstration program, and establish provider network requirements to ensure appropriate access to services.

12. Continue to support the existing networks of local, non-profit, public, and small business providers, including Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs), during the development and implementation of the demonstration.

Give providers ongoing technical assistance, training, and incentives to maximize their ability to keep up with the demands for high quality, cost effective services, and the use of technology systems. Consider the results of the LTSS rate setting and reimbursement review as part of developing the demonstration. (See also Proposed Strategy 4.2.)

13. Enhance coordination and integration of mental health and substance abuse services for LTSS consumers.

Design the demonstration to promote and support the growth of person-centered mental health and substance abuse services within the Commonwealth while coordinating with LTSS, if the individual so chooses. Among other things, consider the use of telepsychiatry and telemedicine; MA reimbursement for advanced practice professionals (e.g., psychiatric nurses and nurse practitioners); and MA reimbursement

for appropriately trained and experienced workers to expand the availability of mental health and substance abuse services. Break down the funding silos between the Office of Long-Term Living (OLTL), Office of Medical Assistance Programs, Office of Mental Health and Substance Abuse Services, and the Pennsylvania Department of Aging (PDA).

14. In preparation for the demonstration, develop and implement comprehensive educational programs to assist participating consumers understand the demonstration and evaluate their options; help providers make necessary changes in current practices to prepare for new business models; and inform managed care organizations of current LTSS programs to facilitate the development of partnerships between the plans and current LTSS providers.

15. Work with legislative leaders to inform them about and obtain their support for the demonstration, including securing the necessary budget flexibility to successfully implement the demonstration. (See also Proposed Strategy 4.2.)

16. Establish data and reporting requirements and make appropriate system modifications to obtain necessary data to monitor, measure, and evaluate the demonstration and its impact on consumers and the existing FFS program. (See also Proposed Strategies 3.1 and 3.2.)

RATIONALE:

1. Better coordination of physical health services, mental health services, substance abuse services and LTSS could result in better outcomes, such as avoidable hospitalizations or drug interactions, and better choice and consumer satisfaction, such as remaining in the home or another community setting rather than relying on institutional care.
2. Innovative funding models to address LTSS for the elderly and disabled must be identified and considered as MA funding of LTSS to those populations continues to grow at an unsustainable pace.

PROS:

1. Voluntary enrollment would allow individuals the choice to participate in a demonstration or remain with their existing program.
2. A coordinated integrated LTSS delivery system could reduce the per capita costs associated with services for nursing facilities, hospitals, and prescription drugs.
3. A coordinated integrated LTSS delivery system could better align LTSS the concepts of consumer choice, person-centered care, by aging in place through better health and social outcomes, improved access to services,

CONS:

1. Until implementation is realized and money is eventually saved by decreased services in institutional settings, there could be a cost increase for system change/startup including costs for paying both FFS and capitation in the first year and costs for standardized waiver benefits.
2. Testing models and voluntary enrollment would delay making a more coordinated system available statewide.
3. Consumers might not receive necessary services under one or more of the models which they would have

<p>a greater range of services along the care continuum, more consumer-friendly services, the elimination of service and care-setting silos.</p> <ol style="list-style-type: none"> 4. Development of coordinated LTSS and mental health and substance abuse systems would make those systems more sustainable. 5. Testing various models would permit the model(s) that best serve Pennsylvania’s unique healthcare delivery and social support systems and the need for long-term financial sustainability to be identified. 	<p>under the current FFS system.</p> <ol style="list-style-type: none"> 4. Testing and the voluntary nature could result in low take up rate, which could be problematic with risk arrangements and demonstration evaluation. 5. Obtaining CMS approval on 1115 demonstration waiver and memorandum of understanding, and reaching an acceptable financial arrangement with CMS on Medicare savings could delay implementation. 6. Some providers might need to modify their business model to prepare for new models. 7. Implementing multiple demonstrations at the same time would be administratively difficult. 8. Stakeholders, including state and local agencies, might oppose change, preferring to keep the status quo.
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MEASURABLE OUTCOMES:

1. Utilization Measures:
 - a. Per capita nursing facility days
 - b. Per capita re-hospitalization rates
 - c. Per capita ER visits
 - d. Consumer acuity assessment at enrollment and at comparable time intervals during the demonstration – pre and post
 - e. Hospitalizations/100 beneficiary months
 - f. Per capita personal care hours
 - g. 3-year or longitudinal Community survival rate
2. Satisfaction Measures:
 - a. Consumer satisfaction with physical health, mental health, substance abuse, and informal support services
 - b. Provider satisfaction
 - c. Per capita complaints and grievances
3. Service Delivery Measures:
 - a. Timeliness of claim payments
 - b. Timeliness of service delivery
4. Network Adequacy Measures:
 - a. Access standards
 - b. Provider payment methodologies – needs to be measurable – (e.g. percent of providers reimbursed using payment methodology, percent cost coverage, percent demonstration providers paid at a percent of FFS payment)
5. Sustainability Measures:

- a. Comparison of Demonstration Models and FFS Expenditures:
 - i. Per capita, risk adjusted expenditures on LTSS services for demonstration populations by delivery system model and FFS – pre, during and post demonstration.
 - ii. Per capita, risk adjusted expenditures on nursing facility services by peer group by delivery system model and FFS – pre, during and post demonstration.
 - iii. Per capita, risk adjusted expenditures on waiver services by waiver by demonstration model and FFS – pre, during and post demonstration.
 - iv. Per capita, risk adjusted expenditures on acute care services by demonstration model and FFS – pre, during and post demonstration.
 - v. Per capita, risk adjusted total savings and state share savings between delivery models and FFS.
 - vi. Yearly percentage increase in per member per month payments for demonstration delivery models and FFS.

ANTICIPATED COSTS OR BUDGET IMPACT:

The estimated fiscal impact of the demonstration is Low.

A repositioning of funds, including Medicare funds, may be needed in order to fund the system changes needed to implement the demonstration. This could include costs associated with services that are not currently covered by a 1915(c) waiver, but are identified as a necessary part of a care plan under a managed FFS model (e.g. home modifications, heavy chores).

There will be upfront development and implementation costs and resource requirements for state staff and outside vendors, as well as ongoing operational costs. However, once the implementation takes place it is also expected that a cost savings will be realized due to the reduction of services in higher cost settings (nursing facility and hospital) and unnecessary services (hospitalizations) due to the lack of care coordination.

PROPOSED IMPLEMENTATION TIMELINE:

- 3/1/15 to 3/1/16 – Stakeholder process and demonstration design
- 3/1/16 to 7/30/16 – Request for Proposal process (draft, respond, and select)
- 7/1/16 – Include in 16/17 budget
- 7/1/16 to 1/1/17 – Submission of 1115 or waiver applications and Managed Care Organization (MCO) contracts and negotiations with CMS
- 9/1/16 to 12/31/16 – Complete readiness reviews of plans/providers
- 1/1/17 to 3/31/17 – Educational meetings in demonstration areas and enrollment into demonstration
- 4/1/17 – Demonstration effective date
- 1/1/19 to 6/30/19 – Evaluate demonstration and make recommendation on expanding statewide

NOTES:

Model Considerations:

The stakeholder group should consider the following types of service delivery/care

management models in developing demonstration models:

- Patient-Centered Medical Home Models such as Home Based Primary Care Independence at Home, and when integrated with waiver services through a AAA, ElderPAC;
- New Primary Care Medical Home models such as enhanced medical day care, nurse practitioner house calls, and home care services;
- Leveraging existing accountable provider organization (APO) models, such as Living Independence for the Elderly (LIFE), to develop new demonstration models including LIFE-like models for non-LIFE populations such as individuals with disabilities (e.g. Inglis model);
- Developing new community-based care management team based models such as a Care Transitions for dually eligible individuals requiring post-hospitalization. These individuals will be using their Medicare Part A benefit at home or in a skilled nursing facility for short term rehabilitation. The population should be aggressively care managed and facilitate home and community based (HCB) services waiver funding (i.e., immediately upon discharge from a Medicare skilled nursing facility);
- Developing different payment methodologies for services including episodes of care.

Demonstration Population Considerations:

- There should be a small demonstration for Nursing Facility Ineligible individuals, but the majority will continue to be served under the current FFS model.
- Voluntary enrollment could be problematic with getting plans to participate due to concerns with sufficient risk pools.

PROPOSED STRATEGY 1.2:

Conduct analyses of the existing LTSS system to identify and eliminate gaps and barriers in care coordination and service delivery. Coordinate the results of these analyses with the design and implementation of the demonstration.

GOAL:

1. Enable older adults and adults living with physical disabilities to remain in their homes and live independently as long as possible.
2. Improve coordination of an individual’s services physical health, mental health, substance abuse, social and housing services, and LTSS, if the individual so chooses.

3. Ensure that LTSS services are coordinated and delivered in a manner that reflects and respects the racial and ethnic values and preferences of Pennsylvania’s ethnically diverse populations.

PROPOSED IMPLEMENTATION ACTIVITIES:

1. Conduct a feasibility study of the following:
 - a. Adding coverage of home modifications (including modifications to a rental property), activities of daily living (ADL) technology, and remote service technology in all Medicaid waivers and the Act 150 program;
 - b. Permitting nurse delegation, or other alternatives to nurse delegation, to enable direct care workers (DCWs) to provide additional services for LTSS consumers;
 - c. Providing MA reimbursement for advanced practice professionals (e.g., psychiatric nurses and nurse practitioners);
 - d. Providing MA reimbursement for appropriately trained and experienced workers to expand the availability of mental health and substance abuse services;
 - e. Eliminating restrictions that limit housing options in domiciliary care for LIFE consumers;
 - f. Allowing interim care plan approvals;
 - g. Removing limitations on paying family members to provide personal care;
 - h. Permitting reimbursement for costs related to the use of service animals;
 - i. Modifying estate recovery policies to exempt MA HCB services; and,
 - j. Permitting MA HCB services to be provided in personal care homes and assisted living residences.

The study should examine the legal, operational and financial implication of each proposed modification to the system and identify the action steps required for any modification determined to be operationally, legally and financially feasible. Feasible changes should be implemented as soon as possible and should not be delayed or contingent on implementation of the demonstration.

2. Convene a study group to evaluate the policy, operational and financial implications to the Commonwealth of adopting the Community First Choice Option (CFC Option), or other financing options, in order to offer personal care services under the Medicaid State Plan.
 - a. The study group should include adults with disabilities and adults who are 60 years old or older and their representatives/caregivers, LTSS and other service providers and their representatives, and staff from the Commonwealth agencies.
 - b. The study group should (i) consult with the Centers for Medicare and Medicaid Services (CMS), those states that have implemented the CFC Option and those states that withdrew CFC Option State Plan Amendments; (ii) analyze and report on CFC Option feasibility; and, and (iii) consider innovative proposals that push the boundaries of the CFC Option regulations in order to better fit the needs of

Pennsylvania.

- c. The study group should complete its analysis and report in sufficient time to enable the Commonwealth to make a final determination on whether to pursue the CFC Option or some other alternative so that, if appropriate, the necessary funding authority may be included in the 2015-2016 state budget.
 - d. If the study group finds adoption is not recommended in the current policy/regulatory environment, then the study group should recommend the policy and regulatory changes that would be required to make adoption preferable.
3. Conduct a longer term gap analysis to identify:
- a. Additional services that should be covered to strengthen the LTSS system, empower its users with choices, enable them to receive person-centered care and to age in place;
 - b. Aspects of the LTSS delivery system that limit choice, hinder the ability to provide person-centered care or to age in place, or hamper the flexibility needed to adapt to changing long-term care needs and opportunities;
 - c. Any waiver, State Plan, legislative, regulatory and other innovative options needed to address service gaps and barriers; and
 - d. Alternative and innovative funding streams being used in other states, as well as innovative models being offered at the federal level for utilization by states to address identified service gaps.
- This gap analysis should also assess the policy and fiscal implications and feasibility of addressing identified service gaps, and whether any legal or regulatory barriers exist that limit or prevent changes necessary to address the gaps. Where feasible, identified gaps and barriers should be addressed immediately. Changes should not be delayed or contingent on implementation of the demonstration.
4. Consider and coordinate results of these analyses in the design and piloting of the demonstration.

RATIONALE:

1. Better coordination of physical health services, mental health services, substance abuse services and LTSS could result in better outcomes, such as avoidable hospitalizations or drug interactions, and better choice and consumer satisfaction, such as remaining in the home or another community setting rather than relying on institutional care.
2. Innovative funding models to address LTSS for the elderly and disabled must be identified and considered as MA funding of LTSS to those populations continues to grow at an unsustainable pace.
3. CMS is currently offering incentives for states to expand their Medicaid coverage for person-centered home and community based attendant services and supports, including the CFC Option. Public comments received during the Commission's public hearings recommended that Pennsylvania pursue the CFC Option.
4. The Commonwealth may have laws, regulations or policies which hinder its ability to

<p>implement new services, settings or LTSS models of service delivery and financing, or which deter or prevent users of LTSS from consumer choice, person-centered care, and an ability to age in place.</p> <p>5. Current estate recovery policies may discourage individuals from seeking HCB services which could prevent or delay more costly inpatient services.</p>	
<p>PROS:</p> <ol style="list-style-type: none"> 1. A coordinated integrated LTSS delivery system could reduce the per capita costs associated with services for nursing facilities, hospitals, and prescription drugs. 2. A coordinated integrated LTSS delivery system could better align LTSS with the concepts of consumer choice and person-centered care, by aging in place through better health and social outcomes, improved access to services, a greater range of services along the care continuum, more consumer-friendly services, and the elimination of service and care-setting silos. 3. Development of coordinated LTSS and mental health and substance abuse systems would make those systems more sustainable. 4. The CFC Option would afford PA the same opportunity as other states to benefit from the enhanced federal match. 5. The CFC Option would allow additional funds from enhanced match to be used to reimburse transition costs from an institutional to HCB services setting and to support adults with disabilities and chronic conditions to “self-direct” services, thereby affording maximum choice and control over the services they receive. 	<p>CONS:</p> <ol style="list-style-type: none"> 1. Stakeholders, including state and local agencies, might oppose change, preferring to keep the status quo. 2. Additional oversight responsibility by the state would be required if the CFC Option is adopted, imposing additional burdens on an already strained system. 3. Adoption of the CFC Option could have a substantial fiscal impact due to a woodwork effect (i.e., individuals who would not otherwise seek or receive services under the current system applying for and receiving services).
<p>MEASURABLE OUTCOMES:</p>	

ANTICIPATED COSTS OR BUDGET IMPACT:

The estimated fiscal impact of the analyses is Low. This estimate does not include any costs relating to changes recommended as a result of the feasibility study, the adoption of the CFC Option, or any changes to eliminate gaps and barriers identified in the gap analysis.

If Pennsylvania chooses to implement the CFC Option, it will qualify for a six percent (6%) increase in federal matching funds for personal care services. Even with the enhanced federal match, the estimated fiscal impact of the CFC Option is estimated to be High (more than \$25 million in state funding) due to an anticipated increase in services.

There is also a possible cost impact to those entities that would provide the CFC Option as a result of required quality assurance system and council. *Of note:* If the CFC Option benefit is implemented, within the first 12 months of that implementation the state must maintain or exceed the level of expenditures for home and community based attendant services provided under the state plan, waivers or demonstrations for the preceding 12 month period.

PROPOSED IMPLEMENTATION TIMELINE:

1/1/15 – Gap analysis studies should begin following submission of report

NOTES:

RECOMMENDATION 2 – IMPROVE SERVICE DELIVERY IN THE LTSS SYSTEM

PROPOSED STRATEGY 2.1:

Streamline, standardize and expedite eligibility determination for all MA LTSS programs across all levels of care.

GOAL:

Provide older adults and adults with disabilities timely access to cost effective and quality LTSS in the setting of their choice.

PROPOSED IMPLEMENTATION ACTIVITIES:

- 1. Streamline the process:
 - 1. In coordination with current Budget Incentive Program (BIP) initiatives, modify the Compass system to expand capacity to accept applications and supporting documentation for all LTSS programs.
 - 2. Increase the use of technology to facilitate more timely exchange of information and eliminate duplication of efforts.
- 2. Standardize:
 - 1. Adopt consistent elements in assessment tools for all programs.
 - 2. Apply the same eligibility standards and requirements, including allowing “spend down” to the same income levels, regardless of whether individuals seek LTSS in nursing facilities or in HCB settings. (See also Proposed Strategy 4.1.)

<p>3. Expedite the process:</p> <ol style="list-style-type: none"> 1. Develop and use a preliminary financial screening tool to determine whether an applicant for LTSS is likely to be determined MA eligible. Use Lottery funds to advance payment for services on an interim basis for individuals over age 60 who are determined likely MA eligible pending a final determination of their eligibility. Identify an alternate funding source to pay for services on an interim basis for individuals under age 60 who are determined likely MA eligible. 2. Take appropriate measures to enable HCB services to commence pending eligibility determinations by permitting the development of an interim service plan for HCB services, including submitting waiver amendments and revising 55 Pa. Code Chapter 52 regulations — Long Term Living Home and Community Based Services. 	
<p>RATIONALE:</p> <p>Historically, the eligibility process for MA LTSS has been long, tedious and difficult to navigate. For HCB services, the process can take 4 months or more and must be completed before services can commence. A delay in initiation of HCB services could result in unnecessary nursing facility placement due to the lack of an alternative.</p>	
<p>PROS:</p> <ol style="list-style-type: none"> 1. Improved timely access to services. 2. More cost effective provision of services. 3. More consumer friendly provision of services. 4. More consumer choice since consumers may have access to HCB services in a timely manner 5. Improved ability to capture data and report outcomes. 	<p>CONS:</p> <ol style="list-style-type: none"> 1. HCB services providers’ reluctance to assume the financial risk to support initiative. 2. Decreased access to finite HCB services waiver slots if individuals who become MA eligible through "spend down" occupy a waiver slot during their spend-down period, thereby taking up a slot for services. 3. Substantial financial impact of allowing "spend down" to higher income level due to a woodwork effect.
<p>MEASURABLE OUTCOMES:</p> <ol style="list-style-type: none"> 1. Percent reduction in the average length of time between application and receipt of HCB services, including reductions for older minorities. 2. Improved communication with consumer as measured through consumer satisfaction surveys. 3. Increase in the number of individuals served in the community and in the home. 	
<p>ANTICIPATED COSTS OR BUDGET IMPACT:</p> <p>Fiscal Impact is High (greater than \$25 million of state funds) due to the "spend down" eligibility changes that could increase HCB program enrollments. However, some offsetting cost savings may be realized as the result of decreased use of institutional care. In addition, if there are a finite number of slots available and some of those slots are used by people with "spend down" then the paid services for that individual in a month may be less than</p>	

someone without “spend down”.
PROPOSED IMPLEMENTATION TIMELINE: The Commission did not propose an implementation timeline.
Notes:

PROPOSED STRATEGY 2.2: Pursue a multi-dimensional approach to increase education to promote personal planning for and awareness of LTSS needs.	
GOAL: Delay the need for more costly and restrictive levels of care by building preventive services into a more coordinated, person-centered model of LTSS.	
PROPOSED IMPLEMENTATION ACTIVITIES: <ol style="list-style-type: none"> 1. Build on existing programs (both public and private) to educate the public on the necessity for planning for their long-term need. Simplify access to information and support. 2. Promote education surrounding long-term care insurance and the Long-Term Care Partnership. (See also Proposed Strategy 4.1.) 	
RATIONALE: Providing increased access to health and wellness prevention programs and education on private LTSS coverage options will enable older adults and adults with disabilities to live safely and independently for as long as possible; thereby deferring the need for publically funded and more intensive, expensive and restrictive levels of LTSS.	
PROS: <ol style="list-style-type: none"> 1. Enhanced consumer education and ability to participate in important health related decisions. 2. More consumer friendly services. 3. Better individual planning for long-term care needs as a result of financial incentives for the purchase of long-term care insurance. 	CONS: <ol style="list-style-type: none"> 1. Insufficient provider staffing and financial resources to support initiatives. 2. Insufficient state staff resources to develop programs. 3. Less formal provider infrastructures. 4. Individual discomfort with accessing a database.
MEASURABLE OUTCOMES: <ol style="list-style-type: none"> 1. Growth in number of Pennsylvanians purchasing long-term care insurance. 	

ANTICIPATED COSTS OR BUDGET IMPACT:

The estimated fiscal impact of this proposed strategy is Low and accounts for staff time related to supporting education efforts.

PROPOSED IMPLEMENTATION TIMELINE:

The Commission did not propose a timeline.

Notes:**PROPOSED STRATEGY 2.3:**

Expand access to evidence-based health and wellness programs, including both physical health and behavioral health.

GOAL:

Delay the need for more costly and restrictive levels of care by building preventive services into a more coordinated, person-centered model of LTSS.

PROPOSED IMPLEMENTATION ACTIVITIES:

1. Collaborate with primary care physicians, AAAs, CILs, county and private LTSS providers in order to maintain or enhance health and wellness.
2. Continue to involve the AAAs and CILs as essential components of the LTSS system in their roles as stakeholders, advocates and service providers.
3. Develop and integrate a voluntary health and wellness evaluation for participants in all programs and service offered through PDA, MA waiver programs, senior centers, respite centers, personal care homes, domiciliary care, and assisted living facilities.
4. Develop a voluntary longitudinal database, or Residential History File (RHF), to track a person's health and wellness and use of LTSS throughout the continuum. (See also Proposed Strategies 3.1 and 3.2.)
5. Promote the development of partnerships (among state agencies, HCB services providers, county government, and private partners) that encourage the evolution of communities in which to age and live well.
6. Support consumers' participation in sports and other recreational activities.
7. Facilitate the exchange of information on innovative solutions in housing and transportation that support independent living.

RATIONALE:

Providing increased access to health and wellness prevention programs will enable older adults and adults with disabilities to live safely and independently for as long as possible; thereby deferring the need for publically funded and more intensive, expensive and restrictive levels of LTSS.

<p>PROS:</p> <ol style="list-style-type: none"> 1. Enhanced ability to capture data and to report outcomes. 2. More consumer friendly services. 	<p>CONS:</p> <ol style="list-style-type: none"> 1. Insufficient provider staffing and financial resources to support initiatives. 2. Insufficient state staff resources to develop programs. 3. Less formal provider infrastructures. 4. Individual discomfort with accessing a database.
<p>MEASURABLE OUTCOMES:</p> <ol style="list-style-type: none"> 1. Growth in health and wellness programs. 2. Percent of providers using assessment templates. 3. Implementation of Caregiver Wellness Checks in Medicare and/or Medicaid Managed Care: percent of plans compliant with this requirement and percent of beneficiaries having wellness checks. 4. Creation and use of longitudinal database to monitor health and wellness and utilization of long-term services and supports throughout the continuum. 5. Growth in respite services and number of participants. 	
<p>ANTICIPATED COSTS OR BUDGET IMPACT:</p> <p>Fiscal impact is Medium due to the cost of developing the longitudinal database and related activities.</p>	
<p>PROPOSED IMPLEMENTATION TIMELINE:</p> <p>Approximately 3 years. (need detailed time table if adopted)</p>	
<p>Notes:</p> <p>Free resources: National Center on Health and Physical Disability, Challenged Athletes Foundation</p>	

<p>PROPOSED STRATEGY 2.4:</p> <p>Increase affordable, accessible housing options and expand home modifications to enable individuals who need LTSS to remain in or return to their homes.</p>
<p>GOAL:</p> <p>Enable individuals needing LTSS to maximize their level of independence and live as safely and independently as possible.</p>
<p>PROPOSED IMPLEMENTATION ACTIVITIES:</p> <ol style="list-style-type: none"> 1. Improve the home modification program to help address difficulties with individuals remaining in or returning to their homes by taking the following actions: <ol style="list-style-type: none"> a. Include home modifications as a covered service in all MA HCB services waivers and under Act 150. (See also Proposed Strategy 1.2.) b. Re-establish regional Construction Officers to monitor and assure home

- modification projects paid for with MA and Commonwealth funding are designed and completed appropriately.
- c. Create mechanisms to allow progress payments for home modifications, work and materials while projects are completed and to reimburse for home modifications prior to an individual’s discharge from a post-acute setting. (See notes.)
 - d. Improve the timeliness of the MA waiver home modification approval process.
 - e. Establish linkages with programs, such as Habitat for Humanity, to assist with home modifications in order to allow more individuals to “age in place.” (See also Proposed Strategies 1.1 and 4.1.)
2. Make MA HCB services available in additional settings to the extent permissible under federal law and regulations:
 - a. Allow for MA HCB services to be provided in Assisted Living Residences and other allowable settings.
 - b. Add and promote the use of Family Group (Shared) Living as a covered service in MA HCB programs.
 3. Identify mechanisms and sources to provide increased financial support of \$10 per day to personal care homes and to expand the Housing Trust Fund. (See also Proposed Strategy 4.3.)
 4. Charge the Pennsylvania Housing Finance Agency (PHFA), the Pennsylvania Department of Aging or other appropriate state agency with evaluating the cost/benefits of emerging housing options, such as “Green Houses,” “naturally occurring retirement communities,” single family and multi-family limited equity partnerships, cooperatives, safe havens, and Fairweather Lodges, and assess each setting for access to available funding streams.
 5. Take appropriate measures to promote increased collaboration among PHFA, the Department of Economic and Community Development, public housing, and private developers/landlords to maximize the availability of and access to low income accessible housing options for individuals transitioning out of long-term care facilities, including expanding the use of “targeted transitional housing priorities” and the Keystone Renovate and Repair program.

RATIONALE:

Individuals in need of or receiving LTSS need increased housing options in order to maximize their ability to live safely in the community. Currently, there are insufficient resources available, and, as a result, limited choices for individuals who have a housing barrier or a need/desire move to another appropriate community care setting.

PROS:

1. Improved consumer choice and control
2. More cost effective provision of services over the long term
3. Strengthened housing stock in Pennsylvania
4. Creation of an acceptable housing related “spend down”—allowing

CONS:

1. Insufficient financial resources to implement due to initial costs although could save money in the long term. (budget neutrality over time)
2. Getting appropriate affordable home modification expertise
3. Insufficient state staff resources to

<p>private funds to off-set additional costs</p> <p>5. Increased housing options for HCB services recipients</p>	<p>develop the program.</p> <p>4. Additional costs for existing programs to meet the new CMS definition of a Community setting</p>
<p>MEASURABLE OUTCOMES:</p> <ol style="list-style-type: none"> 1. Percent of HCB services waivers and other state programs that cover home modifications 2. Number of individuals served in Assisted Living Residences receiving waiver services 3. Number of individuals served in Family Group (Shared Living) homes in the waivers 4. Number and capacity of Family Group (Shared Living) homes. 5. Percent change in the number of nursing facility long-term care bed days 6. Percent of personal care home beds that are open for SSI recipients 7. Percent change in the number of facilities that accept day one SSI 	
<p>ANTICIPATED COSTS OR BUDGET IMPACT:</p> <p>Fiscal impact is High due to the cost of increasing reimbursement to personal care homes and increased funding to the Housing Trust Fund.</p>	
<p>PROPOSED IMPLEMENTATION TIMELINE:</p>	
<p>Timeframe</p>	<p>Activity</p>
<p>January 2015</p>	<p>Submit application to amend all waivers to include home modifications and assisted living, and family group (shared) living</p>
<p>Spring 2015</p>	<p>Establish a mechanism to provide home modification technical assistance and training for all waiver providers</p>
<p>February 2015</p>	<p>FY 2015/2016 Governor’s budget proposal includes identified LTCC initiatives.</p>
<p>July 2015</p>	<p>Establish a work group through PHFA to expand home modifications through other non-profit organizations (Habitat for Humanity, Housing Trust Fund), additional efforts with transitional housing prioritization and the exploration and fostering of Housing alternatives</p>
<p>July 2015</p>	<p>FY 2016/2017 budget signed into law, which includes necessary funding for HCB services waiver expenditures and other costs recommended by the Long-Term Care Commission</p>
<p>NOTES:</p> <p>Because of federal restrictions that limit payments to when a home modification is completed and only pay for home modifications when a consumer is not in an inpatient setting, alternative state funding sources are necessary to make payments for home modifications as phases are completed and to pay for home modifications for individuals who are hospitalized or in another inpatient setting.</p>	

The Housing Trust Fund, which was established by the PA Legislature in 2011, is administered by PHFA and was initially partially funded through revenues from Marcellus Shale impact fees. It provides a flexible source of funding of at least \$5 million annually to address a range of affordable housing issues, including the development of new affordable homes, repair of existing homes, and foreclosure/homeless prevention programs, but only in counties with shale wells, currently 37 of PA's 67 counties.

PROPOSED STRATEGY 2.5:

Take appropriate actions to ensure unpaid caregivers' good health and well-being by tailoring interventions to prevent the adverse health effects of caregiving.

GOAL:

Enhance services provided to unpaid caregivers to enable them to support LTSS clients in the community.

PROPOSED IMPLEMENTATION ACTIVITIES:

Take the following actions to promote unpaid caregivers' good health and well-being to ensure and maintain their critical role in the LTSS delivery system:

1. Develop and utilize a risk assessment tool to identify caregivers at highest risk for adverse health outcomes.
2. Encourage unpaid caregivers to take advantage of Medicare/Medicaid wellness checks already available.
3. Encourage coverage for respite care under long-term care (LTC) insurance plans, and integrate education regarding respite care insurance benefits into the APPRISE Program.
4. Address safety issues with home assessments and alterations as well as patient monitoring devices and assistive technology.
5. Address self-care and preventive health behaviors of unpaid caregivers via education, monitoring, personal health records and facilitating access to primary health care services.
6. Provide support to assist unpaid caregivers navigate needed resources and connect with support groups through the PA LINK. Such resources may provide instrumental assistance, information, and peer support.
7. Help with depression and distress by providing assistance with care coordination and counseling offered through the Family Caregiver Support Program. Explore and implement, where feasible, alternative approaches including: teaching relaxation techniques, scheduling pleasant events for caregivers to attend, treatment of prolonged grief, and coaching on transitioning to new and from previous roles.
8. Provide respite, voluntary education and counseling opportunities, and other supportive services to caregivers.

RATIONALE:

Most LTSS in Pennsylvania are provided by unpaid caregivers. If the LTSS delivery system is to function effectively and be sustainable now and in the future, measures must be taken to improve health related quality of life for unpaid caregivers, and to delay, mitigate or prevent the adverse health effects of caregiving on them. Particular focus should be on those caregivers at highest risk for adverse health outcomes. (See notes below).

<p>PROS:</p> <ol style="list-style-type: none"> 1. Promoting caregiver well-being enhances health related quality of life, thereby reducing pressures on the already stretched professional resources available. 2. Maintaining or enhancing caregiver health helps to improve the quality of care that caregivers themselves are able to provide their loved ones. 3. Maintaining or enhancing caregiver health prevents caregivers from developing health issues or becoming patients as a result of stressors of caregiving. 	<p>CONS:</p> <ol style="list-style-type: none"> 1. Unwillingness of some caregivers to participate in health and wellness programs, in part because of reluctance to take time away from care recipients. 2. Insufficient provider staffing and financial resources to support caregiver initiatives.
<p>MEASURABLE OUTCOMES:</p> <ol style="list-style-type: none"> 1. Caregiver satisfaction including increased rate of satisfaction with quality of life. 2. Development of a risk assessment tool and percentage of providers who use the tool. 3. Improved caregiver health related quality of life. 4. Increased access and utilization of services by caregivers. 5. Decreased rate of nursing facility placement. 	
<p>ANTICIPATED COSTS OR BUDGET IMPACT: The estimated fiscal impact of this proposed strategy is Low and attributable to staff time to develop an assessment tool and assist with educational efforts..</p>	
<p>PROPOSED IMPLEMENTATION TIMELINE: Approximately 3 years (need detailed time table if adopted)</p>	
<p>Notes: Caregivers at highest risk for adverse health outcomes include those providing high levels of care, those with lower income, those who live with the care recipient (adult or child), those who have less education (high school or less), those who have had no choice in taking on caregiving duties, who show impaired self-care and health behaviors, have low levels of social support, experience care-recipient problem behaviors, and who face high levels of stress/depressions/anxiety.</p>	

PROPOSED STRATEGY 2.6:

Pursue a multi-step strategy to eliminate DCW shortages and turnover, beginning with the enactment of legislation establishing a voluntary statewide DCW certification program for DCWs in all long-term service settings.

GOAL:

Elevate the profession of DCWs by facilitating a career ladder for DCWs in all long-term service settings

PROPOSED IMPLEMENTATION ACTIVITIES:

1. Establish a Curriculum Steering Committee composed of trainers, providers and DCW advocates to review current DCW training, including past efforts such as the Robert Wood Johnson Foundation’s Better Jobs Better Care initiative, and develop a state core curriculum.
2. Introduce legislation to adopt the Pennsylvania Direct Care Worker Certification Program.
3. Ensure training is consumer-centered and financially feasible to provider organizations and affordable to DCWs.
4. Develop an incentive for high volume MA providers and DCWs to have DCWs certified by offering a higher MA reimbursement for those agencies with 60% or more certified DCWs.
5. Investigate how DCW wages and benefits could be improved. (See also Proposed Strategy 4.3.)
6. Investigate other ways to address the DCW shortage, including technology use, shared living arrangements and changes to the scope of practice to permit nurse delegation or other alternatives to nurse delegation, and expansion of the DHS medication administration program. (See Proposed Strategy 1.2.)

RATIONALE:

Addressing the DCW shortage, high turnover rate, insufficient training and inadequate wages is key to the success of Pennsylvania’s LTSS delivery system. For the past decade, the government has attempted to deal with these issues through various initiatives including the Department of Aging’s DCW Incentive Funds, the Department of Labor and Industry’s Center for Health Careers, and the Robert Wood Johnson Foundation’s Better Jobs Better Care State Grant program. There have also been studies conducted by Penn State University and the University of Pittsburgh quantifying the vacancies and turnover rates of LTSS provider organizations. However, the problems are longstanding and remain unsolved.

To effectively address them, a multi-step strategy must be pursued, beginning with one standardized curriculum for all DCWs, followed by a needs assessment of consumers to determine if “advanced” certificates would be useful in meeting the needs of consumers and families. Advanced certifications could include Medication Assistance and Alzheimer’s Care. If found useful, these certifications may also serve to establish a career ladder for the DCW profession.

<p>PROS:</p> <ol style="list-style-type: none"> 1. Establishes a “baseline” training for DCWs, no matter what LTSS setting. 2. Does not create an unfunded mandate - the training would be voluntary but incentivized due to the higher MA reimbursement. 3. Promotes a better trained and qualified DCW workforce. 	<p>CONS:</p> <ol style="list-style-type: none"> 1. Budget constraints may initially limit the ability to increase rates to DCWs or to adequately incentivize service providers to support the certification of workers. 2. May be opposed by consumer-directed consumers who believe they should perform the training.
<p>MEASURABLE OUTCOMES:</p> <ol style="list-style-type: none"> 1. Curriculum Committee Appointed 2. Use of comments received from provider to help construct curriculum 3. Adoption of state certification for all DCWs 4. Incentive payments in place for providers and DCW 5. Number of DCW certified 6. Number of provider and DCW receiving incentive payments 7. Reduction in turnover rate 	
<p>ANTICIPATED COSTS OR BUDGET IMPACT: Fiscal impact is High due to incentives and wage costs.</p>	
<p>PROPOSED IMPLEMENTATION TIMELINE: The Commission did not propose an implementation timeline.</p>	
<p>Notes:</p>	

RECOMMENDATION 3 – IMPROVE QUALITY AND OUTCOMES IN THE LTSS SYSTEM

<p>PROPOSED STRATEGY 3.1: Adopt an existing or develop a new single uniform assessment tool by September 30, 2015 that collects comparable data elements at specified intervals for all LTSS consumers in all Commonwealth-funded LTSS settings.</p>
<p>GOAL: Enable the ongoing comparison of consumers’ health and functional status, service needs, costs, and other related data elements to ensure economic efficiency, consistency, and improvement across all LTSS programs.</p>
<p>PROPOSED IMPLEMENTATION ACTIVITIES:</p> <ol style="list-style-type: none"> 1. Review changes to Pennsylvania’s assessment and monitoring tools made in connection with the BIP. 2. Designate an existing advisory committee (or form a new advisory group, if necessary) to obtain stakeholder input and ensure that LTSS participants are included as an integral focus in tool development.

3. Research federal data requirements and existing LTSS metrics used in other states.
4. Develop and validate a tool to collect valuable LTSS metrics on outcomes and person-centered experience, employing data driven decisions to ensure the best use of available resources.
5. Once the tool is validated, require its use upon initiation of services, and at comparable intervals while the consumer is receiving services, including any time that there is a change in the consumer’s care needs (e.g., as currently specified by the MA program for nursing facilities).
6. Pilot the tool in designated geographic areas before implementing statewide.
7. Use the data gathered from the tool to review LTSS program efficacy and economic sustainability, both periodically and over an extended period of time. Integrate information into the RHF. (See Proposed Strategy 2.2.)
8. Monitor and modify the tool as necessary to address any problems or issues and to ensure consistency with federal requirements, including changes made as a result of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which requires the recording and use of standardized data for post-acute providers in order to improve payment methodologies, improve care delivery and base care planning on measurable data.

RATIONALE:

Currently, data does not transfer from one system to another, resulting in potential duplication of effort. Comparable data is essential for development of an effective and efficient LTSS delivery system. Assessing individuals timely and effectively and understanding their individual care needs can help to eliminate unnecessary services and reduce the costs of necessary services.

The collection and use of comparable data is consistent with Section 1057.2 (3.2) of the Public Welfare Code which specifies:

All individuals receiving services under the home and community based waivers shall have a comprehensive assessment of their needs using a tool that provides comparable data elements and at comparable time intervals as specified by the State for Medicaid for nursing facilities.

PROS:

1. Promotes better decision making.
2. Facilitates consumer choice.
3. Ensures more uniform access to LTSS.
4. Fosters improved quality assurance.
5. Could be utilized for MCO, Accountable Care Organization or shared savings models.

CONS:

1. Crosswalk with federal requirements may be a challenge.
2. Costs associated with the development, training and administration.
3. Data sets need to be developed.

MEASURABLE OUTCOMES:

1. Percent of providers and consumers with online access to assessment data.
2. Percent of care plans where services match identified level of need as measured through a random sampling.
3. Use of measurements and monitoring sets in quality improvement program.
4. Percent increase in number of individuals receiving LTSS.
5. Percent of beneficiaries receiving initial assessments using tools in each care setting.
6. Percent of beneficiaries receiving assessments at different intervals using tools.
7. Longitudinal decreases in nursing facility acute care costs and emergency department admissions from better tracking and monitoring.

ANTICIPATED COSTS OR BUDGET IMPACT:

Fiscal impact is Medium due to costs associated with developing the tool, training, oversight, and quality assurance. Any increased costs may be covered, in part, under the BIP.

PROPOSED IMPLEMENTATION TIMELINE:

The Commission did not propose an implementation timeline.

Notes:**PROPOSED STRATEGY 3.2:**

Promote and incentivize the adoption of Health Information Exchange (HIE) and Electronic Health Record (EHR) and other care management systems to enable the electronic transfer of consumer health and service data among individuals, family caregivers, and providers in the LTSS delivery system.

GOAL:

Establish a complete and appropriately accessible single source of information for all LTSS consumer health status, treatment, and assessment information in order to support improved provider and participant monitoring based on outcomes, process, utilization of services and participant/family experience.

PROPOSED IMPLEMENTATION ACTIVITIES:

1. Include LTSS providers in HIE and EHR initiatives in order to help providers use technology more effectively, to connect and integrate providers at all levels within the healthcare and LTSS delivery systems, and to share information among providers, individuals and family caregivers across care settings (with hierarchical levels of access as necessary to meet applicable privacy and security requirements).
2. Ensure that LTSS EHR initiatives allow consumers to “opt out” and the initiatives comply with all applicable federal and state privacy and security requirements, including consumer’s rights to request corrections to and restrict of the use of his or her protected health information.
3. Adopt systems which make health assessment and care planning information, including

- discharge plan information, accessible electronically and in a timely manner to providers and service agencies in order to facilitate access to care and enable the creation of reports to track quality, access, and satisfaction with LTSS, telemedicine, and care coordination services.
4. Explore the possibility of using an existing Pennsylvania entity (e.g., the data warehouse or the Pennsylvania Health Care Cost Containment Council) to collect data from different sources, and make them accessible to different levels of providers using a single portal.
 5. Coordinate, align with and leverage resources of existing technology initiatives including BIP level 1 screening, the state’s Coordinated Health Information Technology (HIT) Plan, and the E-Health Partnership Authority, to include and target LTSS providers as recipients of EHR incentives.
 6. Work with the US Department of Veterans Affairs (VA) and the Pennsylvania Department of Military and Veterans Affairs (DMVA) to integrate data to coordinate and enhance services to Pennsylvania’s veterans, incorporate VA-provided and DMVA LTSS utilization into Pennsylvania’s longitudinal RHF, and to share and incorporate Pennsylvania service and assessment data on enrolled veterans in the Veterans Health Administration (VHA) into VA’s RHF.

RATIONALE:

The creation of a single source of information and records for health assessments, treatment history and service delivery regardless of point of access to the LTSS system will facilitate consumers’ timely access to primary, acute and LTSS services. Greater integration of community and facility assessment and treatment information supports a person-centered approach to measure quality, cost effectiveness and satisfaction with the care/services received. Accessibility and connectivity will improve the timeliness of eligibility determinations; assist providers at all levels creating and implementing treatment/service plans; support community-based and other LTSS service providers in a fiscally responsible and efficient system while aggregating data for longitudinal tracking and analysis.

PROS:

1. Improves timeliness of care. (streamline process)
2. Provides a total client view of information which improves person directed care outcomes.
3. Enhances the ability to measure quality and outcomes.
4. Prevents duplication of services and delays in implementation of care/service plans regardless of setting.

CONS:

1. Current HIE is fragmented and hospital based — must find a way to allow non-hospital system based providers to access.
2. Cost of integration at the LTSS provider level is not funded.
3. Development is dependent on temporary grant funding — HIE.
4. Need to develop business rules to protect data integrity and control levels of access and protect recipient privacy.

MEASURABLE OUTCOMES:

1. Percent of HCB services waiver providers that connect to portal or HIE.
2. Percent of LTSS providers that connect to portal or HIE.
3. Percent decrease in time to access services once LTSS is confirmed.
4. Longitudinal decrease in admissions from LTSS setting to hospital setting.

ANTICIPATED COSTS OR BUDGET IMPACT:

Fiscal impact is Medium. The cost to acquire EHR technology is not included in the estimated fiscal impact of this proposed strategy.

1. There will be costs to assist in training and efficiency improvements once the EHR is purchased.
2. There will be costs to develop, implement, and maintain program.
3. There will be costs associated with provider incentives to purchase technology.

PROPOSED IMPLEMENTATION TIMELINE:**Notes:****RECOMMENDATION 4 – MAKE THE LTSS SYSTEM MORE FISCALLY SUSTAINABLE****PROPOSED STRATEGY 4.1:**

Adopt policies to assure that the greatest numbers of individuals eligible for publicly funded LTSS receive needed services in the safest, most appropriate, least restrictive, and cost effective setting possible. The policies should take into account consumer choice, federal health and welfare assurance requirements, costs, the US Supreme Court’s Olmstead decision, the limited amount of available MA and other state and federal resources.

As part of this effort, review Pennsylvania’s Nursing Home Transition (NHT) and Money Follows the Person (MFP) programs and implement changes, if necessary, to make them more person-centered and timely to support the long-term sustainability of the LTSS program.

GOAL:

1. Serve the greatest number of adults in need of LTSS in the safest, most appropriate, least restrictive, and cost effective setting possible.
2. Increase consumer choice among LTSS services.
3. Apply best practices (both in-state and out-of-state) to the NHT and MFP programs.
4. Improve identification of individuals for NHT.

PROPOSED IMPLEMENTATION ACTIVITIES:

1. Establish a broad stakeholder group to assist in developing guidelines that incorporate consumer choice, fiscal accountability, and consumer safety in determining appropriate

care settings.

2. Consider both costs and consumer choice in determining the most appropriate care setting.
3. Develop a common assessment tool(s) that facilitates the development of an initial service plan and identifies the most cost effective setting. (See also Proposed Strategy 3.1.)
4. Develop programs and resources to identify individuals at risk who are or should be utilizing LTSS. This effort should not be limited to existing programs, but should include gathering information/data from individuals currently receiving services through senior centers, those ineligible for Options or HCB services, or those receiving services through the Healthy PA Private Coverage Option.
5. Assess consumer ability to access home modifications necessary to remain at or return home. (See also Proposed Strategy 2.3.)
6. Improve the NHT and MFP programs.
 - a. Review other states' programs that have resulted in higher transition rates and identify best practices.
 - b. Do a barrier/gap analysis of the current NHT and MFP programs.
 - i. Determine necessary program and operational changes.
 - ii. Make necessary modifications to waivers.
 - c. Create greater incentives and disincentives for NHT providers and nursing facility providers.
 - d. Review the current NHT identification tool, compare it with other tools, and make necessary revisions that result in better identification of the potential NHT population.
 - e. Collaborate with consumers, NHT partners and nursing facilities and coordinate with the efforts of the BIP.
7. Incorporate this proposed strategy and related implementation activities in the development of the demonstration, but do not delay implementation based on the demonstration. (See also Proposed Strategy 1.1.)
8. Consolidate, review, modify as necessary, and routinely evaluate and update Pennsylvania's Olmstead Plan for LTSS services.
9. Streamline eligibility for all care settings and assure that all individuals applying for or receiving LTSS are treated the same under the MA Program with respect to financial eligibility, "spend down", and retroactive payment of providers. (See also Proposed Strategy 1.2.)
10. Implement education on the existing Long-Term Care Partnership Program to increase understanding of LTSS costs and promote the purchase of private long-term care insurance to help prevent individuals from entering the MA program. (See also Proposed Strategy 2.2.)

RATIONALE:

The number of Pennsylvanian receiving LTSS is expected to grow; however there are and will continue to be limited state and federal resources available to support the services they need. Pennsylvania must ensure that those resources are used as efficiently as possible in a manner consistent with law (including the US Supreme Court's Olmstead decision) and that LTSS

services are delivered in the safest, most appropriate, least restrictive, and cost effective setting possible. Pennsylvania has transitioned more than 10,000 individuals from nursing facilities since 2006 and has learned lessons on how to assist individuals and their families in the transition process. Pennsylvania’s LTSS consumers could benefit from reviewing the current NHT and MFP programs, identifying and addressing barriers, and applying best practices to ensure the maximum number of individuals are receiving services in the PA LTSS system. The effort should be done in conjunction with BIP and not create another silo.

<p>PROS:</p> <ol style="list-style-type: none"> 1. Develop an LTSS system that is more sustainable. 2. Improve ability of individuals to be served in the community rather than institutional locations. 3. Increase the number people served by using resources more efficiently. 	<p>CONS:</p> <ol style="list-style-type: none"> 1. Costs related to services not currently covered under all waivers such as home modifications and system and operational changes.
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<p>MEASURABLE OUTCOMES:</p> <ol style="list-style-type: none"> 1. Per capita nursing facility days. 2. Per capita expenditures on LTSS services. 3. Per capita nursing facility transitions. 4. Per capita nursing facility transition targets. 5. Consumer satisfaction. 6. Provider satisfaction. 7. Timeliness of transitions. 8. Percent of “potentially transitionable” residents transitioned.

<p>ANTICIPATED COSTS OR BUDGET IMPACT:</p> <p>Fiscal impact is Low and attributable to resources to develop assessment tools and staff time to support other activities. While costs may be incurred to address NHT barriers or implementing best practices, it is assumed that those costs will be offset from reduced expenditures.</p>
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<p>PROPOSED IMPLEMENTATION TIMELINE:</p> <p>3/1/15 to 3/1/16 – Do research, stakeholder input, and develop recommendations related to NHT and maximizing the number of individuals served.</p> <p>7/1/16 – Any necessary legislative and budgetary changes approved.</p> <p>9/30/16 – Submit necessary waiver amendments.</p>
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<p>NOTES: Investigate how other states have implemented nursing facility rightsizing programs. Any review and discussion related to NHT reimbursement methodology should be incorporated into the recommendation on reviewing LTSS reimbursement. The person-centered choice should be a true choice between receiving services in the community and the nursing facility if the individual so chooses. (See Proposed Strategy 1.1.)</p>

<p>PROPOSED STRATEGY 4.2: Seek legislative authority to allow DHS, subject to appropriate parameters, to easily and quickly transfer funding among the five LTSS line items – Long-Term Care, Home and Community Based Services, Long-Term Care Managed Care, Services to Persons with Disabilities and Attendant Care – when unspent funds are projected within a fiscal year.</p>	
<p>GOAL: Use the Commonwealth’s limited financial resources in an economically responsible manner by providing greater flexibility so that funds do not go unspent within a fiscal year due to the silo funding that occurs by having five separate line items in the annual Appropriations Act.</p>	
<p>PROPOSED IMPLEMENTATION ACTIVITIES:</p> <ol style="list-style-type: none"> 1. Draft appropriation act language, similar to the Children’s Health Insurance Program (CHIP) language, HB 2328 of 2014, (i.e. Act 1A) that allows funding to be transferred from the Department of Insurance to DHS for CHIP enrollees. (See CHIP language in note section.) 2. Obtain the necessary support from the Administration, stakeholders and the Legislature. 3. Ensure that related laws/regulations governing particular funds would be strictly followed (e.g., Lottery funds would only be used to provide services to older Pennsylvanians; nursing facility assessment funds would only be used for payments to nursing facilities). 	
<p>RATIONALE: Increased flexibility in the use of appropriated funds could allow LTSS to be provided to more individuals with needs and would support the demonstration discussed in Proposed Strategy 1.1. Currently if one OLTL line item in the enacted budget has funds available and others have expended all appropriated funds, the unused funds cannot be transferred from the first to the others. Under the current process, a supplemental appropriation act is required to adjust funding from one line item to another. This typically occurs at the end of the fiscal year. Pending enactment of the supplemental appropriations, however, actions may be needed to ensure that expenditures do not exceed appropriated amounts, including closing intake and instituting waiting lists for one or more programs, imposing service caps, per person caps or cuts to provider payments.</p>	
<p>PROS:</p> <ol style="list-style-type: none"> 1. Provides greater flexibility in utilizing funds to serve the greatest number of persons with LTC needs. 2. Minimizes the need for wait lists, service or person caps or provider rate cuts. 	<p>CONS:</p> <ol style="list-style-type: none"> 1. Legislators need to agree to the language providing flexibility. 2. Providers may not feel that they are getting their “share” of the funds.
<p>MEASURABLE OUTCOMES: Increase in number of individuals receiving LTSS.</p>	
<p>ANTICIPATED COSTS OR BUDGET IMPACT: Fiscal impact is No Cost – Budget Neutral.</p>	

PROPOSED IMPLEMENTATION TIMELINE:

FY15-16

NOTES:

The funding would continue to be monitored by program. Implementing this recommendation would allow flexibility in use of funds so all of the money is spent and a greater number of participants are able to be served. DHS would be required to ensure that any funds with legal or regulatory constraints are only used for their designated purpose.

The following language is included at the request of the workgroup to highlight concept and does not indicate consensus that this is the language that should be used. The actual language used to implement this recommendation would be developed by the Administration and Legislature in consultation with stakeholders, and would outline the conditions under which such flexibility to move funding between line items would be authorized. Those conditions would include, but not be limited to, thresholds for under-spending which would trigger ability to transfer funds, legislative input, and timing.

CHIP HB 2328 of 2014, i.e. Act 1A...

Section 2111. Transfer of funds from Insurance Department to Department of Public Welfare.

The Insurance Department, upon approval of the Secretary of the Budget, may make such transfers of funds from the State Appropriation for Children's Health Insurance to the Department of Public Welfare for the purpose of augmenting the State Appropriations for MA payments – capitation plans, MA -- outpatient and MA payments -- inpatient, provided that any such transfer will not result in a deficit in the appropriation from which the funds are transferred. The Secretary of the Budget shall provide ten days' prior notification of any such transfers to the chairman and minority chairman of the Appropriations Committee of the senate and the chairman and minority chairman of the appropriations committee of the House of Representatives.

PROPOSED STRATEGY 4.3:

Undertake a comprehensive review of the current LTSS rate setting and reimbursement systems for all LTSS providers, including personal care homes and DCWs. Make modifications, as necessary, to ensure that: (i) providers receive payments and appropriate incentives that are sufficient to assure adequate access to quality LTSS; and (ii) LTSS rate setting and reimbursement systems are market-driven, efficient and economically sound, fiscally accountable and sustainable over time. The recommendations should be considered in the development of the demonstration. (See also Proposed Strategy 1.1.)

GOAL:

1. Ensure that there is adequate LTSS provider capacity in Pennsylvania.
2. Support and enhance the ability of consumers to choose how and where they receive LTSS as well as ensure that they are served in the safest, most appropriate, least restrictive, and cost effective setting possible.
3. Ensure payments and reimbursement methodologies comply with applicable federal and state requirements.
4. Develop market driven reimbursement systems that address the full range of consumer and person-centered needs and provide incentives for providers who exceed regulations and/or policy directives.
5. Collate quality data used to calculate reimbursement incentives and develop a publically available consumer report card that includes information on available services, satisfaction, and health outcomes.

PROPOSED IMPLEMENTATION ACTIVITIES:

1. Undertake a comprehensive review of current LTSS reimbursement and incentive methodologies including existing MCO methodology.
 - a. Review other appropriate risk adjusted pay for performance criteria, and LTSS payment methodologies and rate setting processes across the nation.
 - b. Review current access to LTSS providers and services across the state.
 - c. Review and compare like services in other states and Commonwealth funded programs.
 - d. Use an independent agency to assess adequacy of wages, benefits and rate reimbursement for DCWs and implement increases which are consistent across all provider groups. (See also Proposed Strategy 2.2.)
 - e. Utilize the LTC Subcommittee and other stakeholder groups to review and make recommendations on methodologies.
 - f. Work with rate setting vendors to determine the impact of proposed changes.
 - g. Initiate any necessary regulatory changes.
 - h. Work with legislative leaders.
2. Develop quality measurement tools to help oversee LTSS programs.
 - a. Implement a standardized measurement tool to facilitate in provider accreditations and certification standards as appropriate.
 - b. Develop report card format to deliver information to the public and consumers in cases where they don't currently exist.

RATIONALE:

Pennsylvania is required to have provider reimbursement rates that are consistent with efficiency, economy, and quality of care and are sufficient to ensure access to necessary services. Currently there are multiple reimbursement methodologies, not all of which are market driven. Pennsylvania should undertake a rate review and develop incentives to ensure that payments are sufficient to provide access to the right level of services, at the right time, and that are coordinated with other types of care that address identified medical and social needs. In addition to the market driven financial incentives, Pennsylvania should identify other avenues that may allow for budget neutral provider rewards and increased consumer knowledge.

<p>PROS:</p> <ol style="list-style-type: none"> 1. Develop a LTSS system that is more sustainable and transparent. 2. Individuals can make better educated decisions about being served in the location of their choice. 3. Meet regulatory obligations. 4. More equitable reimbursement system. 	<p>CONS:</p> <ol style="list-style-type: none"> 1. Could result in shifts of reimbursement over provider types. 2. Associated costs and staff resources. 3. Time required for regulatory process. 4. Incentives could appear as reward for simply meeting standards.
<p>MEASURABLE OUTCOMES:</p> <ol style="list-style-type: none"> 1. Per capita expenditures on LTSS services by acuity. 2. Per capita LTSS costs by provider type and by acuity. 3. Consumer satisfaction. 4. Provider satisfaction. 5. Percent of LTSS eligible individuals who are receiving LTSS services. 6. Risk adjusted 5 year survival rate. 7. Risk adjusted length of time before institutionalization. 8. Risk adjusted hospitalizations and re-hospitalizations. 9. Risk adjusted long term institutionalization rate. 10. Percent of providers exceeding performance metrics. 11. Availability of consumer report card. 	
<p>ANTICIPATED COSTS OR BUDGET IMPACT:</p> <p>Fiscal impact is Low and related to staff and vendor costs associated with research, evaluating and recommending changes. If changes are recommended, there could be a cost impact if not designed to be budget neutral.</p>	
<p>PROPOSED IMPLEMENTATION TIMELINE:</p> <p>3/1/15 to 3/1/16 – Do research, stakeholder input, and develop recommendations.</p> <p>7/1/16 – Any necessary legislative and budgetary changes approved.</p> <p>9/30/16 – Submit necessary waiver and state plan amendments.</p>	
<p>NOTES:</p> <ol style="list-style-type: none"> 1. The review of the reimbursement system should include all LTSS providers including DCWs and personal care homes. 2. A transition rate methodology could be developed to lessen the fiscal impact to providers. 3. All payments should be considered, not just rate based payments. 4. Potential incentives could include relaxed monitoring/survey schedules if legally permissible. 5. Potential incentives should be assessed using research conducted in connection with the SIM application relating to payment model options associated with evolving delivery models such as APOs (e.g. Independence at Home), Patient Centered Medical Homes, Episodes of Care with Prospective Payment Systems, and Community Based Management Teams and could include shared savings between government, providers, and consumers. 	

Appendix 11 – Acronyms and Definitions

AAA – Area Agency on Aging

Pennsylvania's 52 Area Agencies on Aging (AAA) are a source of information for the issues and concerns affecting older people and their caregivers. They serve as local resources, providing person-centered information and assistance on issues and concerns affecting older individuals, their caregivers, and their service providers. They provide resources and assistance across the entire spectrum of services, including HCB services, care facilities, transportation, and a wide range of other public and non-governmental services.

ADL – Activities of Daily Living

The term refers to daily self-care activities such as bathing, dressing, self-feeding, mobility and personal hygiene, within an individual's place of residence, in outdoor environments, or both.

ADRD – Alzheimer's disease and related disorders

Refers to brain disorders that cause memory loss and other cognitive impairments.

APO – Accountable Provider Organization

Accountable Provider Organizations are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an APO succeeds in both delivering high-quality care and spending health care dollars more wisely, they will typically share in the savings achieved for the payor.

BIP – Balancing Incentive Program

This optional federal initiative offers states a higher federal match for implementing certain reforms and reaching a 50/50 balance between institutional and community based funding.

CFC Option – Community First Choice Option

An optional component of the Affordable Care Act, the CFC Option allows states to make personal assistance service a Medicaid State Plan service and, therefore, an

entitlement. States that elect this option will receive a 6% increase in federal matching for this service.

CIL – Center for Independent Living

The Rehabilitation Act of 1973 is the federal law which first authorized independent living centers and programs. Centers for Independent Living (CILs) are agencies where people with disabilities learn empowerment and develop the skills necessary to make lifestyle choices. Centers provide services and advocacy to promote the leadership, independence, and productivity of people with disabilities. Centers work with both individuals and with the local communities to remove barriers to independence and ensure equality of people with disabilities. There are 18 individual CILs throughout the Commonwealth serving all 67 counties.

CMS – Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services is a federal agency that administers Medicare, Medicaid and the Children’s Health Insurance Program (CHIP) in partnership with state governments. CMS also administers private health insurance programs, including Health Insurance Marketplaces, and provides information for health professionals, regional governments, and consumers. It is a branch of the US Department of Health & Human Services.

DCW – Direct Care Worker

A caregiver paid to provide certain services in the home and community setting.

DOH – Department of Health

The Department of Health is responsible for planning and coordinating health resources throughout the Commonwealth. It licenses and regulates a variety of health facilities, such as hospitals, nursing homes, ambulatory surgical facilities and other inpatient and outpatient facilities. In addition, the Department supports outreach, education, prevention and treatment services across a variety of program areas, and provides grants and subsidies to community-based groups to provide essential services.

DHS – Department of Human Services

The Department of Human Services oversees adoption services, child protection services, juvenile justice facilities, state hospitals, long-term care services and supports, early childhood education, child support, medical assistance, employment and training

services, mental health, and supports for individuals with physical and intellectual disabilities, among other things.

DMVA – Department of Military and Veterans Affairs

Pennsylvania's Department of Military and Veterans Affairs (DMVA) has a dual mission: to provide quality service to the Commonwealth's veterans and their families, and to oversee and support the members of the Pennsylvania National Guard (PNG). This is accomplished by providing resources and assistance to Pennsylvania's nearly one million veterans and their families, and providing quality care for aging and disabled veterans; and by preparing the PNG for combat, performing worldwide combat and combat support operations, providing global reach and the projection of U.S. military power in support of national objectives; and, at the command of the governor, providing trained personnel to support state and local authorities in times of natural disaster or civil strife.

ElderPAC – Elder Partnership for All-Inclusive Care

ElderPAC combines community based LTSS through the Philadelphia Corporation on Aging with medical services through the In Home Primary Care Program at the University of Pennsylvania Health System.

EHR – Electronic Health Record

An electronic health record contains information from clinicians involved in a patient's care. All authorized clinicians involved in a patient's care can access the information to provide coordinated care to that patient. EHRs also share information with other health care providers, such as laboratories and specialists. EHRs follow patients to the specialist, the hospital, the nursing home, or even across the country.

Fairweather Lodge

The Fairweather Lodge is a research driven recovery-oriented housing model for persons with mental illness. The model consists of shared housing and shared employment for persons with mental illness. Its goal is to provide emotional support, a place to live, and employment for its members. The program was developed by Dr. George Fairweather in California in 1963 as a result of extensive experimental research.

FFS – Fee-for-Service

The Pennsylvania Medicaid program uses two service delivery models: fee-for-service (FFS) and HealthChoices managed care. In the FFS delivery model, health care providers are paid for each service (e.g. office visit, diagnostic test, or procedure).

Green Houses

The Green House Project has an innovative nursing care model, which offers an alternative approach to the traditional nursing home. Green House homes are unique in their small size with 10 to 12 residents, use of a staffing model that provides more direct interaction, and a home-like layout.

HealthChoices

The HealthChoices Program is the name of Pennsylvania's mandatory managed care program for MA recipients.

Through Physical Health Managed Care Organizations, recipients receive quality medical care and timely access to all appropriate physical health services, whether the services are delivered on an inpatient or outpatient basis. Through Behavioral Health Managed Care Organizations, recipients receive quality behavioral health care and timely access to appropriate mental health and/or substance abuse services.

HCBS – Home and Community Based Services

Home and community based services are also known as Waiver-Funded Services or Waiver Programs. The term "waiver" comes from the federal government "waiving" MA rules for institutional care in order for Pennsylvania to use the funds for HCB services. HCB services provide for supports and services beyond those covered by the MA program, which enable a person to remain in a community setting rather than being admitted to a long-term care facility. There are 6 HCB service programs that serve older adults and adults with physical disabilities. Each HCB service program has its own eligibility requirements and services.

HIE – Health Information Exchange

An electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers, and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care.

IAH – Independence at Home

A Medicare demonstration program that provides chronically ill patients with a complete range of primary care services in the home setting. The program is tailored to

meet the needs of beneficiaries with multiple chronic conditions and functional limitations.

LIFE – Living Independence for the Elderly

Living Independence for the Elderly (LIFE) is a managed care program that provides a comprehensive all-inclusive package of medical and supportive services while leveraging adult day centers. The program is known nationally as the Program of All-Inclusive Care for the Elderly (PACE). All PACE providers in Pennsylvania include 'LIFE' in their name. LIFE provides an option that allows individuals age 55 and older to continue living on their own while receiving services and supports to meet their health and personal needs.

LTCC – Long-Term Care Commission

The Long-Term Care Commission was established by Executive Order 2014-01.

LTSS – Long-Term Services and Supports

Long-term services and supports include both HCB services and nursing facility services. A person who has a medical need for LTSS services may choose which program to participate in. If a person applies for medical assistance and payment of LTSS services, they must also meet the non-financial and financial MA eligibility requirements.

MA – Medical Assistance

Medical Assistance (also known as Medicaid) is Pennsylvania's state-administered health care program for people who have low incomes. MA pays many medical expenses, including physician's services, psychiatric services, nursing facility care, laboratory, clinic and x-ray services, hospitalization and more. Individuals must meet certain requirements for income, age, and medical conditions or disability. Special requirements exist for Medicare beneficiaries.

MCO – Managed Care Organization

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

MFP – Money Follows the Person

MFP is a federal initiative that uses the existing Nursing Home Transition Program to provide assistance to people who live in institutions so they can return to their own communities to live independently.

NORC – Naturally Occurring Retirement Community

A Naturally Occurring Retirement Community (NORC) is a geographic area that has a significant proportion of older people residing in a specific area or in housing that was not designed or planned with seniors in mind. The communities tend to take care of residents to help avoid hospital and nursing home placements and have supports that help to keep individuals healthy, independent, and socially active.

NHT – Nursing Home Transition

The Nursing Home Transition program was developed to assist and empower consumers who want to move from a nursing facility back to a home of their choice and help the Commonwealth rebalance its LTSS systems. The program assists individuals in moving out of institutions by eliminating barriers in service systems so that individuals receive services and supports in the settings of their choice.

OLTL – Office of Long-Term Living

The Office of Long-Term Living (OLTL) within DHS administers MA programs that provide long-term services and supports to older Pennsylvanians and adults with physical disabilities.

PACE – Program for the All Inclusive Care of the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a managed care model that uses an adult day care center as its service hub. PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, able to live safely in the community at the time of enrollment and live in a PACE service area. PACE providers deliver all needed medical and supportive services to seniors with chronic care needs.

PCMH – Person Centered Medical Home

Person Centered Medical Home is a health care delivery model based on each patient having a medical home, which serves as the central coordinator for the patient's medical care. The model emphasizes personal relationships, team delivery of care, coordination across specialties and settings of care, and quality improvement.

PDA – Pennsylvania Department of Aging

The Pennsylvania Department of Aging is the lead agency for the coordination of the Commonwealth's administration of federal and state programs for older Pennsylvanians. In addition to administering the Social Service Block Grant funding, the Department of Aging coordinates a comprehensive array of programs for older adults, their families, and their caregivers. These services include, but are not limited to, information and education on health and wellness issues; a wide range of state funded HCB services that allow older individuals to remain in their communities and homes; nutrition services; caregiver support programs; prescription drug assistance programs; programs for protection from abuse, neglect, abandonment, and exploitation; and advocacy programs to support and empower consumers in resolving concerns and complaints involving long-term care services.

R&R loan – Keystone Renovate and Repair Loan Program

The purpose of this program is to help prevent homeowners from becoming victims of unscrupulous lending practices, prioritize their home repair spending and improve Pennsylvania's aging housing stock for its current residents and future generations. R&R loans can be used to pay for repairs and improvements that increase the basic livability of the home, including additions and construction that makes the home safer, more energy efficient, or more accessible to people with disabilities or people who are elderly.

RHF – Residential History File

A data tool that summarizes information from Medicare and NF Minimum Data Set assessments to track people through health care locations, including non-Medicare paid nursing facility stays.

SCE – Service Coordination Entity

The Service Coordination Entity is responsible for developing the Individual Service Plan and informing the person of their options for selecting a service model.

SIM – State Innovation Model

The State Innovation Model is an innovation program offered by the Center for Medicare and Medicaid Innovation (CMMI), which provides support to states for the development and testing of state-based models for multi-payer payment and health care delivery system transformation. The goal is to improve health system performance for residents of participating states.

SSI – Supplemental Security Income

Supplemental Security Income is a Federal income supplement program funded by general tax revenues that provides cash to meet basic needs for food, clothing and shelter to aged, blind, and disabled people, who have little or no income.

VA – US Department of Veterans Affairs

The United States Department of Veterans Affairs (VA) is a government-run military veteran benefit system with Cabinet-level status. Its primary function is to support Veterans in their time after service by providing benefits and support.