Allison Park, PA

May 9, 2014 1:00 pm - 4:00 pm A.W.
Beattie Career Center, 9600 Babcock Boulevard

Alexander, David A

From: Brenda Dare [redacted]
Sent: Friday, May 09, 2014 2:42 PM
To: AI, LTC-Commission
Subject: Public hearing input: Brenda Dare

If you want to know why we need to change the way things are working in long term care, I'd like you to consider the stories of two people I work with very closely.

Dale is 55 he lived and worked with a seizure disorder successful for more than 15 years. He is a loving son, father, and brother. A serious fall three years ago means that he lies with a spinal cord injury that has taken so much more than just his ability to walk. In the three years since sustaining his injury, he hast truly suffered.
It isn't the adjustment to his injury that's difficult. It is surviving the secondary consequences of nursing home living. He's been in three different nursing facilities. He's survived a stage four decubitus ulcer that resulted in the removal of his coccyx. He contracted MRSA so severe that he couldn't have outside visitors for several weeks.

He'd be here today to tell you his story, but he's recovering from a bout of aspiratory pneumonia resulting from a life threatening bout of gastroparesis. This came about because of a disagreement over the medication the nursing home chose to administer over his request for one that had been effective for him in the past. Three months ago, Dale was health enough. To be discharged. The inability of the system to provide the modification he needs to get into his house. My job is to serve as his.nursing home transition specialist . The current system in place for home modification payment makes me seem more like a stagnation specialist. I implore you to find a way to allow home modification to happen in a timely manner. People are dying while they wait for bureaucrats to deal with ineffective processes and procedures.

The current. Catch 22 of not allowing any payment for modification until after transition is just as archaic as the arguments business owners make over not needing a ramp because no one with a wheelchair ever patronizes the business they own. You cannot LIVE in a place you are unable to enter.

I am a success story of how home and community based services. I've been an Act 150 consumer for a total of nearly 13 years. These services have allowed me to remain an integrated contributing member
of my community. However, I l live with the fear that these services
might be discontinued at any moment. I cannot imagine. Having to choose between remaining free in the community and keeping the job I love so much. Could any member of the commission imagine making the choice between the ability to work and the ability to get out of bed in the morning? Real quality of life means a life free from such unfathomable choices.

What about our future? Students who graduate college and cannot take the jobs they are offered because those jobs would mean they would lose the waiver services they need to live independently. What a black mark on a state that has some of the most vibrant people with diverse disabilities in the nation. Hundreds off thousands of dollars are spent to provide vocational rehabilitation to bright and engaging individuals. However, we are doing our state a disservice by forcing talented individuals to forgo entering the workforce in order to receive vital daily care supports. Is the state actively trying to
discourage people who need care from calling the Keystone state home?
That's not what I want for my home state. It shouldn't be what any of us are willing to accept.

--
Brenda Dare
NHT/IL Specialist

Comments for Long Term Care Commission

5-9-14

My name is Diane Cagey and I am the Program Director for the Attendant Care Program at CLASS - Community Living and Support Services in Allegheny County. We are a large Region 1 non-profit agency that is struggling to continue to provide Attendant Care and Residential services to 350 consumers who depend on us daily, as they have for many years. We have supported some of our residential folks since the mid 70's and in AC we have many that have been with us since 1997 when we assumed the contract. It is the mission of our agency to assist people to live with maximum independence and enjoy the same civil rights that we all want. We are in their homes 365 days a year, and sometimes around the clock.

High quality services to participants can only be accomplished with a qualified, trained and stable work force and a dedicated system of supervision and support. This cannot be accomplished without reasonable compensation to employers. On 6-1-12, OLTL decreased the reimbursement in Region 1 by almost $1.00 per hour for every hour of service provided. Our current rate is within pennies of the rate we had in 2005. Multiplied by about 430,000 hours of PAS service provided per year, this has been devastating to CLASS and, I am sure, many other agencies. Despite our best efforts to maintain a stable work force, there has also been an unfortunate impact on consumers. Many experienced and versatile employees left because of the rate reductions. They are being replaced with entry level workers who will accept the pay rate.

Agencies have hung on as long as they can. I fear that unless there is swift and fair action before the new fiscal year many of us will close shop. We have cut as far as we can. Our Board of Directors questions whether it is financially responsible to continue. This would have a devastating impact on some 350 participants and 400 workers in Allegheny County.

The severe rate cut threatens to impact every one of the key areas the LTCC is discussing. Fair compensation for this life-sustaining work is essential to maintain Access to Services, Quality Outcomes, Provider and Caregiver Support, and the very Provision of Services.

Prevention and Caregiver Support

- CLASS has been fortunate and unusual as an agency that has always health care to staff working 50% or more hours. In the past 2 years employees are paying more of their health coverage costs, wages have been frozen, 401K payments were suspended, overtime for employees who want it, has been eliminated. The result of this on consumers is more frequent changes in their daily attendants. Most people do not like a parade of changing faces in their homes. For persons with complex medical conditions, a caregiver who knows them well is vital to preventing hospital admissions and readmissions. The regular attendant will know their baseline and can quickly identify changes that are out of the ordinary and need medical attention. Identified early, many routine issues are treated at home before they develop into major medical issues.

- In the six months following the rate cut, CLASS saw a 56% increase in the number of requests for assistance with uncovered shifts that we received from other agencies (tracked by scheduling software). As time has gone on, agencies have been less willing to fill in for one another. There used to be about 15 agencies who would work very closely together to make sure participants had what they needed. Now there are two or three.
- The change in fiscal management has resulted in many caregivers being unpaid and incorrectly paid and there are long waits for new caregivers to be signed up. Services were much better and faster under the previous system. People got better service when the process was decentralized and it was no more expensive. Consumers and their attendants reported that they liked knowing who to call if they had a question. The new process to enroll is cumbersome. As a result of this change, 500 PA jobs were lost to other states.
- To avoid paying overtime, many agencies contact the SC agency when they have a call off instead of finding a way to replace the worker themselves. (Some SC agencies will take little action to help find a replacement– the consumer is just stuck.) This affects their support system, if they have one - family members, friends, neighbors, etc. Many of them are elderly, working, or simply not available to provide frequent assistance. Some individuals do not really have the informal supports they need, especially with the increased frequency they are needed. Backup caregivers get burned out or simply cannot regularly do this physical work. People are asked to be on call at a moments' notice regardless of what they may have planned in their life or job for the day.

Accessibility

- **Act 150 Program:** Because of the waiting list imposed in 2010, there is virtually no access to HCBS for those over income waiver limits. They can more easily get assistance by going to a nursing home. Many are at an income level where they cannot pay full freight, but need personal care assistance to get ready for work each day. People who need the service are limiting what they choose to do so they don't lose services. They have no other choice. PA was a LEADER in our nation by having this option available. This visionary service is now effectively lost. The waiting list has made this totally unavailable. Only people nearing age 60 seem to get enrolled.
- Because of the rates – especially in Region 1 – many companies consider Waiver clients to be their least desirable business. They lose money on these cases. Most are no longer interested in providing services to this group. While they may be on the list of providers, they limit the number of Waiver cases they will accept. They may also select those who are "easy to serve". Individuals with higher level needs, unusual hours, inaccessible locations, or those requiring workers with more advanced skills, are having difficulty finding providers.
- The IEB phone number and enrollment process is not well publicized or well known. Consumers get incorrect information when they call. They are told they are ineligible on the phone without notice of right to appeal. There is no transparency. Consumers feel they have no advocate; the IEB won't talk to agencies that consumers call for help.

Provision of Services

- As waivers become more streamlined, opportunities for individual choice decline, as the system implements protective and paternalistic measures to protect the more vulnerable in the group. ACW/Act 150 consumers have less control over decisions that are made as waivers maintain control of decisions, daily routines, etc. The ACW/Act 150 offer a high degree of personal choice that must be preserved.
- Approvals for minor schedule changes by Case Managers or other 3rd parties, creates scheduling nightmares for providers. Consumers and providers must have the freedom to make reasonable changes so people can pursue family activities, employment, etc.
- It is important (if our system moves toward Managed Care) that providers with knowledge and expertise in issues related to disability, not just aging issues or the medical model of services, are included as the system is designed.
- The current system is more fragmented with the separation of PAS and SC agencies. Participants often do not know who to call for what they need. Staff members have more difficulty communicating freely. Everything takes more time to accomplish.

Quality Outcomes And Measurement

- Quality is being measured by paper and numbers. No one is visiting or talking to consumers, family members, attendants, about quality. Written surveys do not capture all elements of satisfaction and quality like a personal visit could do.
- Region 1 rates are a serious barrier to quality service. Agencies cannot hire or keep attendants, there is too much turnover, and there is no allowance for any training. Rates don't allow for cost of living increases, pay differentials for holidays or cases with higher complexity/skill needs, weekends, or the early/late shifts that working people need.
- Countless attendants (even those with great experience) will not even apply because they can make more money in other jobs, like going door to door to get petitions signed – jobs with better hours, requiring much less knowledge, dedication, physical and mental stress. Consumers are being denied quality workers by the current rates.
- Please consider paperwork reduction for whole process. People who are qualified and want to provide services are chained to computers. Prescribed language that review teams like to see does not capture what is actually happening to people. Wording requirements make authorizations sound like cookie-cutter documents, in stead of focusing on the uniqueness of each person. When certain phrases are required, much information is missed.

Recommendation: To address many of the current struggles all rates statewide should be set at Mercer's mid-range and Region 1 should be further increased to be brought in line with Regions 2 & 3.

	2011*	July 2012 - Current		Mercer Recommended Range		Mid-range of Mercer
			Difference	Low	High	
Region 1	$ 18.08	$ 17.16	(.92)	$ 17.16	$ 21.36	$ 19.26
Region 2	$ 18.92	$ 19.08	+ .74	$ 19.08	$ 22.72	$ 20.90
Region 3	$ 18.08	$ 17.96	(.12)	$ 17.96	$ 22.36	$ 20.16
Region 4	$ 18.80	$ 19.12	+ .32	$ 19.12	$ 26.84	$ 22.98
* Regions were slightly modified in 2012						

Respectfully Submitted,

Diane Cagey, MS, CRC, LPC
Director, Attendant Care Program
Community Living And Support Services
[redacted]

Karen Goroncy

[redacted]

To: Long-Term Care Commission

My name is Karen Goroncy.

I very much welcome this opportunity to speak about long term care waivers. I am an attendant for the one of consumers on the waiver.

I have been his attendant for a number of years and enjoy my career. My job is very rewarding because I get to help my consumer

to stay in his own apartment and to be independent. When I met my consumer, he was quiet, shy, and unsure of himself. He has now grown into a confident young man.

Although it is very rewarding, an increase in pay and affordable health care would benefit me tremendously.

I sincerely feel that the service he receives has very much benefited him by increasing his quality of life.

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I'd like to begin my 5 minutes of speaking time by quoting the DPW mission statement taken directly from the DPW website:

"Our mission is to improve the quality of life for Pennsylvania's individuals and families. We promote opportunities for independence through services and supports while demonstrating accountability for taxpayer resources."

A quality long term care facility should also be concerned with the quality of life for the individuals they serve and are required to be accountable for taxpayer resources by the proper use of Medical Assistance payments

With that said, I would like this commission to consider some very real and concerning issues that Long Term Care facilities are experiencing due to complications imposed on them as they attempt to procure Medical Assistance funds for eligible residents of their facilities.

- The County Assistance Offices are responsible for assisting needy Pennsylvanians in obtaining Medical Assistance coverage. The business office at the LTC facility is responsible to these same individuals to assist them through this arduous MA application process. Ideally, the business office personal and the County Assistance Case Worker should join forces to make this as unproblematic as possible. Unfortunately, this is not what the Nursing facilities are experiencing since the County Assistance Office Caseworkers are overburdened with needless and wasteful regulations that cost the taxpayer money, keep Long Term Care residents from being approved for Medical Assistance coverage, and keep the Long Term Care facilities from financially being able to provide necessary services to their residents.
  - Every year, an MA approved LTC resident must submit information to the CAO for redetermination. This process is needlessly cumbersome for the resident's family, the facility's business office and the County Assistance Office case worker. Many times, the resident's MA will be discontinued and the facility will have to care for the resident with no reimbursement from the state. This redetermination process is unnecessary. An elderly person, who has been MA approved in the past and has no assets, will not have any opportunity to become financially ineligible for MA.
  - The PA162's that are sent to a nursing facility for a resident who becomes approved for MA are incredibly confusing. They do not have the 10th digit of the MA recipient number (as the older PA162's use to have). This 10th digit is necessary for MA billing. A nursing home business office manager was told by the case worker that supplying the 10th digit is a HIPAA violation. HIPAA does not prohibit this, or any other important piece of information, to be supplied to a person who needs it for the purpose of billing. (Please see CFR 164.512)
  - The PA162's that are supplied to the facility do not break down the sources of the resident's income so that the amounts indicated can be verified. One example of the need for this is the PSERS health insurance premium that is deducted directly from pension usually has a 100.00 premium assistance that is given to reduce the cost. This 100.00 is sometimes added

to the total amount of the pension, which means the facility should use the insurance premium amount in total for the insurance deduction on the MA claim. Sometimes, the 100.00 assistance isn't added to the pension total, and the nursing home should only deduct the premium minus the 100.00. In other words, the income breakdown is necessary for the nursing home so that they can bill appropriately.

- The verbiage of the PA162's is ridiculous. For instance, when a resident dies, a PA162 is sent that says "You no longer qualify for Medical Assistance because someone in your household has died. If you do not agree with this decision you can appeal." Seriously, I had no idea that death could be appealed, and why does the wording say, "you no longer qualify." ? Who is reading this notice, the deceased resident? Somebody in Harrisburg was paid to write this nonsense. It should be reworded, if for nothing else, to make the state look a little more intelligent.
- The PA162's should never have the health insurance premium as a deduction to the patient pay listed on the form. This is irrelevant to the billing office since actual verification is needed before the deduction can be done.
- The annual cost of living adjustment PA162 should be sent by March of the new year if there is a change in the resident's income. This does not happen as it should.
- The nursing home is unable to reach the caseworker when there is an issue with any of the MA residents application. They are forwarded to an answering machine and the caseworkers do not return calls. If there is a hearing that the business office needs to be available for, the notice isn't received until a day after the hearing in many cases.
- MA approvals are taking more time than ever before. The caseworkers are, in their own words, inundated. In my opinion, the changes should come down from Harrisburg to streamline this process for the sake of the nursing home, the case worker and even more importantly for the resident.

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COUNTY OF ALLEGHENY

RICH FITZGERALD
COUNTY EXECUTIVE

Public Testimony

Public Input at Pennsylvania Long-Term Care Commission
Allison Park, PA
May 9, 2014

Mildred E. Morrison
Administrator, Area Agency on Aging
Allegheny County Dept. of Human Services

[redacted]

Secretary Mackereth, Secretary Duke and Members of the Commission:

The view a mile above my office frames a metropolitan setting that continues to see the rapid growth in advanced age older adults, a broad swath of accessible general and specialty medical care, a quickly changing financial dynamic of retirement with segments of financially well off seniors counter-weighted by rising numbers of mature adults without the stable pensions and savings adequate to support self-sufficiency over several decades, continuously fluctuating family and caregiver arrangements, and finally ever-evolving expectations and technology. That makes for an interesting view of the future.

I am hopeful that this Long Term Care Commission will be able to craft visionary and honest measures for the future of the Commonwealth. One presumes that all of us involved in this domain have the capacity to modify existing services in smart, realistic ways that when combined with opportunities for beneficial, cost-effective initiatives will yield a system of care trusted and valued by Pennsylvanians.

While the existing array of services are of tremendous value to those being served and reflect decades of investment in skilled care, home and community based services, my remarks will address five opportunities for improvement and innovation rather than a defense of or criticism of current practice. Pennsylvania has a strong base of service providers who should be strengthened not harmed so as to expand the capacity to serve increasing numbers. Across the country advancements have been made when those providing care coordination, home health, in-home personal care and other services have been involved in early planning for change. It is widely anticipated that Pennsylvania will move toward some form of integrated care for dually eligible Medicare and Medicaid and other populations. When that happens, make a place at the planning table for the considerable assets of a robust Area Agency on Aging network to bring our knowledge of the population and imagination re best ways to serve them. Per the often used phrase that if 80% of health care is non-medical then involve those who understand social/economic factors, behaviors, physical and emotional environments that impact the care recipients.

Many stakeholders will hope that long term care moves from a generally reactive mode often at too slow a pace to one of greater awareness so as to help families, caregivers and service recipients plan ahead. Well, the reality is most people do not seek help or seem responsive to information until the crisis occurs. If there is to be a serious effort to shift the paradigm to a proactive approach, then it must be accompanied by the realities of the resources it will take to fulfill its promise in a timely, effective way. It is interesting that the degree of effort and intensity that AAAs and under 60 agencies are able to use to assist a long term resident to move from a skilled nursing facility into community living is far greater than the routine response provided by a request for help at home. Given the tools of skilled staff, established protocols to expedite long term support services, and the cooperation of health care and nursing facilities, multiple agendas could be addressed – consumer receiving services where and how they wish, support for family members who could return to work, reduction in hospital readmissions, and appropriate or focused use of high cost resources to achieve defined outcomes.

Regarding skilled staff. Attention has been given to workforce needs of the front line direct care worker, the invaluable CNA, etc. May I suggest you note the shortage of ably educated and experienced care coordinators be it in the roles of hospital social worker/discharge planner, nursing home admissions worker, manager of a complex senior center-adult day care center-LIFE center, Aging Care Manager, service coordinator for older adults with special needs, senior employment manager, etc. The field inside and outside of governmental agencies would be bolstered by professionals with

bachelors and masters degrees focused on gerontology similar to what is available in child welfare education at universities' social work programs across the commonwealth. (CWEB/CWEL)

A fundamental assumption of PA's public long term care services is that consumers requiring/requesting supportive long term supportive services fall into the categories of Nursing Facility Clinically Eligible or Nursing Facility Ineligible. What is missing is the recognition that many consumers while clearly in need of complex care may not need the comprehensive resources of a nursing facility. Indeed consumers with substantial family/community support complimented by essential long term services can be served at home in various programs, ex. the PA Aging Waiver or LIFE programs. This can also be a major financial savings by acknowledging that everyone who needs care does not require long term nursing home care. At the same time this would recognize that nursing homes are serving a population with a much higher acuity and should be fairly compensated for rigorous care of residents with difficult needs.

Finally, we fail to serve well those at the sunset of life regardless of their age if we do not weave into long term care the right of care recipients to express via advance planning their choices regarding the nature and extent of their care. Thankfully many caring institutions are embracing the consumer's making end of life decisions but it is not a routine part of the informational options offered. I congratulate those skilled nursing homes who have found the gracious voice to raise this topic with residents and their families. Others of us across the continuum of long term care must find ways to enable program participants and families to voice their wishes.

Thank you for this chance to share some thoughts about leveraging a strong consumer oriented provider group including the Area Agencies on Aging re future integrated care endeavors, adoption of a deservedly proactive approach about awareness and action pre-crisis requires sufficient resources, development of well-educated professional work force would benefit the whole continuum of care, consideration of a third eligibility category for community based care, and the need to normalize end of life advance planning. Thank you.

Good morning,

My name is Steven Walls. I am a home care worker, and President of the Southwest chapter of United Home Care Workers of Pennsylvania- which includes Washington, Greene and Fayette Counties. I have been working for people with disabilities for over 35 years, and have been a home care attendant with Tri County Patriots for Independent Living. I've provided services for my brother John, who is my consumer- for 11 years.

We are partners with the Consumer Workforce Council- the umbrella group of five Centers for Independent Living across Pennsylvania.

One of our guiding principles is that "we recognize the value of an effective relationship between Attendants and Consumers which assures the availability of stable, consistent services which are critical to enabling consumers to live independently through Attendants who are paid well and have adequate benefits."

We, as home care workers, take care of some of our most vulnerable citizens. They rely on us for day to day activities- such as bathing, dressing, preparing meals- so they can live independently in their own homes.

Years ago, CIL owners met with the Department of Public Welfare to say that attendants needed a raise. They were asked- then where are the attendants? Since then, got organized. I am here today speaking on behalf of thousands of our members.

We've come to Harrisburg in numbers, with consumers, to press for Medicaid Expansion. Although I was able to sign up for the marketplace through the exchange, around 80% of our members have not been able to do this because of Governor Corbett's unwillingness to sign off on Medicaid Expansion. This needs to change-- when attendants are unable to address our own health issues, we are putting our consumers at risk.

We lobbied with consumers to win the Balancing Incentive Program-- a waiver which will help rebalance our state's budget toward homecare. UHWP (United Home Care Workers of PA) and the CWC – the Consumer Workforce Council worked together to get attendants paid by PPL.

According to the Kaiser Family Foundation, Medicaid spending is 20 Billion 393 Million in Pennsylvania. The national average cost per nursing home resident is $83,000. The average cost to keep that same person living independently in his or her own home is $26,000 per year.

This is a win-win for the state of Pennsylvania- and also for consumers- who in most cases prefer to stay in their homes, rather than a facility.

According to the Kaiser Family Foundation nursing home facilities receive around 50% of Medicaid Spending for Long term Care spending in Pennsylvania. 41% of these dollars go to home health and personal care- which includes

1. Standard home health services
2. 2 personal care
3. 3 home and community based care for the functionally disabled elderly,
4. And services provided under home and community based service waivers.

With the Consumer Workforce Council, we have worked to develop a new agency model- the consumer delegated employer model. Within state laws and regulations, this allows consumers to maintain as much control as possible -- while working with attendants through our union.

We call on the taskforce to do the following:

1. Support Medicaid Expansion in Pennsylvania
2. Support applying to CMS for a Consumer First Choice Option waiver.
3. Support the Consumer Workforce Councils' efforts to improve home care in Pennsylvania.
4. Support raising home care rates so attendants can be paid a living wage.

Fiscal Challenges for Providers of Attendant Care and Home Care Services under Pennsylvania Medicaid Waivers in fiscal 2014-15

Hello, my name is Jan Crockett and I am the Chief Financial Officer for TRIPIL Services in Washington PA. Fiscal 2014-15 will bring a new set of financial challenges to providers of home care services under the Department of Aging and Department of Public Welfare waiver programs, including Centers for Independent Living (CIL). Additional federal requirements, related to the Affordable Care Act coupled with a billing rate that historically has not changed with increasing state and federal regulations, will result in increased financial pressures for the CIL.

1. Affordable Care Act (ACA) (Obama Care)

The Affordable Care Act imposes multiple restrictions on employers. Some of these are:

a. Full Time – The Act defines Full time as 30 hours per week. The traditional definition of a full time worker was 40 hours per week. This lower threshold now requires employers to pay for medical insurance coverage for a larger group of eligible employees. In the past, we restricted attendants to work less than full time to avoid requirements to pay health care benefits that were not calculated in the rate from the State for Medicaid attendant care. We were not happy to do this because it seems unfair to not provide health care benefits similar to those given to other types of office and management workers. Reducing the workers to a less than 30 hour work week would place consumers at risk because it would decrease the quality and reliability of the attendant care workers. However, once again, the Medicaid Waiver rates do not provide for health care costs because the rate is too low.

b. ACA defines the maximum out of pocket contribution of an eligible employee. This is defined as 9.5% of the LOWEST eligible employee's wage. We have not yet found a plan that will be cost effective for both the employee and the employer, but we are still looking. The State is not providing any assistance with this problem.

c. Waiting Period – The Act also requires that the waiting period for medical coverage cannot exceed 90 days. This new requirement also states that if you have an employee that has met the 90 day waiting period, and they leave employment, are rehired, the employee does not have to wait the 90 days again.

2. Billing Rate

The billing rate for Attendant Care Services has traditionally been a rate that has been set and then remains for several years. As stated earlier, the increasing pressures of state and federal regulations necessitate a billing rate that is sensitive to the changes in the Business Environment. We have no information that the State Medicaid managers are aware or prepared to assist with this problem. A crisis is building for January 1, 2015, when all of this takes effect.

3. Examples – Table Form

The following examples illustrate the above concerns added to the current realities of providing attendant care services in Western Pennsylvania. I have used actual data from TRIPIL in these examples.

The different columns show the bottom line or net position of an initial attendant hire, after one year of employment (Year 1), after two years of employment (Year 2), and the proposed federal increase of the minimum wage to $10.25/hour.

This table illustrates that the direct costs of employment are covered for initial hires and after the first year of employment. An attendant working 2 or more years would not have the direct costs of employment covered by the current billing rate. Continuity in staff is not encouraged by the current billing rate structure.

4. Conclusion

In conclusion, increased federal requirements when coupled with existing state and federal requirements demand a billing rate that is sensitive to

these issues. As shown by the examples provided, the current billing rate structure cannot support the cost of the attendant services or the overhead needed to run the home based care program. And remember, studies have shown that it is cheaper to care for an individual in THEIR home than in a Nursing Home. The state must be willing to adjust the billing rate on a basis that is necessary to ensure not only compliance with existing and increasing federal and state requirements, but the retention of dedicated attendants who provide in home services to consumers. Even if the billing rate increases, the overall cost of home based care is less than Nursing home care.

Exhibit A

Assumptions:	Initial Hire	Year 1	Year 2	Inc. Min Wage
Salary	$9.50	$9.70	$9.90	$10.25
Total Yearly Hours (30*52)	1,560	1,560	1,560	1,560
Billing rate /hour $4.29/15 minutes	**$17.16**	**$17.16**	**$17.16**	**$17.16**
Costs per Hour				
Salary	$9.50	$9.70	$9.90	$10.25
Special Day Pay (Holiday)	$0.15	$0.16	$0.16	$0.16
FICA 7.65%	$0.73	$0.74	$0.76	$0.78
Workers Comp	$0.45	$0.45	$0.45	$0.45
State Unemployment 5.954%	$0.31	$0.31	$0.31	$0.31
Medical per ACA	$5.62	$5.62	$5.62	$5.62
Misc. Employee Costs				
Training - Initial/Renewal	$0.10	$0.04	$0.04	$0.04
TB Annual	$0.03	$0.03	$0.03	$0.03
Clearances in state	$0.01	$0.00	$0.00	$0.00
Clearance out of state	$0.02	$0.00	$0.00	$0.00
Total Hourly Costs	**$16.91**	**$17.04**	**$17.26**	**$17.65**
Difference in Currency	**$0.25**	**$0.12**	**($0.10)**	**($0.49)**
% Difference	**1.43%**	**0.69%**	**-0.59%**	**-2.83%**

Note: The above costs reflect the direct costs of Attendant Care. Overhead costs to run the program such as office staff and space, utilities, computers and software, liability insurance, etc.

Flo Moffitt
[redacted]

To: Long-Term Care Commission

My name is Flo Moffit.

I was on ACT 150 for people over the age of 60 from 2004 to 2011. Due to an inheritance, I am no longer on the program but I want to tell you what it meant to me.

I had a stroke in 2000, my husband departed in 2004, and I ended up in a nursing home. I was also a fifth grade elementary school teacher for many years.

The Center for Independent Living in Washington, PA brought me out of a terrible nursing home experience. They hooked me up with ACT 150 and helped me to get back into my condominium. They helped me to find good care givers and I was the employer.

The independent living philosophy and support at the Center for Independent Living got me talking on my own after 7 years. When it all started, I couldn't do anything. ACT 150 worked a miracle for me! If I didn't have it when I needed it, I think I would be dead (if not dead, I would still be in the nursing home unable to speak or feed myself).

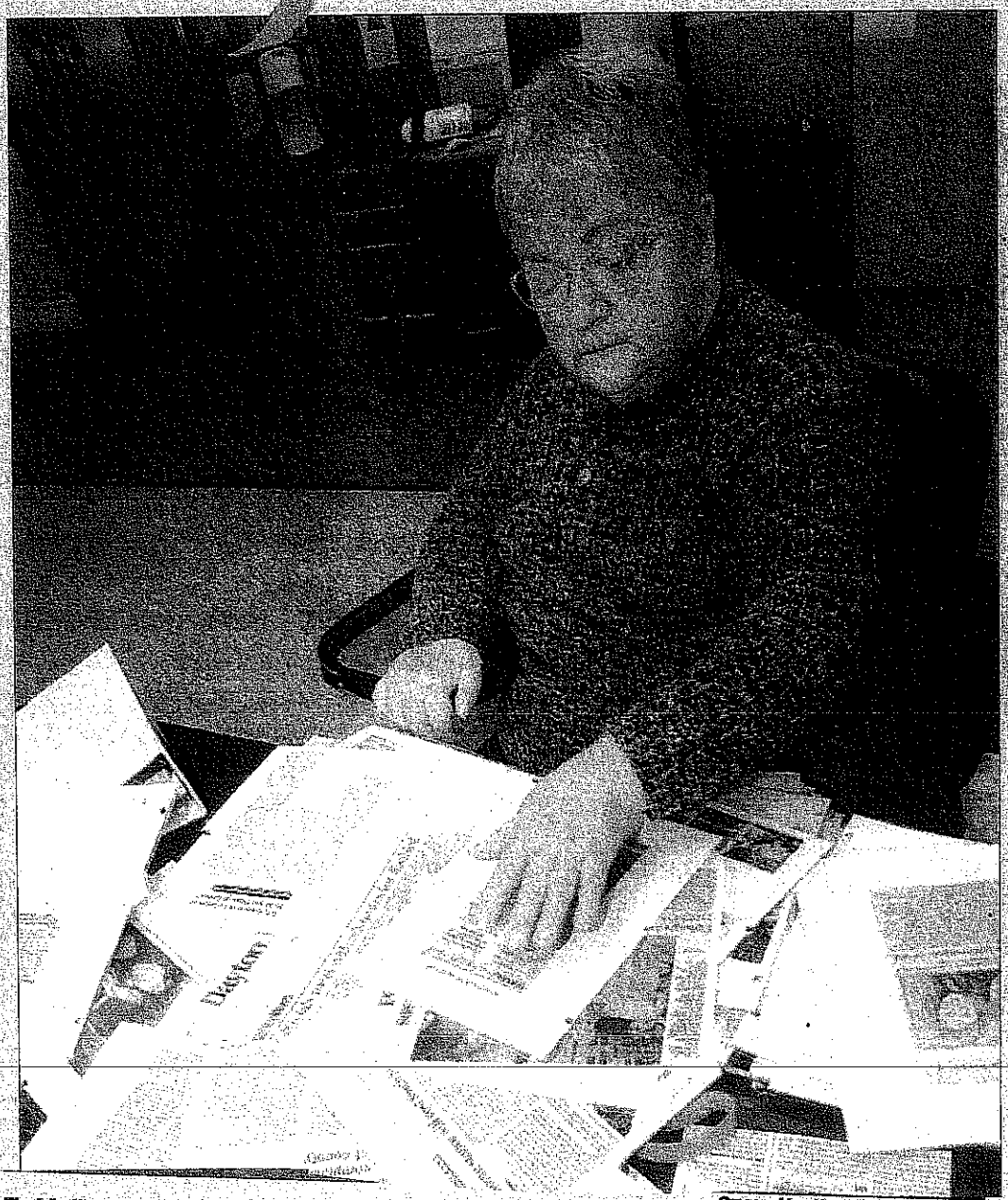
I am not on Medicaid and I have never been on Medicaid. But, ACT 150 and the Nursing Home Transition programs helped me put my world back together.

Since that time as a worker for a Center for Independent Living, I helped find people in nursing homes and bring them out.

We can help each other! People with disabilities can help people with other disabilities and I can prove that statement. I am now working part time in the Bookkeeping Department of a Center for Independent Living.

OBSERVER-REPORTER SUNDAY, JAN. 28, 2007

The battle for Independence



CELESTE VAN KIRK/OBSERVER-REPORTER

Flo Moffit, manager of the resource library at TRIPIL in Washington, works at her desk organizing newspaper articles for the library. Moffit has worked at TRIPIL since September 2005.

After stroke, ex-teacher turns to TRIPIL to gain control of her life

By Tina Calabro
For the Observer-Reporter

It's May 1998, and Flo Moffit, a third-grade teacher at Trinity West Elementary School, is on bus duty. She and other teachers are outside the school, shepherding students to their buses.

Suddenly, Flo loses vision in both her eyes. The 52-year-old had been having trouble with her vision, but nothing as bad as this. Colleagues help her sit down. After 10 minutes, the blindness passes.

A neurologist chalked up the incident to stress and a pre-diabetic condition. He was wrong.

About three weeks later, as Flo cued up a Lifetime movie before climbing into bed for the night, something in her head went "boom." She was having a stroke, and life as she knew it was about to change.

Stroke occurs when the blood supply to a part of the brain is cut off and nerve cells die. Flo's stroke, which occurred in the left side of her brain, resulted in weakness on the right side of her body and aphasia, the loss of speech and language skills. She couldn't walk steadily or navigate stairs. Speaking even one word was an effort. Formerly an avid reader, she could read only a couple of lines before the words became a blur and she would have to look away.

After five days in Washington Hospital and two months of rehabilitation in Pittsburgh, Flo returned to the spacious home on the outskirts of Washington that she shared with her husband and the youngest of her three daughters. Home, however, did not hold the comfort it previously had.

Each morning, her husband helped her dress and get down the stairs to a chair in the den, where she would watch television until he returned from work later that day.

Observer-Reporter

From left, Ron Crouse, Michael Evens, Flo Moffit and Terri Brown, members of Tri-County Patriots for Independent Living, staged a protest June 13, 2006, outside the Union Grill on East Wheeling Street after being denied access because the restaurant is not accessible to those who use wheelchairs.

Despite intensive rehabilitation early on, Flo did not regain the speech or motor skills affected by the stroke. After three years, she still spent most of her days alone in the den. Friends and former colleagues drifted away. Even her marriage was struggling.

Longtime friend Billie Wright stayed in close touch. When she stopped by, she often found Flo in tears. Although Flo spoke little, she managed to tell Billie something she truly believed: "This is it. I'm done."

Billie was distressed over the change in her friend. She sensed – correctly – that Flo's depression was far more debilitating than the physical impairment caused by the stroke.

"I thought I had lost my friend," Billie said. "It was like she had given up. She was so active before. It was hard to see her like this."

Billie urged Flo to contact a local organization for people with disabilities – Tri-County Patriots for Independent Living. She didn't know exactly what the organization could do for Flo, but she knew that it had to be better than sitting in front of the television all day.

September 2001, TRIPIL offices

Flo had taken an access van to a dental appointment. The dentist office happened to be in the same building as TRIPIL, so Flo decided to appease Billie by going in and finding out what goes on there.

Flo didn't know what to expect. "I came in and said, 'What can I do here?' They said, 'Come on in and we'll find out.'"

She didn't realize she was entering a community that encourages people with disabilities to be powerful, independent and proud – and that she was about to reinvent her life.

Independent living centers such as TRIPIL have been around since the mid-1970s when they were funded by the federal government. Owned and operated by people with disabilities, their purpose is to promote self-help, remove societal barriers and improve service systems.

Originally a satellite of Pittsburgh's Three Rivers Center for Independent Living, TRIPIL was incorporated in 1990 as a nonprofit organization serving Washington, Greene and Fayette counties.

Please see Battle, Page D4

Battle; Former teacher turns to TRIPIL to gain control of life

[illegible]

Sept. 21, 2005, Washington, D.C.

[illegible]

Dec. 20, 2005, Flo's home

[illegible]

Kate Blaker
[redacted]

To: Long-Term Care Commission

Good morning to the Committee.

My name is Kate Blaker and I receive long-term care home based services.

I'm asking you to consider several options in addition to what is offered by the long-term care waiver. Primarily, what is important to me is

to maintain control in who I hired and allow into my home. If you remove that control then you will remove the consumer's choice. This would have a huge impact as many people would not want to release their use of the employer model. This is being offered now but rumor has it that managed care is being considered.

This leads to the second option that I ask you to consider. Under the waiver system, hours are designated by timed tasks such as bathing, dressing and assistance with other

daily needs. There is some lead way for differences in time for each task. But under managed care, the assigned time must be followed. No one person takes the same time to do daily care.

Finally, I ask that you consider allowing a substantial cost of living wage increase for personal care attendants. Many continue to live on welfare because of the low wages and also have limited health benefits.

We need to stop the Medicaid basis of funding nursing homes and start funding community choice for all. I must state that ..." I would rather go to jail then die in a nursing home." (A chant from ADAPT)

Good afternoon, my name is Erica Altamare, Medical Assistance Liaison at ManorCare-North Hills, and this is Rachelle Tritinger, Business Office Manager at both the ManorCare Shadyside and ManorCare Pittsburgh. We are here representing the patients that are currently being cared for at our HCR ManorCare facilities. In Allegheny County alone, we have 8 buildings where long-term care patients call home. These buildings consist of our Northside, Shadyside, Pittsburgh, North Hills, Bethel Park, Monroeville Greentree and Whitehall locations.

Today, 56% of patients in these facilities rely on Medical Assistance for Long-Term Care coverage because they are no longer capable of managing their care at a community or personal care setting. Of those patients, 16% are still waiting for a response as to whether their length of stay is going to be covered or not. Unfortunately, 70% are localized in the 4 buildings of the urban areas.

One of the biggest challenges we as a long term care facility face when attempting to get medical assistance coverage is communication between the Department of Public Welfare and ourselves. This barrier presents in both the verbal and written forms of communications.

Being proactive liaisons and patient advocates at our Manor Care facilities, we attempt to maintain regular correspondence with the assigned case worker when it comes to pending applications. We feel this allows for smoother approvals and that the open lines of communication create an easier process for the patient, their family, and the Department of Public Welfare. We are finding more frequently that we are not getting return calls or emails from case workers.

In addition to not obtaining information from calls, we also have difficulty obtaining 162 approvals and timely pending letters. Frequently, we are required to make repeated contact to

obtain a copy of a 162 or receive a pending letter with only 5 days until the deadline due to the time for mailing.

While we are a for-profit facility who stereotypically has a primary concern for payment, we truly care about our residents, and this struggle with IRED punishes the patients and their families. Short turnaround times for pending letters and the lack of knowing the status creates an unneeded stress for a patient who is attempting to recover. Without a Medicaid approval, many vendors will not provide treatment and the facility has to pay for many of the patient's prescription medicines. Additionally, in some situations, we have patients who are unable to discharge to the community because they do not have the insurance coverage or the additional services that Medical Assistance provides.

We believe that communication would be easier with a real time portal, similar to the Pennsylvania Unified Justice System, which would allow for read only versions of documents and statuses. One step further would be integrating this proposed system with Compass to allow for the uploading of documents to IRED's system, which is not currently allowed in Allegheny County. We feel this would allow us to create a mutually beneficial relationship for all parties involved.

ManorCare Health Services Facility Name	Total Inhouse MA	MA Pending Inhouse	Total MA Pending (discharged and inhouse)	MA Pending Greater than 90 Days (discharged and inhouse	Total Beds	% MA Inhouse	% MA Pending Inhouse
*Northside	82	11	11	6	100	82%	11%
*Shadyside	106	28	44	28	150	70.60%	18.67%
*Pittsburgh	131	21	44	21	208	62.98%	10.96%
*North Hills	124	29	28	18	200	62%	14.50%
Bethel Park	90	23	27	12	160	56.25%	14.37%
Monroeville	58	32	26	13	120	48.30%	26.60%
Greentree	73	29	27	14	163	44.70%	17.79%
Whitehall	41	25	25	19	164	25%	15.24%
TOTALS---	705	198	232	131	1265	56%	16%

***Denotes Urban Areas**

*** 56% of cases are over 90 days**

Senior LIFE

Complete Care for Seniors Living at Home

Long Term Care Commission
Gina Graciano
Director of Business Development
[redacted]

Senior LIFE

One in four people in Pennsylvania are over the age of 55. Our state is the fourth "oldest" state in the nation, and our elderly population continues to grow greater as baby boomers age.

Pennsylvania, like other states in this nation is faced with the responsibility and the challenge of caring for our elderly – particularly the sickest and less fortunate of them.

Over 20 years ago, we recognized the importance of CONSUMER CHOICE ... giving seniors the option to grow old where they prefer to grow old -- It's no longer acceptable to force our elderly into nursing facilities against their wishes if they want to be in their home and can be safely served there. (And furthermore, the availability of Medicaid beds in nursing facilities is dwindling.)

These are just some of the reasons that the LIFE Program is more important than ever.

LIFE is the only managed care program operating in Pennsylvania that fully integrates payments from Medicare and Medicaid to serve dual eligible elderly, who are qualified for nursing home placement, but who can AND WANT TO live safely in the community with the appropriate health care, personal supports and assistance with activities of daily living.

LIFE is the ONLY program that provides these integrated medical and personal care services -and we do it at less cost than nursing facility care AND with exceptional outcomes.

LIFE costs approximately 28% less than nursing home care, saving the Medicaid program an average of $21,500 per person/ per year.

For example, diverting nursing home placements to the LIFE option, the State is realizing savings in excess of $107 million dollars (5,000 enrollees X $21,500) in an era of budgetary constraints.

[redacted]

We are committed to working with our local AAAs on behalf of local seniors and hope that through our efforts and this commission, this relationship and process can be improved to live up to and improve consumer choice and provide more eligible seniors with access to services under the LIFE Program.

We had several members that wanted to provide testimony on how they have benefited from the LIFE program, and have been able to remain in the community, however due to the proximity of our programs, and the travel distance for our participants/members, we will be providing written versions of their testimonies.

LIFE Member Quotes

Anna M.
"Before Senior LIFE I had in and out of the hospital and nursing home. They helped me to walk again. I feel so much better and I'm much stronger."

"The physical therapy has really helped me. It has made a big improvement in my back and I can move around much better now."

Linda G.
"My Doctor diagnosed me with Type II Diabetes and started me on medicine and an exercise program. The dietician taught me what foods to eat and the ones I shouldn't. My health has improved so much. I am so happy and so are my children."

Anthony J.
"When I heard about Senior LIFE I told my daughter 'when something is too good to be true, it usually isn't', but I was wrong. Senior LIFE has changed my life and it is the best thing I ever did."

Carla S.
Senior LIFE has helped improve my outlook on life, and it has given my daughter and son-in-law a break from my care. Now I am able to do more for myself."

Alice W.
"Talking with my social worker has helped me so much. I thought there wasn't anything good in my life. But now, I recognize my problems and know I am not alone. They helped me find happiness in my life."

Arnie A.
"Before Senior LIFE I couldn't get out of my home. Now the bus driver picks me up and brings me to the center and my doctor appointments. Now I can see my

It also allows for 15% fewer Medicaid beneficiaries to be in nursing facilities without compromising their health and wellbeing.

And, it isn't just about the cost savings. The LIFE model shows substantiated improvements in the quality of life of participants.

Significant participant outcomes across PACE / LIFE Programs include:

- fewer hospitalizations
- fewer nursing home admissions
- longer survival rates
- increased number of days in the community
- better health and quality of life
- greater satisfaction
- overall better functional status.
- greater adult day health care use
- lower skilled home health visits

LIFE participants are able to remain in their homes and community with their loved ones, and age in place. Caregivers are able to have the peace of mind that their loved ones are getting the quality medical care they need.

It is not every day, that our government can fund a program that has this significant measure of success AND saves money.

The LIFE Program is a win for everyone.

Expanding the Program and improving the determination process will provide better and more consistent access to eligible seniors throughout the commonwealth.

We serve seniors in 11 counties and experience significant geographic variations in AAA NFCE eligibility rates across locations.

The need for the State to adopt a fact-based level of eligibility instrument to improve consistency is paramount.

Such an instrument should be collaborative and subject to public input and comment to assure objectivity.

In addition, a better, conflict-free system to educate and inform seniors about the LIFE Program as one of their options must be developed.

doctor and get my medicine. I get a good meals at Senior LIFE too and have made new friends."

Joe T.

"Everyone helped me so much to get through the grief of losing my wife."

Sonny M
"Coming to Senior LIFE has given me the physical strength – and desire to do more things."

CAREGIVER Quotes

Sister of Senior LIFE member:
I am so happy that my sister is well cared for and it allows me to better care for my needs without having to worry about my sister. I was neglecting myself and my health was getting worse. Now we are both some much better and happier. She would be in a nursing home if it wasn't for Senior LIFE.

Daughter of member
My mother hadn't looked or felt so good in a long time. Senior LIFE saved her life and mine. She was declining and needing more and more care. I have children in school and work full time. The entire family does everything we can for mom, but we needed help. I couldn't put her in a nursing home and was beside myself. Senior LIFE was our savior."

Pennsylvania Long-Term Care Commission Public Meeting

May 9, 2014

Testimony of

John Lovelace

UPMC *for You*

Secretary Duke, Secretary Mackereth, and distinguished members of Governor Corbett's Long-Term Care Commission, thank you for the opportunity to testify today. My name is John Lovelace and I am here today on behalf of UPMC *for You* and UPMC *for You* Advantage.

UPMC *for You* offers physical health care benefits to more than a quarter million Medicaid recipients in 40 Pennsylvania counties through HealthChoices. Recognized as a model program, UPMC *for You* was ranked eighth of all Medicaid programs in the United States in 2012, and was the top-ranked Medicaid plan in Pennsylvania for eight of the past nine years by the National Committee for Quality Assurance. In other words, UPMC *for You* has provided quality care at lower cost than traditional fee-for-service programs, benefiting Medicaid beneficiaries and Pennsylvania taxpayers. Additionally, UPMC *for You* Advantage provides Medicare benefits to almost 18,000 people who also have Medicaid, making us one of the largest dual-eligible Medicare Special Needs plans in Pennsylvania and the 15th largest nationally. Participants in most long-term care programs qualify for these plans serving people with Medicare and Medicaid.

As part of an integrated delivery and finance system, we are proudly part of the University of Pittsburgh Medical Center (UPMC), recognized worldwide for delivering some of the highest quality healthcare in existence. UPMC has been named by US News & World Report to the Honor Roll of America's Best Hospitals for more than a decade. There are only a handful of cities in the entire country that can claim a health system that is ranked as one of the nation's best in 15 of 16 medical specialty areas – and Pittsburgh is one of them. Thus, we proudly offer our community's most vulnerable citizens the highest quality insurance products and delivery network.

At UPMC, I am responsible for government programs, including products that serve people with both Medicare and Medicaid. This is a diverse population that includes low-income seniors, people living with mental illnesses, people with physical and intellectual disabilities, and many others. Many of these individuals have long-term care needs, participate in waivers, or live in institutions.

The topic of long-term care reform is not new to Pennsylvania. Over the past 30 years, the commonwealth has paradoxically trail blazed and lagged behind, often simultaneously. In the 1980s, the Intra-Governmental Council on Long-Term Care was formed, publishing seminal reports, and the independent living movement succeeded in the passage of Act 150, creating pathways for consumer direction years ahead of the federal government. The dedication of the Lottery to older Pennsylvanians has enabled countless people to age in place with dignity and bolstered the Area Agencies on Aging on the coattails of the Older Americans Act. This was followed by early innovations like the State Family Caregiver Support Program which inspired the federal law and the PATH project that paved the way for national nursing home transition efforts. Additionally, our PACE programs are among the largest and most effective in the

nation. Governor Corbett has proudly continued the expansion of home and community-based waivers that have propelled a long-needed rebalancing of Medicaid spending away from institutional care. But, access to institutional care is also essential in a well-functioning long-term care system and in 2013, only California had more 5 star nursing facilities than Pennsylvania within its borders.

Despite these milestones, the commonwealth has fallen somewhat behind in other respects. While PATH and the 2600 Personal Care Home Regulations set Pennsylvania apart, we did not immediately take advantage of Medicaid HCBS waivers and only recently have we begun to license assisted living, but have yet to fund this intermediate level of care through Medicaid. While the commonwealth has invested heavily in recent years, our residents have a 60 percent chance of receiving long-term services and supports in a nursing home while the vast majority would prefer care at home. This year, 25 states are expected to have managed Medicaid long-term care programs in place, many of which will be fully integrated, and sadly, Pennsylvania is not on this list.

This history is important context and illustrates the challenge before you in meeting this Commission's bold charge. It is well known that Pennsylvania is one the oldest states in the nation. Simply put, we got old first and have more people over age 85 than the typical state. Nowhere is this more apparent than southwestern Pennsylvania, where over 3 percent of our population is over 85 – this exceeds the national average by more than 50 percent. As a result, we are facing demographic challenges decades ahead of others. The Commission is well positioned to establish a policy framework that advances Pennsylvania and the nation at this critical time.

Prevention and Caregiver Support

Prevention and caregiver support will in the long-run promote aging in place and financially stabilize the Medicaid long-term care system. Public health, Medicaid diversion, and Medicaid improvement in the area of long-term care require different strategies and solutions.

Public health and education have proven especially challenging. Still, too few save and too many believe that Medicare will be there for long-term care. Important assets like free family caregiving hold the entire system together, yet most "caregivers" do not associate themselves as such, only answering to "friend," "neighbor" or "daughter." Respite and reliable places to turn are keys to the Commission's work. The 211 system, APPRISE, and the "no wrong door" mindset of the Pennsylvania Link are promising and must be supported with adequate investments. The Departments of Health, Aging, and Public Welfare collectively can contribute to changing attitudes and educating the wave of baby boomers on the realities of what is covered, what is not, and how to plan for their future in an era of increasing longevity. The

opportunity is now, as many are caring or have cared for a parent navigating the complicated long-term care system.

Preventing people from ever needing the support of Medicaid is more complicated. Unfortunately today, a person is far more likely to exhaust their resources "spending down" their hard earned assets in a nursing facility rather than on lower cost, home-based alternatives. Put another way, very few nursing home residents were "Medicaid Day One" yet more than two thirds are supported by it today. Reversing the nursing facility entitlement and incenting community-based Medicaid spend down would extend the ability to self-fund care and allow many more middle class families to pass along assets intergenerationally.

Confronting improvements to Medicaid may have the simplest solutions for prevention. We must address cost and quality issues for Pennsylvanians who are dually eligible for Medicaid and Medicare. For the most medically frail or disabled dual eligibles who receive services from a disparate and misaligned system of payers and providers, it is imperative to explore how to better deliver long-term care in a way that also reduces cost pressures to the state and its taxpayers.

In the long-run, all dual eligibles should be part of an inclusive and integrated care system, including medical and long-term care services, to address many of the cost and quality issues resulting from poor coordination. Reaching this goal, however, is complex. A robust stakeholder process, amendments to the State Medicaid Plan, and approval by CMS all take time. However, amending HealthChoices contracts to include dual eligibles is something that could be accomplished today.

The duals have already spoken in our region. For example, Allegheny County has the highest concentration of Medicare-eligible residents in the Commonwealth, of whom, 62 percent have chosen a Medicare managed care plan to coordinate their health care. In addition, our county's HealthChoices plans currently serve 98 percent of duals enrolled in a Medicare Special Needs Plan and 100 percent of non-dual Medicaid participants.

Today, long-term services and supports are an all-or-none proposition. A person whose daily needs are increasing and whose function is in decline may not receive Medicaid-supported personal care until they are nursing home eligible. A personal care option would yield long-run savings far beyond its cost. Plans would judiciously manage this type of benefit, especially when already at risk for the medical services needed by their members.

It is time to reenroll dually eligible citizens into HealthChoices, give them the benefits of longitudinal care coordination, and enhance the ability of plans to offer preventive services as needed.

Accessibility

Access and education are closely related. While more resources exist as compared to many states, Pennsylvania's patchwork is confusing to even those who are very familiar with the many options.

The biggest void in Pennsylvania's long-term care system is access to affordable care in congregate settings. As we live longer and diseases like Alzheimer's and dementia are more common, supportive and supervised environments are of critical importance. Comparably fewer people with such cognitive and memory impairments are currently served by Medicaid HCBS and are instead living in nursing facilities with relatively lower clinical needs. A first step would be to offer HCBS Waiver services in licensed Assisted Living Residences. Broader access to options such as structured family caregiving, shared living, and supportive housing are also of critical importance and are core components of other states' continua of care.

Access is also hampered by the speed at which families access services at times of crisis. This is worsened by the pressures placed on hospitals seeking a timely and safe discharge. As families in crisis have little choice but nursing facilities, opportunities are missed. Pennsylvanians would be well served if the commonwealth were to offer same day eligibility and service packages. Nursing facilities can afford the risks of waiting for eligibility because the person is either retroactively eligible or spends down their resources. Parity with the preferred, lower cost alternative only makes sense.

Related, access to high quality, disability-competent care is severely lacking. Health plans in integrated models have more incentives to align their physical health networks with the long-term care needs of their members. Today, we may not know which members are wheel chairs users – it is not on application or on a claim – and may only know through voluntary assessment or care management. Therefore, advising members and incenting physicians to have things like accessible scales and taking more time for setup and transfer only becomes easier and more scalable. The work of Commonwealth Care Alliance in Massachusetts is a notable example.

Provision of Service

In the realm of service provision, the Commission will hear a variety of themes, but many will lead back to care integration, or the lack thereof. Medical services are funded and managed separately from long-term services and supports. This unnecessary fragmentation leads to excess utilization, duplication of efforts, miscommunication, missed opportunities, and frustrating member, provider, and caregiver experiences.

As a Medicare Special Needs Plan, we are held to a higher standard than normal Medicare Advantage Plans. We have a formal Model of Care approved by CMS which serves as

the framework for clinical action. Some specific areas of focus are assessment, care planning, interdisciplinary team meetings, and assisting in transitions in care.

The nearly 18,000 members who we serve are diverse and very different from the more than 100,000 Medicare-only members served by UPMC Health Plan. Notably, they are younger than a traditional Medicare beneficiary with 58 percent of our members under age 65. As mentioned, we currently serve many waiver participants and people living in nursing facilities. Due to incomplete data, we approximate that nearly 1,000 are Aging Waiver participants, a similar number of people are on physical disability waivers, 1,400 people live in nursing facilities, and more than 3,000 people are served by intellectual disability programs who have Medicare Advantage coverage through UPMC, with even more in our HealthChoices plan.

We also have a MIPPA Agreement, named for the Medicare Improvement and Patient Protection Act of 2008, which requires Medicare SNPs to have a state contract. This contract requires us to coordinate areas like transitions in care, with among others, Area Agencies on Aging and service coordination entities. Unfortunately, there are barriers to such coordination that start with accurate member and service coordinator identification. For clear reason, we cannot share personal health information without consent or without regard to state and federal privacy laws.

In the short run, the commonwealth can globally create business associate agreements to allow voluntary coordination and exchange regular data with plans to allow access to waiver participant data and identify service coordination entities. This will enable simple, yet effective improvements.

Longer run, integrating long-term care with medical care is critical. By having a single point of accountability, a health plan would bear risk and be incented to do what the member wants most – receive quality care and remain independent in their homes as long as possible.

For example, consider a waiver participant transitioning home from a hospitalization with a new medication list. This member's family is unreachable during this time of crisis, leaving the HCBS service coordinator and personal care attendant out of the loop, creating missed waiver visits. Waiver services temporarily stop. Now the member is on her way home, a little confused, with a new medication list, a complicated set of discharge orders, an empty refrigerator, and a health plan trying to reach her. Unfortunately, she misses her follow-up appointment with her PCP and calls 911 a few days later and is readmitted. This series of events repeats itself and she ends up in a nursing facility long-term.

While hypothetical, this is exactly the type of situation we can do better to avoid. The health plan knows the member had been hospitalized, but does not know she had a service coordinator or waiver services. If they did, a coordinated discharge could have occurred. Waiver supports could have been ready to catch the member with updated orders and

medications reconciled in conjunction with the health plan's interdisciplinary team and a practice-based care manager on the team coordinating a next day PCP visit. This example can partially succeed with care coordination but only truly excel with integrated resources and better organized delivery.

A slight twist on this example would be this same member and the same chain of events, but occurring prior to the member seeking waiver eligibility. A health plan responsible for both Medicaid long-term care and Medicare medical services would be eager to expedite services and authorize personal care prior to discharge. Currently, eligibility and care plan initiation can take weeks, resulting in higher cost and lower quality care.

Further, a Medicare plan responsible only for the Medicare nursing facility stay has little to gain financially by working with the family toward HCBS alternatives. This is complicated by Medicare plans having difficulty obtaining Medicaid data to confirm the residence of members. Meanwhile, a nursing facility resident loses her HCBS supports coordinator due to her institutional status.

Examples of missed opportunities for coordination are far more common and should not be accepted. Plainly put, health plans have every incentive to do more up front to realize savings from unplanned and inefficient care. This is most advantageous when the plan is accountable for all aspects of the continuum to promote prevention and strong primary care, nursing home avoidance, and aging in place.

Quality Outcomes and Measurement

A managed care program should be designed with quality and accountability in mind. A health plan needs enough flexibility to create its own network and not necessarily inherit all Medicaid providers currently under contract. While this is controversial, the ability to focus more narrowly and have performance-based arrangements will strengthen the delivery system. Additionally, health plans will need to embrace the great strides in quality assurance made over the past decade. Relying on the finest existing infrastructure will be the route taken by plans and we should not expect less.

Quality should also be driven by outcomes, not by overly prescriptive processes. A health plan with discretion to provide some HCBS to members prior to waiver eligibility is a good example. In this case, avoiding rapid decline by acting early could be a beneficial way to avoid costs in future episodes. The black or white, eligible or not system can be too slow to pick up on these more subtle needs and too late to avoid nursing facility placement. Similarly, too much review of care plans prior to service initiation may enhance quality but at a cost – families and discharge planners call when in crisis. The ability to offer same day services is an important component when offsetting more expensive institutional care.

Moreover, these same types of principles apply to management of nursing facility services. HealthChoices plans are only responsible for the first 30 days of an institutional stay. Similarly, Medicare Advantage plans are accountable for the skilled visit, not the long-term custodial care. Since a Medicare plan sees only the Medicare claim, a person may not always be visible to the plan when Medicaid is paying the bill. A plan at full risk with accountability for areas like admissions, readmissions, and unplanned emergency visits would help improve quality as well.

Lastly, health plan quality metrics should embrace and not duplicate existing standards, such as HEDIS. Building from such a foundation is more efficient and effective.

Closing Remarks

In summary, I would like to affirm our agreement with the position taken by the Pennsylvania Association of Medicaid MCOs and highlight why our recommendations are important for the Commission's consideration.

To help guide the Long-Term Care Commission deliberations, the commonwealth should propose a framework for a MLTSS model. We recommend the framework include the following components:

- Dual Eligibles should be re-enrolled in HealthChoices in 2014. This is an essential first step to more longitudinal solutions to managing care preventively.
- MLTSS should be implemented in geographic phases. Amending the current HealthChoices' contracts will expedite the process. This would be expedient, leverage the experience of high quality plans like ours, and be subject to the rigors of competition during normal procurement cycles. A separate procurement would only fragment the system further.
- The model should begin with older adults and people with physical disabilities. The infrastructure is largely similar, with providers participating in waivers for those over and under the age of 60, and both populations will benefit from enhanced coordination that have diversionary impacts on nursing facilities. However, the timing and implementation for all Medicaid beneficiaries, including people with intellectual disabilities, should be considered as well.
- Enrollment should be mandatory to achieve the best success and to realize significant savings. Voluntary models create duplicative infrastructure while maintaining a significant administrative cost for the state. Mandatory models can offer meaningful choice, especially when plans are given flexibility to creatively implement the program.
- Consumer direction and control must be integrated into the program. Self-directed services in Pennsylvania are a beacon to other states that we need to build upon with higher standards of quality.

- While the LTC Commission deliberates, the commonwealth should pilot models in FY 2014-15 and seek broader implementation in 2015.

Thank you for the opportunity to address this important issue today and I am available for any questions or clarifications that the Commissioners may have.