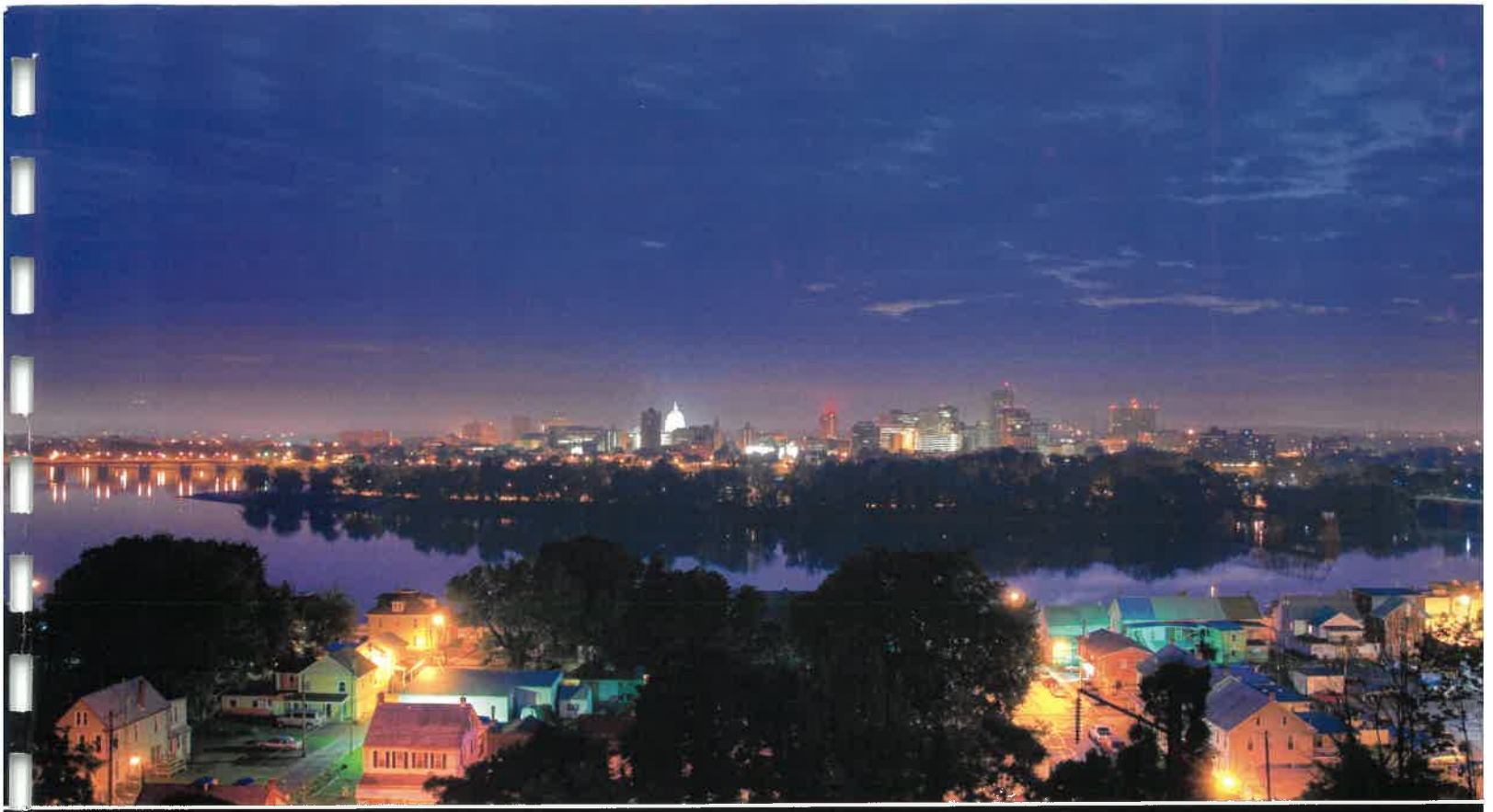


Pennsylvania Senior Care and Services Study Commission:

Final Report

Contents

Harrisburg, Pennsylvania, skyline, by David Coleman: cover and contents photo.
University of Pennsylvania School of Nursing, LIFE Program:
photos on pages vi, 2, 8, 27, 29, 36, 42, 46, 48, 50, 51.
Department of Aging/Oral History Project, Tom Olin photographer:
photos on pages 3, 4, 7, 10, 14, 17, 18, 21, 30, 37, 41, 43, 44, 49.
Dreamstime: photo on page 22.

Executive Summary

In June 2007, Pennsylvania Public Law 49, Number 16, Act 16 provided for the establishment of a Senior Care and Services Study Commission to assess the older population's need for care and services.[1] The Commission, created May 1, 2008, was charged with the following tasks:

- to review current care, services, and resources available to Commonwealth residents age 65 and older;
- to project the future need for care and services through the year 2025;
- to evaluate the ability of the current systems to meet the projected needs; and
- to project the resources necessary to meet the projected need and to make policy recommendations as to how the projected need can best be met given current resource limitations.

The Commission comprises nineteen members, including: Cabinet Secretaries of Budget, Health, Public Welfare, and Aging; individuals appointed by the majority and minority leaders within the Pennsylvania State Senate and House of Representatives; and nine individuals appointed by the Governor representing a range of stakeholders with experience related to long-term living. The Commission completed a report addressing the first of the four stated purposes in May of 2009. This "interim" report describes demographic characteristics of Pennsylvania's older adult population and currently available care, services, and resources. The final report addresses the last three purposes, including the Commission's policy recommendations.

As we analyzed the many issues the Commonwealth faces now, and will face in the future, in providing care and services for older adults, we identified some guiding views and assumptions moving forward. First and foremost, our current health and long-term care (LTC) systems are neither adequate nor sustainable. Given limited resources, we must prioritize public programs for consumers with the greatest needs. However, government programs such as Medicare and Medicaid cannot be expected to finance all care and services for older adults, especially given that most Americans don't want to increase funding of public programs through taxation. Ensuring that care and services are available for current and future older adults requires Pennsylvanians to make hard choices. The public needs to understand it will require bringing additional revenues into the system and increased personal responsibility for financial planning.

The Commission identified four critical focus areas which we believe offer opportunities for change to help us achieve a more sustainable system by 2025: financing and prioritization of resources; improving wellness; aging in place and care coordination; and workforce. To address identified barriers, we present policy recommendations which we believe will move us toward our 2025 goals. In developing these recommendations, the Commission focused chiefly on actionable steps within the purview of Pennsylvania state agencies.

POLICY RECOMMENDATION #1:

Develop strategies to educate Pennsylvanians about the need to plan for long-term care needs and increase self-funding of long-term care through various mechanisms, such as: improving incentives for purchasing long-term care insurance and/or participating in the Long-Term Care Partnership under Act 40.

POLICY RECOMMENDATION #2:

Provide additional incentives for self-funding of long-term care through implementation of a social insurance program modeled on the Class Act as enacted either through federal or state legislation.

POLICY RECOMMENDATION #3:

Assess the feasibility of developing and implementing an integrated financing system (Medicare, Medicaid, state funding) across the care continuum to eliminate care silos and delay or prevent nursing facility admission through better care coordination and timely interventions.

POLICY RECOMMENDATION #4:

Review gaps, barriers, and redundancies in current information systems, reimbursement, and service delivery as they relate to care coordination and care transitions across the care continuum and utilize funding initiatives under the American Reinvestment and Recovery Act of 2009 and the Patient Protection and Affordable Care Act of 2010 when available to fill identified gaps and barriers.

POLICY RECOMMENDATION #5:

Maximize use of technology such as telehealth and assistive devices to improve outreach, care coordination, accessibility, and safety for older adults living in the community.

POLICY RECOMMENDATION #6:

Develop a cross-agency collaborative approach to promote better nutritional choices and physical activity in schools, workplaces, and senior centers.

POLICY RECOMMENDATION #7:

Develop statewide strategies to promote a greater emphasis on wellness principles into business practices.

POLICY RECOMMENDATION #8:

Examine the feasibility of defining and requiring a minimum level of wellness coverage and chronic care management (including self care management) for all health insurance providers conducting business in the Commonwealth. The feasibility review shall include an assessment of the Commonwealth's legal authority to implement this requirement.

POLICY RECOMMENDATION #9:

Assess the feasibility of providing access to basic health coverage to direct care workers through public and private low-cost programs to enhance recruitment and retention.

POLICY RECOMMENDATION #10:

Promote employer initiatives to support elder care such as offering flexible work schedules and elder care information and referral services through a statewide campaign educating employers on the economic and other impacts of caregiving on businesses.

POLICY RECOMMENDATION #11:

Leveraging new federal funding, develop and implement curricula for health care professionals and direct care workers in gerontology, chronic care management, long-term care, and senior and family-centered interdisciplinary care to maintain a quality care workforce.

POLICY RECOMMENDATION #12:

Promote cross-training or blended job roles for long-term care workers to achieve greater efficiencies in service delivery and coordinated career progression to attract frontline workers to the field.

As a Commission, we have taken an honest accounting of where we are in providing care, services, and resources for older Pennsylvanians and considered what is necessary to ensure we can meet the needs of the future older adult population. In examining these issues and the available data, we have proposed what we believe are realistic, "doable" action steps to move us closer to a sustainable and flexible array of supports and services for older Pennsylvanians. Given the many promising efforts which are already in place, we are confident in the Commonwealth's potential to make these changes.

Section 1.
Background of Commission

In June 2007, Pennsylvania Public Law 49, Number 16, Act 16 provided for the establishment of a Senior Care and Services Study Commission to assess the older population's need for care and services.[2] The Commission, created May 1, 2008, was charged with the following tasks:

- to review current care, services, and resources available to Commonwealth residents age 65 and older;
- to project the future need for care and services through the year 2025;
- to evaluate the ability of the current systems to meet the projected needs; and
- to project the resources necessary to meet the projected need and to make policy recommendations as to how the projected need can best be met given current resource limitations.

The Commission comprises nineteen members, including: Cabinet Secretaries of Budget, Health, Public Welfare, and Aging; individuals appointed by the majority and minority leaders within the Pennsylvania State Senate and House of Representatives; and nine individuals appointed by the Governor representing a range of stakeholders with experience related to long-term living. A list of members of the Commission can be found in Appendix B.

The Commission held seven in-person meetings and numerous teleconferences. Working groups were formed to focus on financing and the development of draft recommendations.

The Commission completed a report addressing the first of the four stated purposes in May of 2009. This "interim" report describes demographic characteristics of Pennsylvania's older adult population and currently available care, services, and resources. The final report addresses the last three purposes, including the Commission's policy recommendations. The Commission received staff support from the Commonwealth of Pennsylvania Office of Long Term Living and Thomson Reuters, a State contractor.

Section 2.
Report Methodology and Development of Recommendations

This report summarizes the Commission's findings from a year and a half of information gathering and structured discussion. Our main sources of information were: testimony from seven public meetings around the state (described below); policy research literature and background reports; primary and secondary data analysis; and presentations on topics such as the Pennsylvania Chronic Care Initiative and use of technology in home care. We analyzed data from state agencies, the Pennsylvania State University (PSU) State Data Center, the Medical Expenditure Panel Survey (MEPS), U.S. Census, and many other sources. We were fortunate to be conducting our work just as PSU was completing a long-term care fiscal impact study for the Pennsylvania Office of Long Term Living. This study included a survey of Pennsylvanians ages 50 and older, stakeholder focus groups, demographic projections, and development of an econometric model to predict Medical Assistance (MA) long term living expenditures through 2030. We were very grateful for this valuable resource and for PSU researchers' willingness to present their findings. In addition to these sources, Commissioners contributed their wide-ranging knowledge and professional and personal experiences.

As we finalized our report, the Congress passed federal health care reform and President Obama signed the Patient Protection and Affordable Care Act of 2010 (PPACA) into law.[3] These new policies and programs will have immediate and long-term impacts on older adults' access to health and long-term care (LTC). The PPACA contains numerous provisions which are designed to improve older adults' access to health and LTC, and quality of care, such as:

- the gradual elimination of the Medicare Part D coverage gap (the "doughnut hole");
- increased coverage of preventive services under Medicare;
- the creation of a voluntary insurance program to help people finance LTC (CLASS Act);
- incentives for states to expand Medicaid home and community-based services;
- funding targeted to improving care coordination, care transitions, management of chronic conditions and delivery systems such as the medical home practice model;
- funding to strengthen and expand the health professional and direct care workforce, especially as pertaining to geriatrics and addressing the needs of people with complex health conditions;
- the creation of an office within the Centers for Medicare & Medicaid Services to improve coordination of Medicare and Medicaid for dual-eligibles;
- improvements to elder justice and support for a national criminal background check program for LTC workers; and
- increased transparency of nursing home quality standards.

Federal health care reform will also affect state governments, most notably in the expansion of state Medicaid programs and establishment of state-based insurance exchanges.

We describe provisions of the PPACA throughout the report where applicable. Overall, we found that our policy recommendations, developed prior to passage of health care reform, aligned with many PPACA provisions. Given the newness of the law and uncertainty regarding its future impacts, we did not attempt to factor these changes into our analysis of older Pennsylvanians' future demand for health and LTC services and the resources needed to provide them.

PUBLIC MEETINGS

During the fall of 2008, the Commission convened seven meetings in locations throughout the Commonwealth to solicit public input. Over 270 people attended the meetings, with a minimum of four Commissioners at each meeting. Meetings were held in the following locations: State College, Meadville, Youngwood, Pittsburgh, Harrisburg, Germantown and Nanticoke. Appendix C contains the notice used to inform the public about the meetings.

We received oral and written testimony at each site from a variety of stakeholders who had comments on a broad range of topics. Many who testified were consumers who spoke passionately about their own experiences both as recipients and providers of care. Area Agencies on Aging (AAAs) testified about their growing role in assisting older adults while also facing waiting lists and flat funding for services.[4] Transportation issues were also raised, particularly related to serving older adults in rural areas.[5] Wellness was another key topic. Those who testified identified senior centers as playing a major role in public education, early detection, and prevention efforts. However, they also noted a constant struggle between wanting to do more in this area, and lacking resources to do so. Housing issues were also prominent. People requested more assisted housing options to facilitate nursing home transition and suggested changing the Personal Care Home policy such that people would not have to leave when their care needs reached a nursing facility (NF) level of care. Also, some raised the importance of incorporating universal design features into new housing stock.[6]

Other topics included the need for better wages and benefits for direct care workers, an overarching vision for senior services of the future (including areas such as senior communities, quality improvement, and technology) and greater consideration of the LTC needs of people with hearing and vision limitations, as well as for people with intellectual and developmental disabilities.[7] Not surprisingly, much of the testimony focused on inadequacy of current funding in virtually all aspects of care and services. A summary of these meetings and individual transcripts are posted on the Commission's website at **http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733454&mode=2**.

We have incorporated many of the comments made at the public meetings throughout this report. The public's input was invaluable in bringing the most critical issues to the forefront.

DEFINITION OF TERMS AND SCOPE OF REPORT

In this report we use the terms "long-term care," "long term living," and "long term services and supports" interchangeably. The Commission interpreted the terms "care," "services," and "resources" (referenced in Act 16) broadly, considering a wide range of care, services and resources available to older Pennsylvanians. Resources are defined as both financial and nonfinancial capital.

Over the course of our study, we refined our focus mainly to care and services we considered to be most critical to supporting older adults' ability to age in place in the setting of choice, with an emphasis on publicly-funded care, services and programs. This decision was guided by the comments we received at the public meetings as well as the collective experience of the members of the Commission. In our review of public comments, we found that people's chief concerns regarding current and future care, services and resources focused on: AAA and MA services and supports, the direct care workforce, housing, and transportation. We acknowledge that the report does not directly address several topics which are vitally important to older adults' wellbeing and successful aging—such as employment, civic engagement, and freedom from exploitation and abuse.

DEVELOPMENT OF RECOMMENDATIONS AND GUIDING PRINCIPLES

After describing the current array of care, services and resources for older Pennsylvanians, the Commission turned to the tasks of projecting future need for care and services and assessing the current system's capabilities to meet those needs and the resources required. As we analyzed the many issues the Commonwealth faces now, and will face in the future, in providing care and services for older adults, we identified some guiding views and assumptions moving forward.

First and foremost, our current health and LTC systems are neither adequate nor sustainable. Given limited resources, we must prioritize public programs for consumers with the greatest needs. However, government programs such as Medicare and Medicaid cannot be expected to finance all care and services for older adults, especially given that most Americans don't want to increase funding of public programs through taxation. Ensuring that care and services are available for current and future older adults requires Pennsylvanians to make hard choices. The public needs to understand it will require bringing additional revenues into the system and increased personal responsibility for financial planning.

Passage of the CLASS Act under health reform provides an alternative source of funding for long term services and supports (LTSS), which reduces some of the pressure on the Medicaid program (further discussed in Section 4). However, the future impacts of federal health care reform on trends in health and LTC spending are uncertain, including how the new provisions will affect state government and individual spending.

Given this uncertainty as well as the unknown potential for significant medical and/or technological advances, we believe the most reasonable approach is to make incremental changes now with the goal of mitigating service demands and associated costs and leveraging existing resources more effectively. Pennsylvania will be a leader and test case in this effort given that our population is aging faster than most of the country. These changes will require collaborative approaches between public and private

entities, they must be person-centered, and they must be reflective of and responsive to the increasingly diverse needs and preferences of older Pennsylvanians.

The Commission identified four critical focus areas which we believe offer opportunities for change to help us achieve a more sustainable system by 2025: financing and prioritization of resources; aging in place and care coordination; improving wellness; and workforce. Sections 4 through 7 explore these themes. Each section begins with the Commission's long-view resolution of where we want to be by 2025. We then describe key issues and progress the Commonwealth has made and discuss barriers to further progress. To address identified barriers, we present policy recommendations which we believe will move us toward our 2025 goals. In developing these recommendations, the Commission focused chiefly on actionable steps within the purview of Pennsylvania state agencies. A workgroup prioritized and refined a set of preliminary recommendations, which the full Commission then reviewed and approved.

"Are things where we want them to be? No. But, we have gone through a tremendous period of growth in numbers of people, especially the oldest of the old. In hindsight, I think we have absorbed a lot of that in a positive way. I think the same sort of creativity is what will get us through to 2025."

—Public testimony (Meadville)

• • •

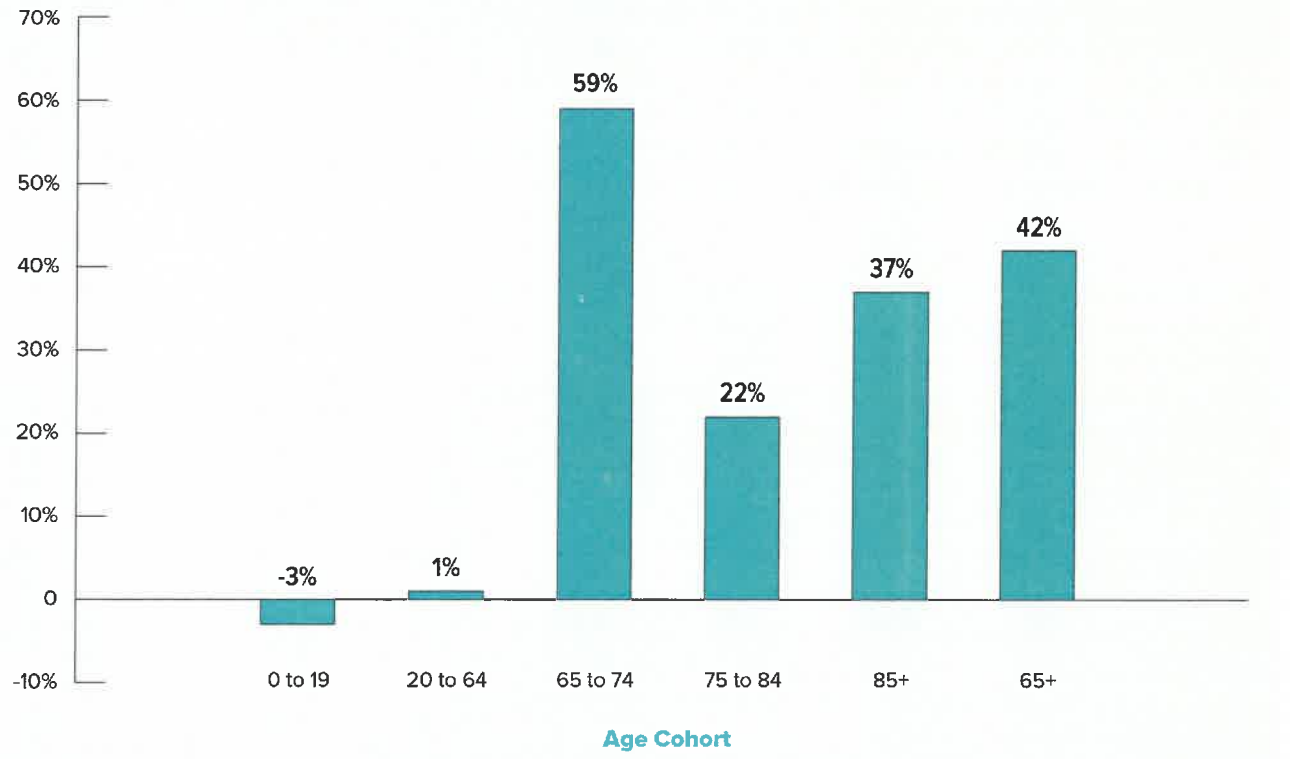
Section 3.
Demographic and Other Trends Related to Older Adults

We don't know what the future holds in terms of medical and technological advances, changing disease patterns, the national and state economic conditions, immigration and migration, and other key factors which influence care and service systems for older adults. The best we can do in considering how to address current and future service needs and the resources required to meet these needs, is identify demographic trends which are expected to shape the older adult population over the next 15 years.

SHARE OF POPULATION AGE 65 AND OLDER AND 85 AND OLDER

Based on PSU population projections, the fastest growing age cohort in Pennsylvania will be the 65 and older group, which is expected to increase by 42 percent between 2000 and 2025.[8] The 85 and older group is expected to increase by 37 percent during that timeframe. The share of people age 65 and older will increase from 15.6 percent of Pennsylvania's population in 2000 to an estimated 21 percent by 2025. The 85 and older group will increase from less than one percent of Pennsylvania's total population in 2000 to 2.5 percent by 2025. Figure 1 below shows projected Pennsylvania population growth rates by age cohort between 2000 and 2025.

Figure 1: Projections of Pennsylvania Population Growth Rates between 2000 and 2025: by Age Cohort



Source: Thomson Reuters analysis of Penn State University State Data Center Population Projections.

It is important to note that the aging of the population is not a temporary trend that will pass when the baby boom cohort moves through its old age.[9] In the early twentieth century, advances in public health decreased infant, child, and maternal mortality, shifting mortality more toward older adults.[10] The resulting increases in life expectancy and a trend of decreasing birth rates are expected to change the age distribution permanently.

OLD AGE DEPENDENCY RATIO

Pennsylvania has the third highest ratio of older adults to working age adults in the U.S., at 25 percent (2008).[11] This means for every 100 working age adults, there were 25 older adults. This ratio is projected to increase to 38 by 2025.[12] As the ratio of children to working adults is not expected to decrease significantly during the same time period, overall burden on working age adults will increase markedly.

LIFE EXPECTANCY

Life expectancy in the U.S. at birth, at age 65, and at age 75 has increased significantly over time.[13] The average life expectancy has increased by seven years since 1970 from 70.8 to 77.7. People age 65 in 2006 are expected to live another 18.5 years, compared 15.2 for those who were 65 in 1970. By 2020, the Census Bureau projects life expectancy will increase to 79.5.[14]

Longer life expectancy itself does not necessarily equate with greater demand for health and LTC services. However, by 2025, the combination of the projected increase in the number of the "oldest" old and decrease in working age adults to provide financial and other support will most likely lead to higher demand for care and services.

GENDER

Gender plays an important role in care and services for older adults because women are the majority of this age group, are more likely to be poor, and more likely to live alone. In 2006, women made up 57 percent of Pennsylvanians ages 65 to 84 and 72 percent of those ages 85 and older.[15] These shares are expected to shift downward slightly by 2025 with women projected to make up 55 percent of those ages 65 to 84 and 66 percent of those ages 85 and older.[16] Older women are twice as likely to have income below the poverty level: 13 percent of females ages 75 and older in Pennsylvania have income below poverty compared to six percent of males.[17] Nearly three-quarters of older Pennsylvanians living alone are female. Thus, women are more likely to need publicly-funded LTC services. In fact, in federal fiscal year 2008, females comprised 72 percent of Pennsylvania Medicaid beneficiaries ages 65 and older and accounted for 77 percent of this age group's Medicaid NF days. Women also make up 77 percent of consumers served in the OPTIONS program.[18]

INCREASED DIVERSITY

The older adult population of 2025 will be more diverse in many ways as compared to today's older adults. These differences must be factored into development of care and services, such as requirements related to cultural competency (e.g., language, household structure, social and caregiving preferences and networks).

As described in the Commission's *Initial Review*, the increase in older Pennsylvanians' racial and ethnic diversity by 2025 is expected to be fairly small on a statewide level (from 93 percent White in 2000 to 90 percent

by 2025). However, there are many communities within Pennsylvania which have significant racial and ethnic minority older adult populations. Given that growth rates among these populations, especially Hispanics/Latinos, are expected to be much higher than those for Whites, there will be localities in the Commonwealth with majority racial and ethnic minority older adult populations.

The future older adult population will also be more diverse in other ways such as living openly as lesbian, gay, bisexual or transgender (LGBT). In a national study MetLife Mature Market Institute and the American Society on Aging conducted in 2006, over three-quarters of respondents indicated they were mostly or completely "out" to their social network.[19] The LGBT population is projected to make up five to 10 percent of the greater older adult population and differ from the straight older adult population both in terms of challenges and resources.[20]

INCREASED ACUITY OF NURSING FACILITY POPULATION

Assessment data show that the acuity of Pennsylvania's NF population has increased over time and exceeds the national average. The percentage of Pennsylvania NF residents who need extensive assistance with three or more activities of daily living (ADLs) has increased from 57 percent in 2002 to 64.5 percent in 2008.[21] And, Pennsylvania's share of NF residents who require this level of assistance exceeds the national average by 11 percent. One theory as to why the acuity of Pennsylvania's NF population is high relative to other states is that the Commonwealth devotes a large amount of funding to home and community-based services (HCBS) for older adults through earmarked Lottery funds. As discussed in Section 4, the combination of state-only and Lottery spending on HCBS is higher on a per capita basis in Pennsylvania than in most other states. Acuity in nursing facilities may be increasing because expanded HCBS (both state- and Medicaid-funded) could be drawing "healthier" people with LTC needs.[22]

BEHAVIOR AND CHARACTERISTICS

There is much speculation about how older adults of the future will differ from today's elderly population and the impact this will have on health and LTC supports and services. As stated above, they will be a more diverse group. Baby boomers have higher levels of education and computer literacy compared to today's older adults. Then there are less tangible characteristics associated with boomers which are expected to shape their care and services such as: expectations of having choice, valuation of individualism, comfort with questioning authority, interest in assuming an active role in their care decisions, and use of complementary medicine.[23] Given health risks such as obesity, boomers are expected to have more chronic conditions than their predecessors. Yet, they are also described as more active and vital, thus it's hard to know how these two seemingly conflicting traits will shape the need for care and services.

Section 4.
Financing and Prioritization of Resources

Commission's long-view resolution for 2025: *Resources must be available to ensure older Pennsylvanians have options for where they receive long-term care, and receive high-quality, cost-effective and evidence-based care that is delivered through an efficient system.*

WHY IS THIS IMPORTANT?

Given that financial and non-financial resources are finite, we must strike a balance between Pennsylvanians' needs for services and supports and the Commonwealth's revenues to support these programs. There is ample evidence that many older adults are not currently receiving the supports and services they need to live independently in the community. In the near-term, the recession and related housing bubble and bust have reduced the financial means of many older adults, and those approaching retirement, creating legitimate worry about covering retirement, health and LTC costs. The longer-term outlook is also worrisome in that federal entitlement spending is "on an unsustainable path" given the historical and projected growth in per capita health care spending and aging of the population.[24]

Absent significant unforeseen changes in the future which could alter the trajectory of older adults' demand for services and/or our ability to pay for these services, resources for care and services for older adults will likely become even more limited by 2025. With projections that one in five Pennsylvanians will be an older adult by that point, it is imperative to establish effective ways to reduce demand and use available resources effectively and flexibly to provide care and services in consumers' setting of choice. This goal is articulated in the Rendell administration's 2020 Vision Report:

"High-quality long-term living options that give consumers a choice about where they receive care and support services, whether in institutional or home and community-based settings, will be available in Pennsylvania. Funds will be prudently managed to ensure availability to more people and a goal of 50% home living and 50% institutional care will be optimized, helping Pennsylvanians remain independent as they age."

FISCAL OUTLOOK

The current recession has hit Pennsylvania hard.[25] Pennsylvania's statewide unemployment rate increased from 5.3 percent in June of 2008 to over nine percent in June of 2010.[26] Although Pennsylvania is faring better than the nation, on average, on housing indicators such as prevalence of foreclosures and negative equity and loan-to-value ratios, three metropolitan areas of the state are listed in the Mortgage Bankers Association top-50 areas for negative equity (Pittsburgh, Philadelphia and Newark-Union).[27] According to the Federal Reserve Bank of Philadelphia's Coincident index, a monthly measure of states' economic health based on a composite of four indicators, Pennsylvania's index is below the national average and has declined by 10 percent in the past year.[28]

Like most states, Pennsylvania faces significant budget concerns. In October 2009, the Commonwealth passed a budget for FY 2009–10 which reflected a $1.9 billion decrease in state spending from the previous year

"We can never hope that the taxpayers and the lottery meet what the growing needs are going to be."

—Public testimony (Pleasant Gap)

and a $524 million decrease in overall budget spending (which includes federal stimulus funding). Despite the decrease in spending, the economic recession continues to impact Pennsylvania through loss of revenues, as evidenced by a FY 2009–10 year-end deficit of $294 million. Other state budget challenges include the expected end of federal fiscal relief in 2011 and a dramatic increase in public pension costs in 2012.[29]

IMPACT OF THE ECONOMY ON OLDER ADULTS

The down economy has also affected older Pennsylvanians' ability to pay for their own care and services, especially long-term supports and services (LTSS). Many retirees and those close to retirement age have experienced significant reductions in assets, both in their "nest eggs" and in the value of their homes. Whereas people tend to think older adults' retirement accounts are shielded from swings in the stock market, this is generally not the case. Prior to the recession, households headed by people age 50 and older held half their retirement assets in equities.[30] Analysis of the current financial crisis shows that assets in retirement accounts dropped 33 percent between September 2007 and March 2009.[31] While retirement account assets have rebounded by 23 percent since then, they are still below 2006 levels and significantly below their peak value in 2007.[32]

The value of a primary residence has traditionally constituted the majority of older adults' wealth, and is especially critical to middle income households.[33] Based on 2007 Federal Reserve survey data, over 85 percent of households headed by someone age 65 to 74 own their own homes, with a somewhat lower share of 77 percent for households headed by someone age 75 or older.[34] The value of a primary residence accounts for roughly two-thirds of assets for households headed by people age 65 and older.[35] The "older" boomer cohort also has the majority of household assets tied up in a primary residence (60 percent), though their assets portfolios tend to be more diversified compared to people ages 65 and older.

As a result of the housing "bubble" and "bust" of the last decade, many older adults are in a financially vulnerable position given the importance of home equity to their overall assets and the mortgage debt they incurred through refinancing and borrowing against home equity.[36] While mortgage debt has increased among people of all ages, the increase among older adults has been dramatic in the past ten years. Among families with household heads ages 65 to 74, over one-third have mortgages or home equity loans, an increase of 43 percent between 1998 and 2007 (compared to a six percent increase for older Boomers). The median value of mortgages and home equity loans for this age group has more than doubled during the same time period from $35,000 to $85,000. It is particularly problematic for older adults to incur debt and experience erosion in home equity and overall net worth because they typically have fixed incomes and rising health and LTC costs. Further, advanced age limits the ability to recoup lost funds through employment and/or waiting out down cycles in the housing and stock markets.

Loss of retirement savings and home equity could force older adults to remain in the workforce longer than they had planned. However, the overall lack of jobs appears to be prohibiting their employment. The unemployment rate for people age 65 and older recently reached the highest level since 1948.[37] The unemployment rate for this age group in July 2010 was 7.4 percent compared to 4.2 percent in July of 2007.[38]

The impacts of the economic turbulence of the past decade are reflected in retiree surveys. The Employee Benefit Research Institute (EBRI) surveys workers and retirees annually on topics such as confidence about having enough money for retirement and health and LTC expenses, and retirement savings.[39] In 2009, workers' and retirees' responses showed decreased confidence in having enough money to live comfortably through retirement compared to previous years.[40] Only 13 percent of workers and 20 percent of retirees reported they were "very confident" on this measure in 2009 compared to 27 percent of workers and 41 percent of retirees in 2007.[41] Thirteen percent of workers and 25 percent of retirees in 2009 reported being "very confident" they would have enough money in retirement to pay for medical expenses. Even lower percentages of workers and retirees were "very confident" they would have enough money to pay for LTC: 10 percent of workers and 15 percent of retirees. All responses showed decreases from previous years.

Results of PSU's Long-Term Care 50+ Survey also show concern among Pennsylvanians age 50 and older about their ability to pay for LTSS.[42] Nearly three-quarters of respondents said they were somewhat or very worried about their ability to afford LTSS. Given that 94 percent of all respondents anticipated using Medicare to pay for LTSS, presumably even higher percentages of people would be worried about their ability to afford LTSS if they knew that Medicare's coverage of these services is very limited.[43]

PENNSYLVANIA'S CURRENT PUBLIC FUNDING OF SERVICES FOR OLDER ADULTS

Pennsylvania currently devotes a large share of its public funding to services for older adults, including LTSS. In federal fiscal year 2008, people ages 65 and older comprised over a quarter of Pennsylvania's total Medicaid spending of $12.5 billion, with this population comprising only nine percent of all beneficiaries with a paid claim.[44] Nearly 80 percent of the Commonwealth's Medicaid spending on this age group went toward NF services.[45]

Pennsylvania's state-only funding for services and supports for older adults is very generous as compared to other states. Based on data collected by the National Academy for State Health Policy and AARP, Pennsylvania expended $182 million in 2007, ranking 4th in the country in state-funded HCBS on a per capita basis.[46] An essential component to this funding is earmarked Lottery funds: Pennsylvania is the only state in the country that designates its state lottery proceeds solely to programs for older adults.[47] In State Fiscal Year 2008–2009, the Lottery devoted nearly 30 percent of its $3.1 billion in sales to these programs, including a large pharmaceutical assistance program (PACE).

"I don't know how I'm going to afford to pay for the help that I'm going to need, whether it's in the home or in a residential place. I'm glad there's medical assistance, and frankly, I mean, not everybody knew those terms, but especially with what's going on with the economy, you know, you can plan all you want, but that doesn't mean that that nest egg that you built is going to be there."

—Public testimony
(Westmoreland County)

PROJECTED LONG-TERM CARE AND HEALTH CARE COSTS AND OLDER ADULTS' ABILITY TO AFFORD CARE

Long-Term Care

It is difficult to project how much LTSS will cost across payer sources by 2025 and whether older Pennsylvanians will generally be able to afford them. As noted previously, the passage of federal health reform, changes to federal and/or state tax code, medical advances and other factors could dramatically change demand, service delivery, and financing. However, there are a few ways to examine this topic, holding these factors steady.

At the most basic level, we can estimate older Pennsylvanians' MA LTC spending in 2025 by adjusting current per capita MA LTC expenditures by projected population growth. This would not account for any changes over the time period in inflation, delivery systems, utilization, technology, etc., but shows how significantly expected population growth alone would impact expenditures. Table 1 below shows that expenditures would increase by 24 percent from $2.9 to $3.6 billion during this time period if population growth were the only factor. Figure 2 depicts the current and projected expenditures by age group.

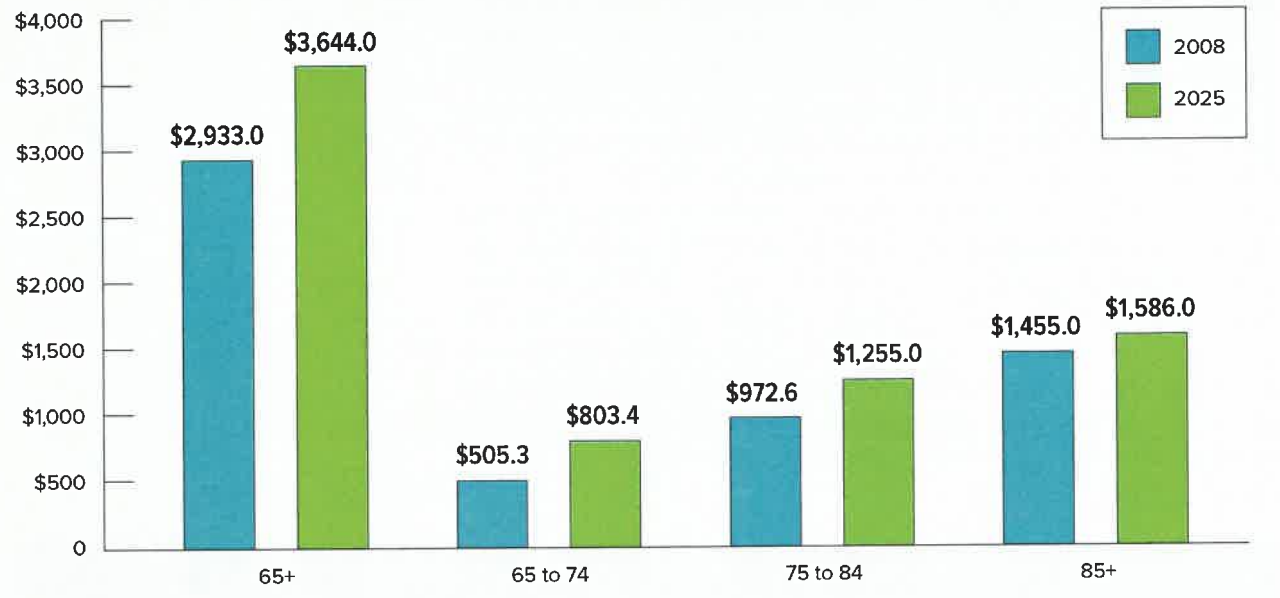
Table 1. Pennsylvania FFY 2008 MA LTC Expenditures for Persons Ages 65 and Older and Projections to 2025

Age Group	Total MA LTC Expenditures (FFY 2008)	# of Beneficiaries Using any MA Services	Per Capita MA LTC Expenditures	# of Beneficiaries Projected for 2025 based on PSU Population Projections by Age Group from 2010 to 2025 (see notes below)	Total Projected MA LTC Expenditures in 2025
65 to 74	$505,277,929	77,923	$6,484	123,898	$803,354,632
75 to 84	$972,616,103	61,586	$15,793	79,446	$1,254,690,678
85+	$1,455,404,294	51,636	$28,186	56,283	$1,586,392,638
65+	$2,933,298,326	N/A	N/A	N/A	$3,644,437,948

Source: Thomson Reuters analysis of MSIS State Summary Datamart, FFY 2008 (CMS interactive database containing state-reported Medicaid statistical information).

Note: For the purpose of this analysis, LTC includes the following MSIS service categories: NF, ICF-MR, mental health facility for persons age 65 and older, home health, home and community-based services waivers, personal care, targeted case management and hospice. The analysis is limited to persons ages 65 and older (age groups in the Datamart cannot be customized, thus it was not possible to examine spending for those ages 60 and older). The PSU State Data Center population projections by age group are based on the general population; they are not specific to the MA population. Percentage increases in population between 2010 and 2025 were as follows: 59% for those ages 65 to 74; 28.7% for those ages 75 to 84 and 8.8% for those ages 85 and older.

Figure 2. MA LTL Expenditures for Pennsylvanians Ages 65+ by Age Group: Actual 2008 Compared to Projected 2025 (in millions)



Source: Thomson Reuters analysis of MSIS State Summary Datamart FFY 2008 and PSU population growth projections by age group.

Note: Long term living services include: nursing facility, ICF-MR, inpatient mental health facility, home health, personal care, targeted case management, HCBS waivers and hospice.

A national study used an econometric model to estimate the risk of using LTC for people currently turning age 65 and the cost of that care through their lifetime.[48] The findings were, on average, people would need LTC services for three years and would need to set aside roughly $50,000 (in 2005 dollars) to pay for this care. However, an even more interesting finding of the study was the significant variation around those averages. Nearly a third of people would not have any LTC needs during their lifetime, whereas 20 percent would need LTC for five or more years. Further, while the majority of people (60 percent) would have LTC expenditures of less than $10,000, nearly one-fifth would have expenditures of $100,000 or more.[49]

Another study commissioned by AARP estimated the lifetime probability of needing LTC services and the lifetime costs of supporting people with LTC needs in the community (including those living in nursing homes who could be cared for in the community). The study found that 44 percent of males and 72 percent of females would develop a disability in at least two activities of daily living for at least three months, or become cognitively impaired, after turning 65 (with paid services starting at an average age of 82). The average lifetime service costs associated with ensuring that all individuals who develop a disability can remain in their homes and have all their needs met was $175,000 (in 2002 dollars).[50] The median cost of maintaining someone age 65 or older with LTC needs at home was $135,000 (in 2002 dollars).[51] In 2009 dollars, this would be $161,000. Projecting to 2025 at average annual inflation rate of 2.5 percent, this would be $239,000.[52]

As part of a Long-Term Care and Fiscal Impact study commissioned by the Office of Long Term Living, PSU developed an econometric model to project total MA LTC spending for older adults and people with physical disabilities through 2030.[53] The Commission requested use of this model

to test the feasibility of projecting MA LTC spending through 2025 under several assumptions about average annual inflation: zero, a base case reflecting historical trends (estimated as 2.6 percent), and three percent. The results of this statistical analysis indicated these values would be $4.4 billion, $6.7 billion, and $7.1 billion, respectively, by 2025. The current spending was estimated to be roughly $3.9 billion.[54] The analysis was based on the current mix of consumers in terms of the share living in institutions versus the community.[55] See **Technical Notes** for a description of the PSU model and some of its assumptions.

The PSU statistical model and other econometric approaches described above are instructive in identifying the magnitude of future resources needed for LTC at the individual and state level (specific to MA-eligible individuals). Upon reviewing the methodology and underlying assumptions of the PSU model, the Commission ultimately determined its scope was too limited to estimate with a reasonable degree of certainty the expected resources required to meet the care and service needs of older Pennsylvanians by 2025. The main limitation is the narrow focus on MA long term living programs rather than a broader spectrum of publicly-funded health and LTC services.

Health Care

Health care costs too can be a significant burden for older adults. In analysis of 2006 Medical Expenditure Panel Survey (MEPS) data, researchers found that over a quarter of noninstitutionalized people age 65 and older spent more than 20 percent of their household income on health care.[56] This share is much higher for certain groups such as people in fair or poor health status, people with income below 200 percent of poverty and those in the 85 and older age group. The majority of this spending goes toward premium payments (e.g., Medicare, employer-sponsored retiree coverage and Medigap). Fidelity investments estimated that a couple retiring at age 65 in 2009 would spend $240,000 on health care costs (excluding LTC) over the remainder of their lifetime.[57] While federal health care reform may reduce Medicare beneficiaries' out-of-pocket health spending through provisions such as the gradual elimination of the Medicare Part D coverage gap, it is difficult to project how the new law will affect older adults' health care costs over the long-term.

One way to assess older Pennsylvanians' current and future ability to pay for LTC and health care is to compare estimates of average household income and assets for people age 65 and older to their potential LTC and health care costs (assuming no LTC insurance). To the extent possible, the figures presented are specific to Pennsylvania. This analysis is presented in Table 2.

Table 2. Financial Resources Compared to Potential LTSS and Health Care Costs: Older Pennsylvanians

Financial Resources/Costs	Amount	Notes/Methodology	Data Source and Date
Resources:			
Annual income	$29,810	PA Median individual age 65+	U.S. Census, American Community Survey, Average 2006–2008
Net total assets	$251,000	National* median figure of financial and nonfinancial assets for all households with heads age 65 +	Federal Reserve 2007 Survey of Consumer Finances
Net financial assets	$51,200	See above—limited to financial assets for those with financial holdings	Same as above
Net home equity (median for households with a primary residence)	$149,000	See above—limited to households with primary residence	Same as above
Potential LTSS and Health Care Costs (One Year):			
One year in a nursing facility	$88,695	Statewide average of $243 per day in a private room	2008 MetLife Market Survey of Nursing Home and Assisted Living Costs
One Year of Assisted Living	$34,152	Statewide average monthly cost of $2,846	Same as above
One year of home health—5 days a week at 3 hours per day	$15,000	Statewide average of $20 per hour for a home health aide for 50 weeks (for a person with limitations in at least 2 ADLs)	2008 MetLife Market Survey of Adult Day & Home Care Costs
3 days a week of Adult Day Center	$8,550	Statewide daily cost of $57 multiplied by 3 for 50 weeks	Same as above
1 year of average out-of-pocket health care costs (community-dwelling population)	$2,959	National* average for people age 65+. MEPS excludes institutionalized people, thus this amount should not overlap with the NF costs above.	2006 MEPS Household Component

Sources: noted herein.

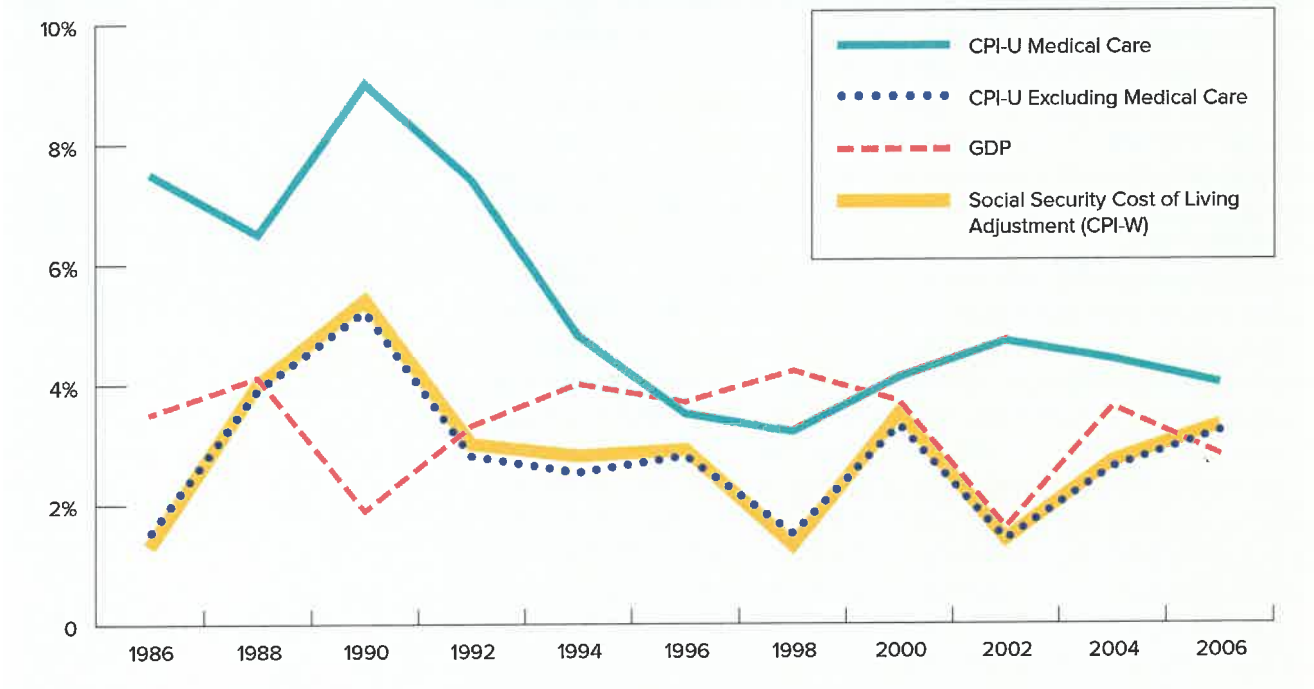
* State-level data sources not available.

As shown, LTSS are quite costly when compared to the median income and assets of older adults. The average cost of one year of residential care (NF or assisted living) far exceeds the average income of an older Pennsylvanian. NF care also exceeds the average financial assets of a household headed by someone age 65 or older (based on national data). If an average older Pennsylvanian devoted all of his or her income to the cost of assisted living, and paid for the remainder out of financial assets, these assets would be depleted within a year. Someone with significant and ongoing home health needs would need to pay over half of his or her average income for a home health aide.

Other factors affecting the future affordability of health and long-term care services

Looking to the future, assuming there are no significant changes in growth of health care spending[58] and older adults' income and net wealth, it will become even more difficult for older adults to afford these services. As shown in Figure 3, consumer prices for medical care have risen faster than those for goods and services without medical care and the economy as a whole since the 1980s and these trends are expected to continue.[59] Also, increases in medical care prices exceed increases in Social Security income because the cost of living adjustment for Social Security is tied to the consumer price index for urban wage earners and clerical workers (the gray line with dashes in Figure 3). Social Security makes up at least half of total income for nearly two-thirds of older Pennsylvanians and one in four rely on it as their only source of income.[60]

Figure 3. Percent Changes in U.S. Price Indexes and GDP: 1986–2006



Source: Thomson Reuters analysis of 2009 Economic Report to the President, Statistical Tables, and Social Security Administration Cost of Living Adjustment Series.

The outlook for solvency of the Social Security and Medicare programs is another cause for concern as these programs are critical supports for low- and middle-income older adults. The 2009 Trustees Report on Social Security estimates that program expenditures will exceed tax revenues by 2016, depleting reserves by 2037.[61] And the Medicare program's solvency is even more precarious, with projections that the Hospital Insurance fund will be exhausted by 2029.[62]

Growth in health care spending, especially public spending, has shown no signs of abating. There are numerous provisions in the new health care reform law designed to reduce this spending. But, there are mixed views as to whether the law will achieve this. The Congressional Budget Office and CMS Chief Actuary differ in their estimates of the impact health care

reform will have on health care spending. The actual impacts of the law will not be known for many years.

According to health spending projections recently released by the Centers for Medicare & Medicaid Services, health care spending as share of GDP is expected to exceed 17 percent in 2009, the largest one-year increase in health spending as share of GDP since the National Health Expenditure Accounts started tracking this in 1960.[63] Public spending is projected to account for more than half of all health care spending by 2012. Growth in health care spending isn't necessarily a bad or good thing. Researchers have pointed out that costs for some are revenues for others. However, it is unlikely that these revenues are accruing to older adults unless they are employed and/or financially invested in the industry. While older adults account for a disproportionate share of this spending, this is not necessarily a benefit to them as higher spending doesn't guarantee better outcomes or quality.[64]

WHAT IS PENNSYLVANIA DOING NOW?

The Commonwealth is undertaking a number of activities to help people plan for their LTC needs and costs and utilize public funding more effectively. Some examples of these efforts are Pennsylvania's participation in the federal LTC Awareness Campaign, implementation of a LTC Partnership Program, offering group long-term care insurance (LTCI) to state employees, participation in the Money Follows the Person Demonstration, Nursing Home Transition and Services My Way Programs, and development of programs which integrate financing and health and LTC services such as Living Independently for Elders (LIFE).

In 2008, Pennsylvania participated in the U.S. Department of Health and Human Services "Own Your Future" Long-Term Care Awareness Campaign. This effort, aimed at increasing awareness of the need to plan for LTC, featured a letter from Governor Rendell mailed to 1.7 million state residents between the ages of 45 and 65 with information on how to order a planning toolkit. The response rate to the campaign was 18 percent (measured by requests for the toolkits). Pennsylvania's response rate was the second highest among the 25 states participating in the campaign. The Commonwealth contributed its own resources by adding information on LTC insurance (LTCI) to the Department of Insurance Web site and purchasing television and radio spots and Internet advertising. While results are not yet available, a study of states which implemented Own Your Future campaigns prior to Pennsylvania showed increased planning actions and take-up of LTCI after the campaign.[65]

Also in 2008, Pennsylvania launched a Long-Term Care Partnership Program to encourage the purchase of LTCI. This program allows people to purchase private LTCI with an understanding that they can access Medicaid without impoverishing themselves should the LTCI not cover all of their LTC costs. As of December 2009, 15 out of over 90 insurers in Pennsylvania participated in the program and over 1,000 policies had been purchased.[66]

Most permanent state employees may purchase group LTCI as one of their voluntary employee benefits.[67] This benefit was first offered in 2009 and allows employees and their family members to choose from four plans with varying benefit levels. Only 1,636 people have purchased an optional state employee LTCI plan so far, out of roughly 80,000 state employees and an unknown number of eligible family members.[68] Most enrollment occurred during the initial rollout, with very little increase since then.

In order to use public LTC dollars more effectively and maximize consumer choice, the Commonwealth administers programs which allow people to transition people out of institutions (the Money Follows the Person and Nursing Home Transition programs) and manage their own LTC budgets (Services My Way).

Pennsylvania's Money Follows the Person and Nursing Home Transition Programs

Pennsylvania is one of the 30 states participating in the federal Centers for Medicare & Medicaid Services Money Follows the Person (MFP) Rebalancing Demonstration Program. This program provides funding to states to help them balance their LTC systems towards more community-based care and transition Medicaid recipients living in institutions back to the community. The Commonwealth began enrolling individuals in MFP in July 2008 and has moved over 400 people out of institutions thus far, over two-thirds of whom are older adults who were living in nursing facilities. Health care reform not only extended the MFP program through 2018 and provided significant additional funding, it also changed eligibility criteria such that persons residing in nursing facilities for three months or longer could qualify for enrollment in MFP (excluding short-term rehabilitative stays). Prior to this, only persons who had been residents for at least six months could participate. States found this requirement hampered their transition efforts in that many nursing home residents had lost their housing and informal supports by six months.

In addition to MFP, the Commonwealth has had a Nursing Home Transition program since 2006. This program has transitioned roughly 2,000 people age 60 and older out of nursing facilities in the past two years. Persons who do not qualify for transition through MFP because they are not eligible for Medical Assistance may qualify under Pennsylvania's NHT program. Area Agencies on Aging administer both the MFP and NHT programs for older adults.

Pennsylvania's Services My Way (Cash & Counseling) Program

Pennsylvania's Services My Way (SMW) program is modeled on the national Cash & Counseling demonstration program, in which four states piloted flexible spending accounts, including employment authority, for persons receiving Medicaid-funded LTC services. Within individual budgets, consumers could choose the shares of funding going to the purchase of direct care, goods and services. The premise of Cash & Counseling is that given a fixed budget, flexibility on what can be purchased, and support in budget management and employment of attendants, consumers will choose goods, services and providers which maximize their quality of life. In evaluations of the original Cash & Counseling demonstrations, not only did participants have greater satisfaction and better health and wellbeing outcomes, but states also saved in Medicaid expenditures through reductions in the use of high-cost services such as hospital and nursing home admissions.

While many Pennsylvania HCBS waivers offer consumer-directed attendant care services, SMW provides even greater consumer control in that consumers are given a budget and flexibility to purchase the goods and services they believe will meet their community support needs and maintain their independence. Currently, SMW is offered in two waivers (Aging and Attendant Care) and 17 counties: 23 consumers participate.[69] The Commonwealth will evaluate findings from the program and make recommendations on statewide implementation.

Pennsylvania is gaining experience with integrated financing and care models through its LIFE programs, modeled on the national Program of All-Inclusive Care for the Elderly model. The LIFE program has had many successes in improving the wellbeing of participants, including increasing their mobility and ability to manage their chronic conditions and decreasing social isolation and related depression.

Pennsylvania LIFE Programs

Pennsylvania has more LIFE programs than any other state. There are currently 19 LIFE programs across the state with enrollment of over 2,200. An additional seven sites are under development. LIFE provides integrated Medicare and Medicaid primary, acute and LTC services to people ages 55 and older who require a nursing facility level of care. An interdisciplinary team delivers care and services to participants, mainly in an adult day care setting.

The Commonwealth is also developing an integrated Medicare and Medicaid program called the Integrated Care Option for people ages 60 and over who are dually eligible for Medicaid and Medicare and enrolled in Medicare Special Needs Plans (SNPs). Roughly 50,000 dual-eligibles in this age group are currently enrolled in SNPs which provides the Commonwealth with a unique opportunity to better coordinate Medicare and Medicaid services for this population. As stated earlier, the vast majority of MA spending for this population goes toward NF services. Through integrated care, the Commonwealth can establish incentives for plans to better coordinate acute and LTC, increase access to community-based services and supports and reduce institutionalization of older adults.

Finally, to better facilitate the Commonwealth's goals related to rebalancing the LTC system, Governor Rendell restructured the Departments of Public Welfare and Aging to create a unified Office of Long Term Living. He also combined institutional care and HCBS into one budget line item, making total long term living funding more fungible.

"You have done the impossible; my mother was always withdrawn from socializing and we felt that she was waiting to die; she only wanted to be around family. Because staff have shown how much they care and worked diligently with her, my mother looks forward to going to the LIFE center, talking with other participants and staff, as well as participates in activities. My mother smiles more, talks more, and lives more."

—LIFE Success Stories,
Office of Long Term Living

• • •

WHAT BARRIERS AND SYSTEM CONSTRAINTS DOES PENNSYLVANIA FACE?

The Commonwealth faces some significant constraints in meeting the current and future needs of its older adult population. For one, there is a tension between the public's appetite for care and services and willingness to fund these services through higher taxation. Also, there is a basic lack of understanding about LTC and how it is financed. Further, adults tend not to plan for their care and service needs. Finally, there are state and federal administrative barriers to integrating financing and care (though federal health reform addresses these issues).[70] Given the trajectory of health care spending and population demographics, new resources will need to be available by 2025.

POLICY RECOMMENDATIONS

POLICY RECOMMENDATION #1:

Develop strategies to educate Pennsylvanians about the need to plan for long-term care needs and increase self-funding of long-term care through various mechanisms, such as: improving incentives for purchasing long-term care insurance and/or participating in the Long-Term Care Partnership under Act 40.

There is considerable research showing that people do not save sufficiently for retirement, including health and LTC costs. In the recent EBRI study of workers and retirees, most people reported having saved money for retirement, but their savings were below $25,000. Less than a quarter of each group reported having savings of $100,000 or higher. Finally, the survey shows that the majority of workers, 56 percent, do not calculate how much money they will need in retirement. Even in non-recessionary periods, national studies have found roughly two-thirds of community-dwelling older adults do not have sufficient savings to pay for one year of nursing home care.[71] Further, national survey findings show correlations between health status and income and wealth whereby those reporting lower health status (e.g. "fair" or "poor") tended to have lower income and wealth compared to those reporting their health status as "very good" or "excellent." The implications are that those in most need of care and services are least able to pay for these services.

Many adults approaching retirement age do not understand the risk of needing LTC, nor do they know how it is financed. Penn State's 50+ LTC Survey revealed a critical gap in knowledge in that 94 percent of those surveyed reported they anticipated that Medicare would pay for LTC. As noted in the Commission's interim report, Medicare's coverage of LTC is limited to skilled nursing care provided in a skilled nursing facility (SNF) or in the home through a Medicare-certified home health care agency. And, these benefits are further limited by eligibility criteria and, in the case of SNF, duration of the care. Further, a much larger share of people reported anticipated use of private LTCI than is reflected in Pennsylvania coverage rates. Nearly half reported they planned to use private LTCI to finance their LTC needs, whereas data on the number of in-force LTCI policies in Pennsylvania suggest market penetration is more like six percent.[72] Thus, people may be mistaking other insurance coverage for LTCI. Regardless of what percentage of Pennsylvanians actually have LTCI, we know that on a national level, LTC and other private insurance only finances about seven percent of total LTC spending.[73] ***Another troubling finding from the PSU 50+ survey is that over two-thirds of respondents reported they planned to use MA to pay for LTC.***

POLICY RECOMMENDATION #2:

Provide additional incentives for self-funding of long-term care through implementation of a social insurance program modeled on the Class Act as enacted either through federal or state legislation.

For many reasons, the variation and associated financial and nonfinancial risks related to LTC use and costs are challenging to address through any one of the current private or public options (e.g., LTCI, tax credits and deductions, Medicaid, Older Americans Act and state-funding). Accordingly, a complementary approach of utilizing both private and public mechanisms to protect against catastrophic loss seems most promising.[74] The Community Living Assistance Services and Supports (CLASS) Act, which is included in the recently passed federal health care reform, will establish a disability insurance fund financed through voluntary payroll premiums. While this program is designed to supplement other resources rather than finance all of a person's LTSS needs, it is still an important new source of financing for LTC.

Community Living Assistance Services and Supports (CLASS)

The PPACA establishes the Community Living Assistance Services and Supports program (CLASS): a publicly-administered, national voluntary insurance fund to help pay for long-term services and supports. Employed individuals ages 18 and older may participate in CLASS through payroll deductions or an alternative mechanism for individuals with more than one employer, those whose employers choose not to participate, or persons who are self-employed. Individuals whose employers participate will be enrolled in the program automatically, but can opt-out.

Premiums will be developed by the Secretary of the U.S. Department of Health and Human Services (HHS) based on actuarial estimates over a 75-year period.[75] CLASS provisions prohibit adjustment of premiums (underwriting) based on any factor other than age. Premiums for certain individuals (e.g., low-income) will be subsidized.

In order to receive benefits under CLASS, individuals must have a functional or cognitive impairment expected to last at least 90 days and must have paid premiums for at least five years (including three years in which they were employed). Benefits will be at least $50 per day and paid directly to beneficiaries in cash. Benefit amounts will vary depending on the individual's level of impairment and duration of benefit payment is unlimited as long as the person meets the eligibility criteria. In addition, CLASS will provide advocacy services and counseling on how to access and coordinate LTC services.

Many details of the program remain to be developed by the HHS Secretary, including premium amounts, range of daily benefits and level of impairment which will trigger benefits. The law does not specify a date by which the program must begin enrollment.

POLICY RECOMMENDATION #3:

Assess the feasibility of developing and implementing an integrated financing system (Medicare, Medicaid, state funding) across the care continuum to eliminate care silos and delay or prevent nursing facility admission through better care coordination and timely interventions.

Finally, even when states are committed to developing programs which integrate multiple financing sources and acute and LTC service delivery, they face many barriers in implementing these programs. Start-up is costly as it usually requires additional staffing and procurement activities, and extensive changes to information systems. Such programs usually require either state plan amendments or federal waivers, which are labor-intensive and lengthy undertakings. And, federal requirements related to Medicare and Medicaid are often out of sync and not flexible enough to allow funds to be used for the most effective services.[76] Despite these challenges, we urge the Commonwealth to continue to explore efforts which integrate financing from multiple sources such as the Integrated Care Option. The creation of a Federal Coordinated Health Care Office at the Centers for Medicare & Medicaid Services is a promising step in advancing states' efforts to integrate financing and service delivery for dual-eligibles.

Section 5.
Aging in Place and Care Coordination

Commission's long-view resolution for 2025: *Older Pennsylvanians will have access to a full range of coordinated, flexible services and housing options to support "aging in place" defined as having the choice to live within a community which fosters independence and meets their care and service needs.*

WHY IS THIS IMPORTANT?

Most people prefer to age in their own homes or other community setting of their choice. In Penn State's Long-Term Care 50+ Survey, over 90 percent of respondents indicated a preference to receive care in their own homes, and over three-quarters indicated a preference to receive care in a residential setting such as assisted living (people could choose more than one preferred setting). In fact, based on national data, the vast majority of people using LTC services do live in the community, with most being supported through informal (unpaid) care.[77]

Yet the current system is very strained, with people on waiting lists for services and supports and many unpaid caregivers undertaking tremendous physical, emotional, and financial burden. There are a number of critical resources which must be in place to support people as they age in place, such as affordable and accessible housing, help with ADLs (including instrumental activities or "IADLs"), accessible and safe transportation, and coordination of medical and LTC needs, to name just a few.

Recent research examining the factors that influence success of HCBS in keeping older adults in community settings found that receipt of paid assistance in IADLs and awareness of their own unmet needs were the most significant.[78] This supports the importance of identifying needs and providing assistance earlier rather than waiting until people have developed more serious impairments. In this section we focus on community supports and services. We discuss unpaid caregiving and the workforce issues in Section 7.

UNMET NEED FOR SERVICES AND SUPPORTS AMONG OLDER PENNSYLVANIANS

It is difficult to accurately measure current unmet need for services and supports among older Pennsylvanians because the available tools for tracking this, such as waiting lists, do not fully represent all who are in need. For example, waiting lists for AAA services do not include people who requested services but were currently ineligible for existing programs. Nor would waiting lists capture people who have unmet care needs, but do not request help either because they don't recognize their needs, don't know where to go, or for other reasons (e.g., the stigma of asking for help).

In the last national survey which examined unmet need for LTC services, one in five people who needed LTC had unmet needs for care.[79] In Penn State's 50+ LTC survey, 12 percent of caregivers reported that the person they cared for had unmet needs after informal and formal care were taken into consideration and eight percent of people receiving care reported having unmet needs. Looking at a more impaired population of dual-eligibles on waiting lists for home and community-based waivers in six states, researchers found that more than half of people who needed help with ADLs reported

unmet needs.[80] Over half of people with unmet needs reported a serious consequence from not receiving care, such as falling, not being able to bathe or shower, or wetting or soiling themselves.

As of July 2009, 46 out of 52 AAAs reported having waiting lists for supports and services. Roughly 2,700 older Pennsylvanians were waiting for services through the OPTIONS program and over 380 were waiting for services through the Family Caregiver Support Program.[81] In addition, there were hundreds of people receiving some services through the OPTIONS program but waiting for additional services such as personal care, home support, home delivered meals, and personal emergency response systems.[82] Of the 175 consumers waiting for home-delivered meals, most were at nutritional risk (based on a standard screening tool). At the Commission's public meetings, many representatives of aging agencies spoke about the difficult decisions they faced in allocating scarce resources. Some operate under the policy that it is better to serve fewer people but provide adequate services, whereas others serve as many as possible but knowingly provide less than the needs identified in individual's care plans.

In terms of MA long term living services, Pennsylvania does not have a waiting list for its primary HCBS waiver serving older adults, the Aging waiver. However, 442 people age 65 and older are on a waiting list for waivers operated by the Office of Developmental Programs.[83] Pennsylvania does not provide personal care as an optional benefit through its MA program, thus people who do not meet NF level of care cannot get this type of assistance through MA. As NF care is a mandatory MA benefit, people who meet the financial and functional criteria have unrestricted access to NF care. However, in practice, there may be constraints in some areas based on the availability of MA beds.

"We actually have reductions in care plans. We have five or six hours a week and all of a sudden we get from a county saying reduce it to four. I don't know how the person needed six and now they need four. They're getting older, I can't imagine they're getting better."

—Public testimony (Westmoreland County)

• • •

AFFORDABLE AND ACCESSIBLE HOUSING

A crucial component of older adults' ability to age in place is availability of affordable housing in which people with mobility or other impairments can safely reside. As noted previously, the vast majority of older adults own their own homes. However, that doesn't mean their homes are affordable and appropriate to their needs. Nearly 30 percent of Pennsylvania households in which the householder is age 65 or older have housing costs at or exceeding 30 percent of household income.[84] Housing cost burden is significantly greater for older Pennsylvanians who are renters, with over half of such households paying rents equivalent to 30 percent or more of their household income.[85] Of renters deemed by the U.S. Department of Housing and Urban Development to have "worst case needs," over 20 percent are defined as elderly households (those with a head or spouse at least 62 years old).[86] These are very low income renters who do not receive housing assistance and either have severe housing rent burden (paying more than half their income in rent) or severely substandard housing.[87] Of all elderly household renters, three-quarters have problems either with rent burden or inadequate housing.[88] Rent burden comprises the vast majority of the problems. According to the Intra-Governmental Council on Long Term Care's Housing Alternatives Work Group, Pennsylvania has a higher percentage of older renters than other states.[89]

Older householders are also more likely to live in older homes, which may be more difficult to modify to meet accessibility standards. Based on Census data, two-thirds of older Pennsylvanians live in homes which were built prior to 1970 compared to 58 percent of non-elderly adults.[90] This is

especially an issue in Philadelphia and other urban areas where most of the housing stock consists of row houses with two to three floors, narrow passageways, outside and indoor steps, and no first-floor bathrooms.[91]

Public and subsidized housing

There are three main types of public or assisted housing programs in Pennsylvania: HUD public housing, properties financed through low-income tax credits, and housing choice vouchers (formerly Section 8). There are some Section 202 properties, the only federal housing program focusing solely on the elderly, but they do not comprise a significant share of the State's subsidized housing. Overall, just over a third of HUD public housing units in Pennsylvania are designated for the elderly.[92] Only a small share of these are accessible: 10 percent of all HUD housing units in Pennsylvania have accessible features, most of which are units designated for people with disabilities. Nineteen percent of households using housing choice vouchers in Pennsylvania are elderly families (including families defined as both elderly and disabled).[93]

While there is no statewide source of information on waiting lists for public and subsidized housing, individual housing authorities track this information. Collecting this information for multiple housing programs across all Pennsylvania counties was beyond the scope of this project. However, we present examples of waiting lists and average waiting times for two Pennsylvania counties with high percentages of older adults in the table below. Note that some housing authorities prioritize certain groups of people (e.g. homeless, veterans), which would shorten waiting times for these individuals. Also, not all housing authorities track the number of older adults on their waiting lists separately from people with disabilities, thus it is difficult to assess the demand specific to older Pennsylvanians.

Table 3. Waiting Lists and Waiting Times for Pennsylvania Affordable Housing in Luzerne and Westmoreland Counties—Older Adults

County/area	Number of older adults on waiting list	Type of waiting list	Average waiting time
Luzerne County Housing Authority	50–60	Vouchers	1–1.5 years
Luzerne County Housing Authority	700*	Public housing	1 year
Westmoreland County Housing Authority	82	Vouchers	2 years
Westmoreland County Housing Authority	Average of 10, but varies widely by property	Public housing	A few weeks–few months

Note: *this includes people with disabilities.

Congregate housing and continuing care retirement communities

The main types of congregate housing for older Pennsylvanians are assisted living facilities, personal care homes and domiciliary care. In January 2011, the Commonwealth will implement its first regulation outlining licensing

requirements specific to assisted living. Personal care homes are "board and care" homes for low-income people with personal care needs and will continue to operate under existing PCH regulations. Older adults whose level of functioning qualifies them for NF care are not eligible to living in personal care homes. Thus, many have not been able to age in place in these settings.

As stated earlier, the average cost of assisted living in Pennsylvania is out of reach for low-income and many middle-income people. Continuing care retirement communities are also typically quite costly (relative to older adults' median income) with an average monthly fee of $2,672 and entrance fees ranging from $60,000 to $120,000 (and some in excess of $120,000).[94]

Individuals who testified at one public meeting stated a need for additional retirement and residential settings for the older deaf community given high rates of isolation and depression among this population.[95]

TRANSPORTATION

As described in the Commission's interim report, Pennsylvania has two primary public transportation programs which assist older adults: Shared Ride and Free Transit. Shared Ride operates in all counties and Free Transit operates in the 52 counties which have fixed route transportation services. Shared Ride subsidizes 85 percent of the cost of door-to-door transportation to medical appointments, shopping, senior centers, and other places. Some AAAs further subsidize the program by paying part or all of the 15 percent cost-share; however, this practice has declined in recent years due to flat funding.[96] Older adults with MA can use the MA Transportation Program at no cost, but that is limited to travel for medical appointments.

At the public meetings, participants raised many concerns about the adequacy of the current transportation system notwithstanding the large investment made by the Commonwealth in programs targeting older adults. Some mentioned that many consumers with mobility impairments who want to use free transit cannot do so because they have difficulty getting to the curb and getting from the point of drop-off to their destination. Others noted that the limited schedule for Shared Ride means that older adults with impairments can't easily leave their homes on weekends and evenings. And, the need to order service a day ahead to qualify for the subsidy restricts access. Shared Ride is relatively costly, even with the subsidy. The Bureau of Public Transportation notes that the average round-trip self-pay is about $4.50.

In rural areas, the transportation concerns raised in the public meetings were somewhat different. Although the Shared Ride program serves these areas, consumers may have to spend considerable amounts of time in transit to accommodate multiple pick-ups. Some consumers living in rural areas also noted that transportation providers had fixed schedules for the dates and times they traveled to specific locations and consumers had difficulty fitting their appointments into those schedules. As attested to at the hearings, and confirmed by the Commonwealth, there is significant variation within the State on aspects of the Shared Ride program such as how services are operated, how fares are determined and the amounts, and service availability (including whether travel may cross county boundaries).[97] Beyond public transit, participants at the hearings also noted the importance of making it easier for older adults to get around within their communities via public walkways and roads.

"I think a continuing care residence might help because then I wouldn't be on a constant search for a good assisted living place and then a good nursing home and hope the nursing home would have an opening when I need it . . ..and I wouldn't be worrying about how much money to reserve for each facility or about running out of money."

—Written testimony

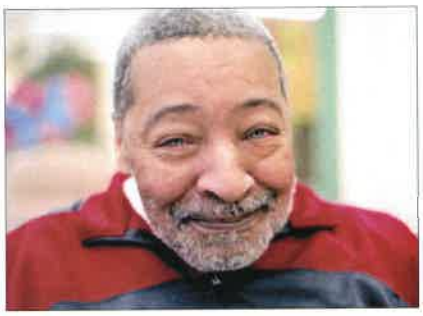
• • •

"I know the focus is to keep people in their communities as long as possible, but there is no community for people who are deaf. They may live in a neighborhood but because of the language barrier, it is not necessarily a community, a place where you can communicate with the people around you. And that is what is needed, especially in the senior years when people are less mobile."

—Written testimony

• • •

CARE COORDINATION



Care coordination is a term that is defined in many different ways.[98] It can range from disease management for a specific population (e.g. adults with diabetes) to the medical home model to comprehensive integrated health and LTC programs. There is much research supporting the benefits of care coordination in improving patient outcomes, but because there are so many definitions and models of care coordination, the research literature cannot readily be used to compare the effectiveness of different coordination efforts. Given the Commission's focus on older adults, we define care coordination broadly as the coordination of health and LTC needs and services through care management and communication among providers and settings.

In its definition of a "high performance" health care system, the Commonwealth Fund, a privately-funded research organization which focuses on improving the health care system, lists "delivery of care through models that emphasize coordination and integration" as one of three key characteristics. The fragmentation within the health care system and between health and aging services and supports inhibits this coordination, resulting in undesired outcomes such as unnecessary hospitalizations. In its analysis of preventable hospitalizations among people using LTC services, the Pennsylvania Department of Public Welfare found that over one-third of NF residents' hospitalizations were preventable.[99] Rates were lower for people receiving services through AAAs (30 percent) and LIFE programs (17 percent), but still left much room for improvement. The Pennsylvania Health Care Cost Containment Council recently released a report documenting the problem of avoidable hospitalizations in Pennsylvania and associated costs.[100] The study found that the vast majority of hospital admissions for four leading health conditions were avoidable at an estimated cost to the Medicare program of $4 billion in hospital charges (excluding emergency room care).

In Thomson Reuters analysis of waste in the U.S. healthcare system and associated costs, authors estimated the annual waste attributed to lack of care coordination to be in the $25 to $50 billion range.[101] Costs are incurred in duplicative tests, avoidable hospitalizations, and adverse drug reactions. In total, lack of care coordination accounts for at least 12 percent of the estimated $700 billion of waste in the healthcare system.[102] Though most of the savings from better care coordination for older adults would accrue to the Medicare program, there would undoubtedly be savings to the Commonwealth in avoidable institutionalizations which are funded by MA. If just half the rate cited above was applied to Pennsylvania's MA spending on services for older adults, it would amount to over $290 million.

Improved care coordination for dual-eligibles is one of the goals of federal health care reform. As noted, the legislation established a Federal Coordinated Health Care office within the Centers for Medicare & Medicaid Services. Thus, states will have long-awaited support for their initiatives to improve care coordination for older adults and dually-eligible people with disabilities.

USE OF TECHNOLOGY AND "NON-REIMBURSABLE" PREVENTIVE SERVICES

There is a vast array of technology and supportive services which help people age in place, but are often not reimbursed by private insurance or public programs. Technology ranges from simple personal emergency response systems to sophisticated home-based telemonitoring. In the public meetings, we heard about uses of technology which were very effective in helping providers monitor older adults with chronic conditions living in the community.

Very simple supportive services such as safety inspections and minor home repairs can make a significant difference in whether an older adult can safely remain at home. As noted at the Pittsburgh public meeting:

"The cost of doing a home inspection, home safety inspection, and providing simple handyman services to correct tripping hazards and fire hazards and other kinds of barriers is negligible. We ought to be paying to have those things done so we're not paying for the consequences of not doing it."

—Public testimony (Pittsburgh)

AGING IN PLACE THROUGH COMMUNITY SUPPORT SYSTEMS

Local communities around the country are developing infrastructures to support aging in place. These grassroots efforts go by a number of names, e.g., neighborhood-based initiatives, elder villages, and aging in place communities. They also use a variety of approaches which range in formality and financing structure (see the Commission's interim report). In addition, there are naturally occurring retirement communities or "NORCs" throughout the country. There is growing awareness at the national level of the effectiveness of these communities in supporting older adults as they age in place, as evidenced by foundation and federal grants.

WHAT IS PENNSYLVANIA DOING NOW?

CONGREGATE HOUSING AND CONTINUING CARE RETIREMENT COMMUNITIES

As noted earlier, the Commonwealth has recently released a final regulation (ALR 2800) which defines assisted living and outlines licensing requirements. Pennsylvania legislation, Act 56, required the regulation, which was released in draft in 2008 and final form on July 17, 2010. Licensure requirements would take effect January 17, 2011. The regulation provides for a new continuum in the Commonwealth's continuum of care. The creation of a distinct assisted living level of care reduces barriers to aging in place in that residents will be permitted to receive support services through a new Assisted Living Waiver (currently under development). Under the State's Personal Care Home regulation (PCH 2600), residents are not permitted to remain in PCHs if they require a significant need for services and supports.

HOUSING

The Commonwealth is working to address the issue of affordable and accessible housing in a number of ways. The Office of Long Term Living has been developing a project called Enhanced Domiciliary Care, which is an expansion of the Commonwealth's Domiciliary Care program and is based on a successful Massachusetts model. The program would serve people who require a nursing facility level of care (NFCE) and who qualify for the State's Medical Assistance Aging HCBS Waiver. An intermediate agency would recruit, train and place consumers in private homes and monitor them through a combination of home provider web-based status reports and oversight from clinical teams. The teams would also ensure the home providers' skills are aligned with consumers' clinical needs.

The Commonwealth has also been operating a small tenant based rental assistance program for about 2 years. It provides housing vouchers for NFCE populations as a bridge to the "Section 8" program.

In 2006, the Pennsylvania legislature enacted the Residential Visitability Design Tax Credit which provides tax credits up to $2,500 for new construction or renovation with visitability features.[103] This was preceded by a similar tax credit implemented in Pittsburgh called the Pittsburgh Visitability Ordinance.

CARE COORDINATION

Currently, older Pennsylvanians can receive care coordination through a variety of programs contingent on meeting applicable eligibility criteria. Medicare beneficiaries can enroll in private-sector Medicare Advantage plans which may provide care coordination, though they are not required to do so. In practice, this care coordination tends to focus mainly on acute health care. AAAs provide care coordination related mainly to long-term services and supports through programs such as OPTIONS. For those who require a NF level of care, LIFE programs provide care coordination which encompasses acute and LTC (described in Section 4). As mentioned, the Commonwealth is planning to expand integrated and coordinated health and LTC options for older adults through the Integrated Care Option (ICO). The ICO differs from the LIFE model in that participants need not require a NF level of care and do not need to attend an adult day care program to receive services.

Self-management programs are promising tools for improving people's ability to manage their chronic conditions. Stanford University has been a national leader in developing, testing and evaluating chronic condition self-management programs: Stanford's Chronic Disease Self-Management Program (CDSMP) was rigorously evaluated using a controlled, randomized design and findings were that the group participating in the self-management program did better than the control group on numerous measures, including lower utilization of costly health care services such as hospital care.[104] The Philadelphia Corporation for Aging received a 5-year grant to offer a CDSMP targeted to older African Americans with one or more chronic conditions, called Harvest Health, which ended in 2008. Outcomes of this project were small but statistically significant improvements in exercise, use of cognitive management strategies, energy/fatigue, and self-efficacy, and reductions in health distress and intrusiveness of illness into other life domains.[105] Pennsylvania was recently awarded $1 million by the Administration on Aging to increase the use of chronic disease self-management programs (CDSMP).[106] In addition, Pennsylvania's Department on Aging offers self-management classes related to chronic conditions through its PrimeTime Health program.

Pennsylvania's Chronic Care Initiative is a significant effort to test organizational and financial arrangements which will better address the needs of people with chronic conditions.

Pennsylvania Chronic Care Initiative

In May 2007, Governor Rendell created the Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission to address a growing concern about the effectiveness of the financing and delivery of health care to Pennsylvanians with chronic conditions. Evidence such as high rates of avoidable hospitalizations and emergency room visits highlight a need to improve the management of these individuals' care. The Commission was tasked with developing a plan to improve patients' quality of life and clinical outcomes, while reducing costs. In its ensuing strategic plan, the Commission outlined a framework for implementing Dr. Edward Wagner's Chronic Care Model (CCM), including an informational, technological and reimbursement infrastructure to support the model. Features of the CCM include: primary care patient-centered care (e.g., a "medical home" model), practice teams, evidence-based care supported by electronic disease registries and assistance for patients to manage their conditions. The resulting effort, called the Pennsylvania Chronic Care Initiative (CCI), is the largest multipayer Patient Centered Medical Home initiative in the country.

In the CCI, seven regional learning collaboratives are underway in six regions throughout the state, with three additional collaboratives under development. The first collaborative started in Southeastern Pennsylvania in May of 2008. Currently, the seven regional collaboratives encompass 171 practices and 783 providers caring for over 1.2 million Pennsylvanians. Medical practices participate in the collaborative for three years, during which they receive education, support and coaching on the use of electronic registries and medical records and other tools to manage chronic conditions. Each collaborative initially focuses on diabetes (adult and pediatric populations) and asthma (pediatric only), but expands to include other chronic conditions during the three-year project period. In addition, the CCI is testing innovative ways to align reimbursement with desired outcomes. All major insurers in the Commonwealth are participating in the CCI, including the Medical Assistance program.

The RAND Corporation is conducting a formal evaluation of the initiative. Though it is too early to obtain these results, first-year outcomes show promising improvements in clinical measures of disease management as well as cost reductions.

HOME CARE AGENCY STANDARDS

An essential component of providing high-quality in-home services to older Pennsylvanians with functional impairments is ensuring that these hands-on services meet minimum standards. In December 2009, the Rendell administration published regulations making licensing of state homecare agencies and registries mandatory. Legislation requiring the licensure of homecare agencies (Act 69) was passed by the Pennsylvania General Assembly and signed by Governor Rendell in 2006. The regulations create industry standards of care and requirements for staff competency and training, including criminal background checks.

USE OF TECHNOLOGY

Nursing graduate students from the University of Pennsylvania educated the Commission on uses of telemedicine and study findings on the value of using telehealth compared to traditional home health.[107] Telehealth has many benefits including: increased access to services; convenience; real-time monitoring of conditions; and reductions in isolation in home-bound older adults, hospitalization and readmissions, and costs.

Pennsylvania is a national leader in covering TeleCare in its Aging Waiver and OPTIONS program.

Coverage of TeleCare in the Office of Long Term Living Aging Waiver and Options Program

To advance the use of technology-supported services for older adults with LTSS needs, the Commonwealth added TeleCare as a covered set of services in the Aging Waiver and the Options program, contingent on the participant meeting specified eligibility criteria. TeleCare is a model of service that uses technology with in-home services to help people with chronic conditions live independently in the community. TeleCare as defined in the service standards, includes the following types of services:

- health status measuring and monitoring—use of wireless technology or a phone line to establish electronic communication between the program participant and the provider that collects critical health condition information (e.g., vital signs);
- activity and sensor monitors—use of sensor-based technology on a 24/7 basis to remotely monitor participants' activities and home conditions (e.g., falls, meal preparation, room temperature) and
- medication dispensing and monitoring—use of a remote monitoring system programmed to dispense medications, track compliance and notify provider or caregivers of missed doses or other noncompliance.

NewCourtland, a Philadelphia-area non-profit provider of community services, affordable housing, nursing homes and programming for older adults, has installed remote monitoring technology called eNeighbor in the homes of some of its clients. The eNeighbor system uses sensors to detect unexplained changes in older adults' activities and automatically issues alerts to caregivers and family members based on the information collected.

Finally, as part of its health reform strategy, the Rendell administration recently announced the launch of the Pennsylvania Health Information Exchange (PHIX). The aim of PHIX is to establish a secure statewide network of electronic medical records to improve access to health information and service delivery and reduce health care costs.[108] Through PHIX, the Commonwealth will leverage federal Health Information Technology grant funds to develop an electronic health infrastructure.

"In our agency, we offer Telehealth services for cardiac disease monitoring. Since January, we have had 250 clients on Telehealth programs and only four have been rehospitalized with cardiac problems. This is something that is not generally recognized by Medicare as a reimbursable service, but it is beneficial to the consumer long-term because it empowers them to be able to provide their own care and teaches them how to take care of themselves. And it certainly lets them stay out of the hospital, which is where they don't want to be, and it also saves money to all of our healthcare dollars by keeping them at home. So anything we can do to enable that is beneficial."

—A home health and rehabilitative services provider (Pittsburgh)

• • •

AGING IN PLACE COMMUNITIES

A number of "aging in place" communities have emerged in Pennsylvania including Senior Network at Penn National and the Supportive Elder Women's Network in Philadelphia. The latter, serving mainly low-income African American women, recently received a grant from the Administration on Aging. There are NORCs in the Philadelphia and Pittsburgh areas as well as Franklin County.

WHAT BARRIERS AND SYSTEM CONSTRAINTS DOES PENNSYLVANIA FACE?

Clearly, as evidenced by waiting lists for programs such as OPTIONS, FCSP and subsidized housing, and the unmet needs identified in the PSU Age 50+ LTC Survey, the Commonwealth is not meeting older adults' and caregivers' current needs for services and supports. Given demographic and economic trends, this gap could only be expected to get worse. Most of those who testified at the public meetings cited lack of funding as the root cause of the inadequacy of the current care and services available to older Pennsylvanians to help them age in place. Yet, this mindset is limiting in that it does not encourage consideration of strategies to maximize existing resources and build on momentum in improving care coordination.

POLICY RECOMMENDATIONS

POLICY RECOMMENDATION #4:

Review gaps, barriers, and redundancies in current information systems, reimbursement, and service delivery as they relate to care coordination and care transitions across the care continuum and utilize funding initiatives under the American Reinvestment and Recovery Act of 2009 and the Patient Protection and Affordable Care Act of 2010 when available to fill identified gaps and barriers.

A high-level examination of information exchange, reimbursement methodologies, and work flows across programs and services would help identify strategic areas where improvements could be made. Further, older adults, for the most part, do not have their health and LTC needs and services coordinated. This leads to duplication of services, misuse of services, deficient transitions among care settings, and potential risks to older adults' health and safety.

POLICY RECOMMENDATION #5:

Maximize use of technology such as telehealth and assistive devices to improve outreach, care coordination, accessibility, and safety for older adults living in the community.

As described earlier in this section, use of technology is making significant improvements in older adults' ability to remain in their homes or other community settings. Yet there are barriers to its use such as state licensure laws, clinical acceptance and very limited or no insurance coverage. Further, some rural areas do not have sufficient broadband coverage to support technologies such as telehealth. We must build on the evidence that technologies such as telehealth bring real value to our systems of care by eliminating barriers to the use of technology in current state policies and programs. State agencies should examine where barriers exist and make changes where they have authority to do so.

Section 6.
Improving Wellness

Commission's long-view resolution for 2025: *Promote a "culture of wellness" in Pennsylvania that emphasizes healthy choices and behaviors starting early in life and continuing lifelong, thus preventing many costly and debilitating health conditions from occurring in the first place.*

WHY IS THIS IMPORTANT?

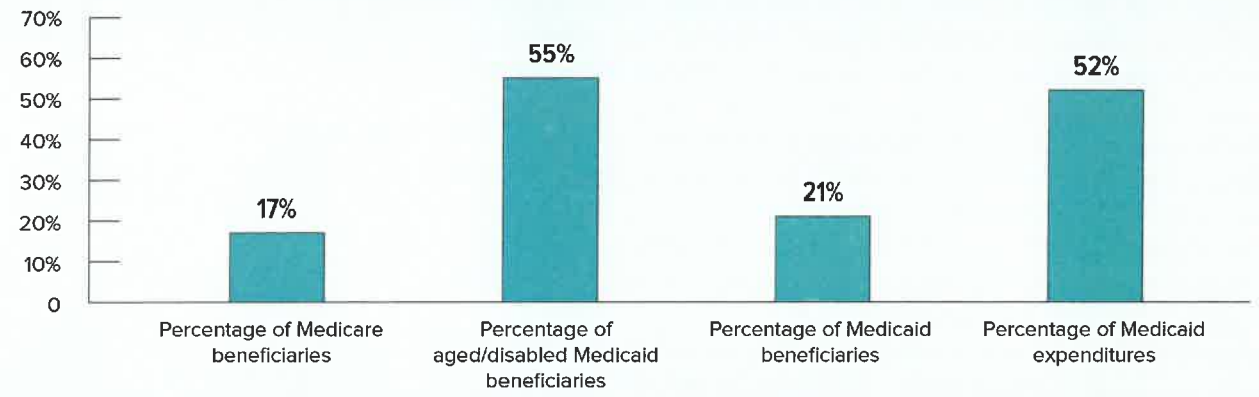
One way the Commonwealth can address the projected growing demand for health care, LTC, and other supportive services is to improve the wellness of its citizenry. This applies to all age groups and will require a cultural shift which can only be achieved through broad-based involvement, including: schools, private and public sector workplaces, state and local governments, places of worship, and local communities. Federal health care reform includes many provisions aimed at improving Americans' access to preventive and wellness services, including grant funding to states.

PREVALENCE OF DISABILITY IN PENNSYLVANIA

An estimated 37 percent of non-institutionalized Pennsylvanians age 65 and older reported having a disability in 2008: 663,513 individuals.[109] Another 68,687 older Pennsylvanians reside in nursing facilities,[110] 458 reside in ICFs-MR,[111] and 96 reside in the South Mountain Restoration Center (a State Psychiatric Nursing Facility).[112] In total, over 730,000 older Pennsylvanians are living in the community and in institutions with disabilities. Further, significant shares of Pennsylvania's older population report two or more types of disability: 12 percent of those ages 65 to 74 and 30 percent of those ages 75 and older.[113]

Prevalence of disability is even higher among low-income older adults because health status is positively associated with income. **Over 50 percent of older Pennsylvanians with income below the poverty level report having a disability.**[114] Specific to older adults who are Medicaid-eligible, a recent study using national diagnostic and pharmacy data found that over 50 percent had three or more chronic conditions.[115] The three most prevalent conditions among aged Medicaid beneficiaries were: cardiovascular (76 percent of the group); psychiatric (36 percent); and diabetes (26 percent).[116] Higher prevalence of disease translates to higher costs. Those who are dually eligible for Medicare and Medicaid, "dual-eligibles," represent about 19 percent of all Medicare beneficiaries, but are much more costly than "non-dual" beneficiaries. Based on a recent study, combined Medicare and Medicaid spending in 2003 on dual-eligibles was higher than Medicare spending on non-duals, despite the fact that there were over four times as many non-duals as dual-eligibles.[117] And, Medicaid financed **56 percent** of aged dual-eligibles' care.[118] As shown below, in Pennsylvania, duals represent over half of MA spending despite comprising less than a quarter of the Medcaid population.

Figure 4. Dual-Eligibles as Percentage of Pennsylvania Medicare and Medicaid Beneficiaries and Medicaid Spending: 2005

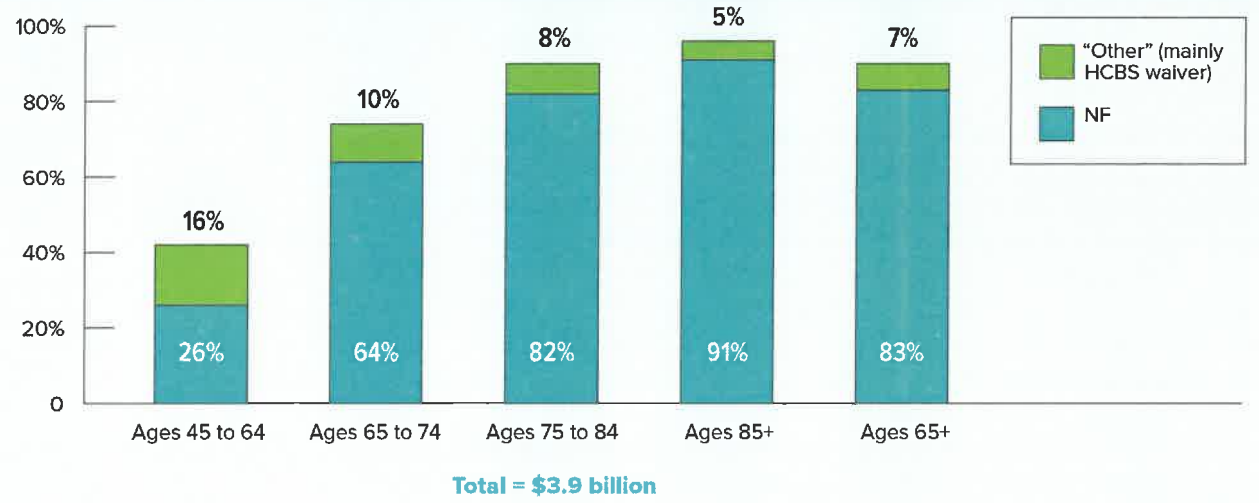


Source: Kaiser Family Foundation; Statehealthfacts.org

MEDICAL ASSISTANCE SPENDING ON OLDER, DUAL-ELIGIBLE PENNSYLVANIANS

As noted, the vast majority of the $3 billion in MA spending on dual-eligible Pennsylvanians age 65 and older goes toward NF care: 83 percent in federal fiscal year 2008. This share varies significantly by age group within the 65 and older population with a high of 91 percent for those ages 85 and older (see Figure 5 below). For dual-eligibles ages 45 to 64, the largest share of Medicaid LTC spending is for care in ICFs-MR (36 percent—not shown), followed by NF care (26 percent). This supports a concern the Commonwealth is well aware of: how to care for people with developmental disabilities who are aging.

Figure 5. Nursing Facility and "Other" Services as Share of Total Pennsylvania Medicaid Spending for Dual-eligibles: Select Age Groups, 2008



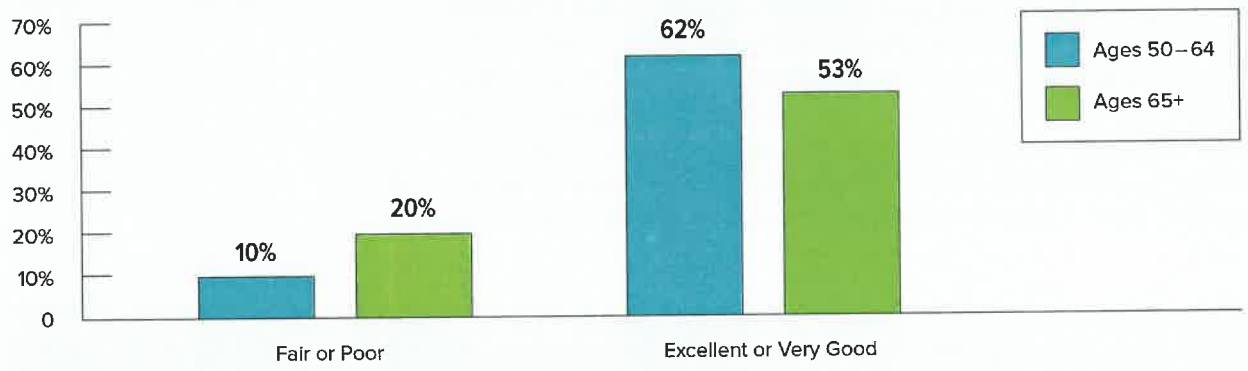
Source: Thomson Reuters analysis of MSIS State Summary Datamart, FFY 2008

MENTAL HEALTH CONDITIONS AMONG OLDER ADULTS

The prevalence of psychiatric conditions among aged Medicaid beneficiaries highlights an issue about which there is growing awareness: depression and other mental health conditions among older adults. Although the prevalence of experiencing serious psychological distress is lower in the older adult population compared to the total adult population (4.5 percent compared to 11.3 percent), suicide rates are higher among older adults and the risk of depression increases with other illnesses and functional limitations.[119] According to the National Institute of Mental Health, depression in older adults is "widely underrecognized and undertreated . . ." and "is not a normal part of the aging process."[120] Further, a recent study found that older adults with select chronic conditions and depression had higher overall health care costs than those who did not have depression.[121]

As shown in Figure 6, just over half of older Pennsylvanians report being in excellent or very good mental health and roughly 20 percent report being in fair or poor mental health.[122] Older Pennsylvanians are twice as likely as those ages 50 to 64 to report being in fair or poor mental health.

Figure 6. Percentage of Pennsylvanians Who Report Mental Health Status as Either Fair/Poor or Excellent/Very Good: Select Age Groups, 2004 – 2006



Source: Thomson Reuters analysis of Pennsylvania Medical Expenditure Panel Survey data: pooled 2004 – 2006.

Note: The prevalence of rating mental health as fair or poor is twice as high for those ages 65+.

Prevalence of depression is quite high among NF residents and researchers have found that presence of a mental illness increases the likelihood of nursing home admissions becoming long stays. Over 51 percent of Pennsylvania NF facility residents are diagnosed with depression, a national average of 50 percent.[123] Researchers at Harvard Medical School and Brown University examined nursing home admissions by state and found that people with mental illness comprised 30 percent of new admissions to Pennsylvania nursing homes and that those admitted with a mental illness were more likely to become long-stay residents (90 days or longer) than those admitted with other conditions.[124] Of residents with very disabling mental health conditions such as schizophrenia or bipolar disorder, 45 percent of those newly admitted in 2004 became long-stay residents compared to 24 percent of those with no mental illness indicated.[125] Some factors cited as contributing to the admission of older adults with mental illness into nursing homes are: Medicaid payment policy, preadmission screening, mental health infrastructure, and availability of community-based supports.[126]

ALZHEIMER'S DISEASE AND OTHER DEMENTIAS

According to the Alzheimer's Association, 13 percent of people ages 65 and older have Alzheimer's Disease and it is the seventh leading cause of death in the U.S.[127] An estimated 280,000 older Pennsylvanians have Alzheimer's.[128]

Alzheimer's disease is the most common type of dementia, accounting for 60 to 80 percent of cases. Dementia is defined as "the loss or decline in memory and other cognitive abilities. It is caused by various diseases and conditions that result in damaged brain cells. . . In order to be classified as dementia, the decline in cognitive abilities must be severe enough to interfere with daily life."[129] Although development of Alzheimer's and other dementias is not a normal part of aging, the prevalence of these conditions and risks of acquiring them increase with age.

Prevalence of Alzheimer's disease varies by race and ethnicity, years of education, Medicaid status and institutional status. A report by the Alzheimer's Association found that Older African Americans and Hispanics are significantly more likely than older Whites to have the disease: African Americans almost twice as likely as Whites and Hispanics about one and a half times more likely. People with fewer years of education are more likely to get Alzheimer's and other dementias. Prevalence also varies by Medicaid status, with dually-eligible Medicare beneficiaries being more than twice as likely to have Alzheimer's and other dementias compared to "non-dual" Medicare beneficiaries: 16 percent of "duals" have Alzheimer's/other dementias compared to seven percent of "non-duals".[130] Eighteen percent of Pennsylvania's NF population has Alzheimer's disease and 41 percent have other dementias.[131]

As expected, older adults with these conditions have significantly higher health and LTC costs compared to those who do not. Older adults with Alzheimer's and other dementias have total health and LTC spending that is three times higher than average spending on these services for people who do not have these conditions.[132] An analysis based on 2004 data found the average annual health and LTC payments from all sources per Medicare beneficiary with Alzheimer's/dementia was $33,007 compared to $10,603 for those without the conditions. Out-of-pocket per-capita costs in 2004 were 29 percent higher for people with Alzheimer's/dementia compared to those without the conditions. And, of particular interest to states, Medicaid per-capita costs were over nine times higher for older adults with Alzheimer's/dementia compared to other older Medicare beneficiaries ($6,605 compared to $718).

Unpaid caregivers of people with Alzheimer's and other dementias provide more hours of help and report higher levels of physical strain and emotional stress compared to caregivers of older people with other conditions.[133] There are an estimated 484,404 unpaid caregivers of persons with Alzheimer's and dementia in Pennsylvania. These individuals provide over 552 million hours of unpaid care at an economic value of $6.3 billion.

Obesity

Obesity is arguably the biggest public health challenge facing Pennsylvania, as it is for all states. Over the past 30 years, national adult obesity rates have doubled and childhood obesity rates have more than tripled.[134] As described by the Centers for Disease Control and Prevention: "American society has become 'obesogenic,' characterized by environments that promote increased food intake, nonhealthful foods, and physical inactivity."[135]

Overall, 27 percent of Pennsylvanian adults are obese and 63 percent are overweight or obese.[136] As shown in Figure 10 below, over two-thirds of Pennsylvanians ages 45 to 54 and three-quarters of those ages 55 to 64 were either overweight or obese in 2009.[137] ***Nearly one-third of people in each of those age groups were obese in 2009***. While the prevalence of being obese is lower among older Pennsylvanians compared to younger age groups, the prevalence of being overweight is similar. Relative to other states, Pennsylvania's prevalence of obesity among adults of all ages is higher than average, ranking 22nd in the country.[138] Being overweight or obese increases the risk of developing numerous serious health conditions such as heart disease, type 2 diabetes, certain types of cancer, breathing problems, arthritis, depression, and many others.[139] And obesity has also been found to increase the risk of developing Alzheimer's disease.[140]

Higher prevalence of disease among obese people translates to higher medical costs, much of which is publicly financed.[141] A 2009 study found that obesity was associated with $147 billion in direct health care costs in 2008, roughly seven percent of total health expenditures on health services and supplies that year.[142] An earlier version of the study (based on 2003 data) had found another $64 billion in indirect costs such as costs to employers from absenteeism and disability.[143] A recent study based on research by Kenneth E. Thorpe of Emory University estimated national and state-level health care costs associated with obesity.[144] In Pennsylvania, "obesity-attributable" health care spending in 2008 was estimated to fall between $3.1 and $4.2 billion. By 2018, if current trends continue, this amount is projected to fall between $8.7 and $18.4 billion. On a per-capita basis, the estimate for obesity-attributable health care spending for adult Pennsylvanians was $393 in 2008, with a projected increase to $1,455 by 2018.[145]

The shares of children and teens who are overweight has skyrocketed, with associated increased prevalence of health conditions such as diabetes. According to National Health and Nutrition Examination Survey data, prevalence of obesity in children has increased dramatically between the 1976–1980 survey and the 2003–2006 survey:

- from 5 percent to 12.4 percent for children ages two to five;
- from 6.5 percent to 17 percent for children ages six to 11; and
- from 5 percent to 17.6 percent for children ages 12 to 19.[146]

As noted above, obesity is linked to many health problems. Obese children are at higher risk for cardiovascular disease and diabetes and are at greater risk of becoming obese as adults.[147] The increase in type 2 diabetes among children is mainly driven by obesity, and has become a "new epidemic" among American children.[148] Nearly 30 percent of Pennsylvanian children ages 10 to 17 are overweight or obese, ranking 32nd in the country.[149] The first lady, Michelle Obama, has made childhood obesity her chief cause.

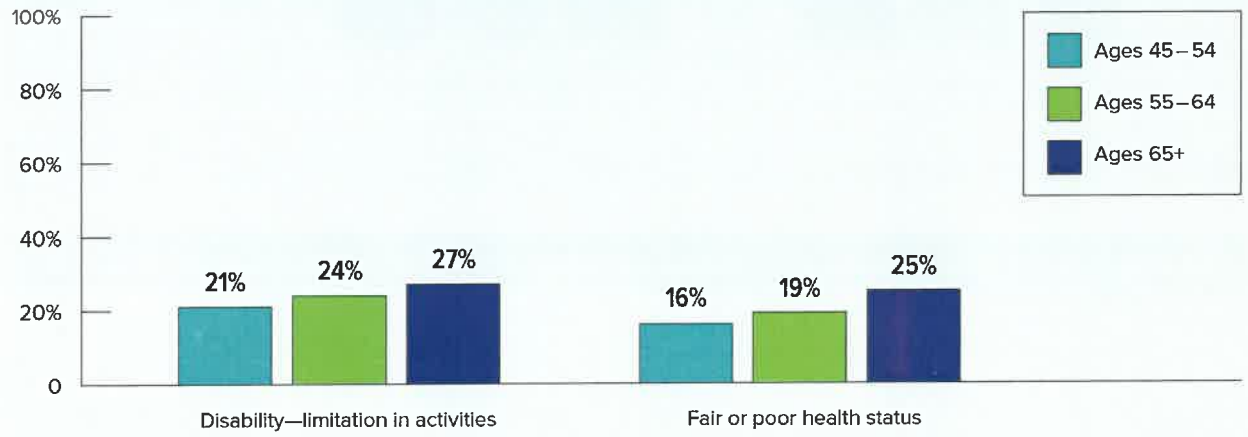
PREVALENCE OF DISABILITY AND SELECT MEDICAL CONDITIONS: PENNSYLVANIA BOOMERS AND OLDER ADULTS

A concern looking ahead to 2025 is that people in the baby boom age cohorts have a high prevalence of disability. According to the Behavioral Risk Factor Surveillance System (BRFSS), 21 percent of those ages 45 to 54 and 24 percent of Pennsylvanians ages 55 to 64 reported being limited in activities because of physical, mental, or emotional problems (only three

percentage points lower than Pennsylvanians ages 65 and older reported).[150] National data show that over 72 percent of community-dwelling people age 50 and older have one or more chronic conditions (compared to 88 percent for those ages 65 to 74, 92 percent for those ages 75 to 84 and 93 percent for those ages 85 and older).[151]

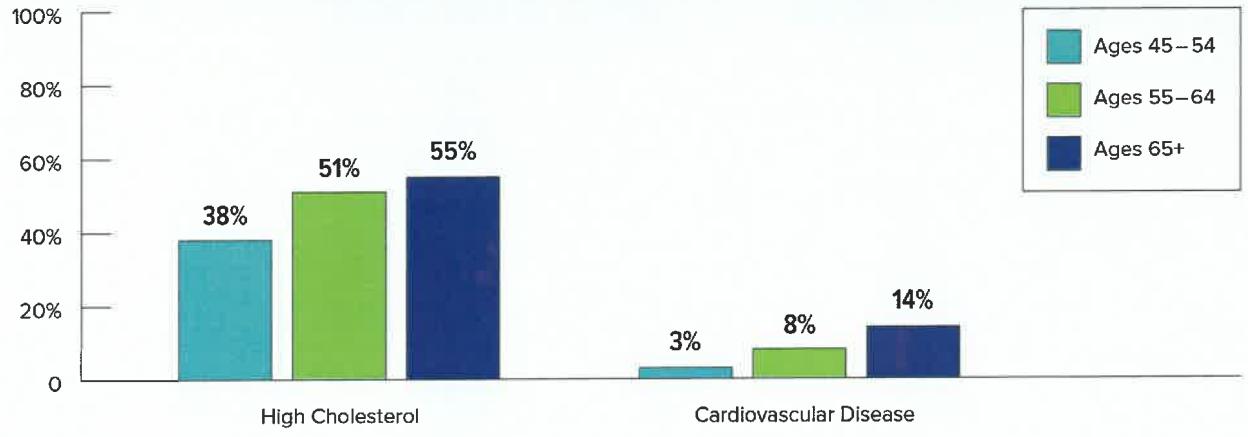
The following charts show prevalence of select medical conditions and health risks for older adults and boomers (defined as those ages 45 to 64 in the charts based on BRFSS data and those ages 50 to 64 in the charts based on Medical Expenditure Panel Survey data).

Figure 7. Prevalence of Disability and Fair/Poor Health Status for Pennsylvanians: Select Age Groups, 2009



Source: Behavioral Risk Factor Surveillance Study, 2009 (self reports).

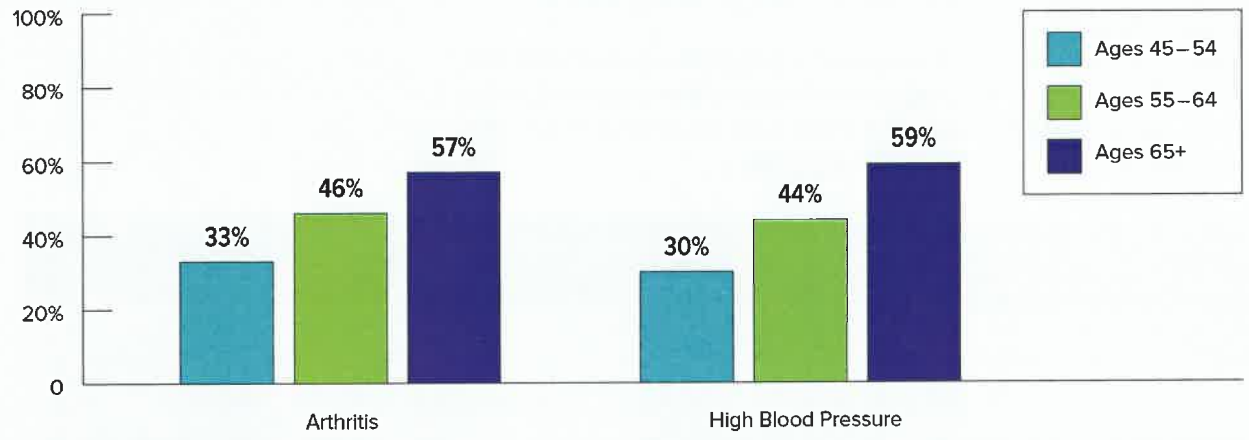
Figure 8. Prevalence of High Cholesterol and Cardiovascular Disease Among Pennsylvanians: Select Age Groups, 2009



Source: Behavioral Risk Factor Surveillance Study, 2009 (self reports).

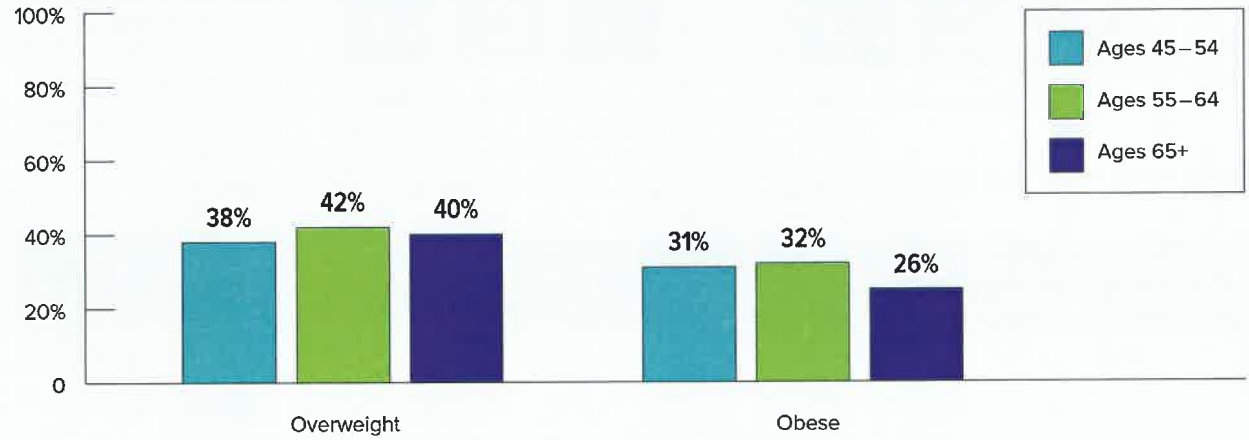
Note: Over half of the "older Boomer" cohort has high cholesterol.

Figure 9. Prevalence of Arthritis and High Blood Pressure Among Pennsylvanians: Select Age Groups, 2009



Source: Behavioral Risk Factor Surveillance Study, 2009 (self reports).

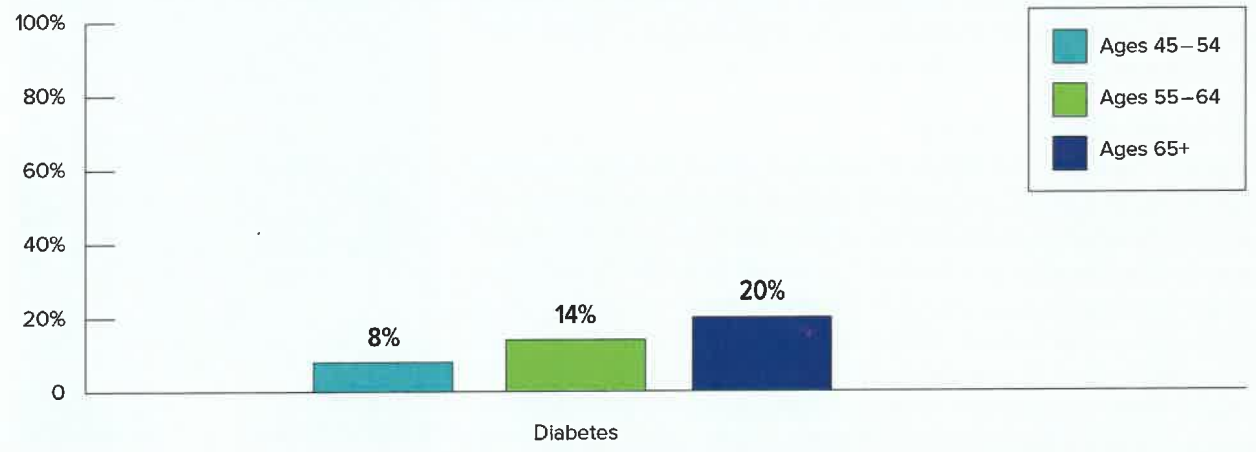
Figure 10. Prevalence of Being Overweight or Obese Among Pennsylvanians: Select Age Groups, 2009



Source: Behavioral Risk Factor Surveillance Study, 2009 (self reports).

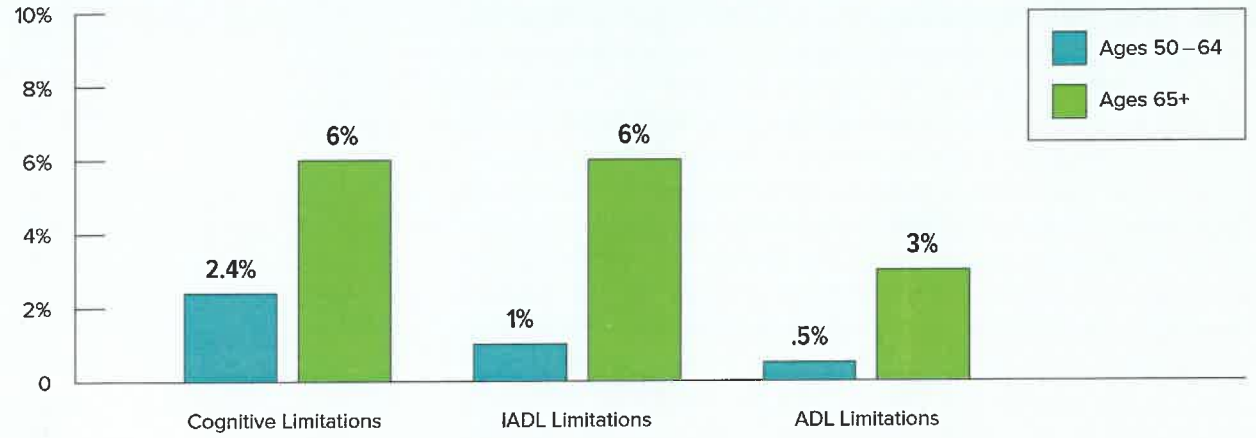
Note: People in the "Boomer" age groups have higher prevalence of obesity than those age 65+.

Figure 11. Prevalence of Diabetes Among Pennsylvanians: Select Age Groups, 2009



Source: Behavioral Risk Factor Surveillance Study, 2009 (self reports).

Figure 12. Percentage of Pennsylvanians with Cognitive, IADL, and ADL Limitations: Select Age Groups, 2004–2006



Source: Thomson Reuters analysis of Pennsylvania Medical Expenditure Panel Survey data: pooled 2004–2006.

RACIAL AND ETHNIC HEALTH DISPARITIES

Racial and ethnic health care disparities at the national level have been well-documented.[152] The Pennsylvania Department of Health publishes seven reports on racial and ethnic disparities by topic on its Web site.[153] In Pennsylvania, Blacks/African Americans have lower (worse) health status compared to Whites on many key measures: infant mortality; late initiation of or no prenatal care; annual AIDS case rate; prevalence of obesity and those reporting fair or poor health; and mortality rates related to diabetes, heart disease, cancer and stroke.[154] Hispanics also have lower health status compared to Whites on some of these measures (infant mortality, late initiation of or no prenatal care, annual AIDS case rate, and obesity), but score higher than Whites on several measures (e.g. the mortality rates noted above). Asians/Pacific Islanders tended to have lower mortality rates

for the diseases mentioned above and lower health risk factors compared to Whites. On measures where data for American Indians/Alaskan Natives were available, this group tended to have higher health risk factors compared to Whites. All racial and ethnic minorities in Pennsylvania have higher rates of being uninsured compared to Whites.

TRENDS IN DISABILITY RATES

There is much debate in the research literature about whether disability rates in older adults will decline, stay the same, or increase in the future.[155] There are trends which support declining disability rates (such as medical advances and increasing levels of education among older adults) and those that support increasing disability rates (such as growing prevalence of obesity, lack of exercise, and dementia). Regardless of the trend, given the expected growth of the overall older population, especially among those 85 and older, there will be larger numbers of people who require supports and services due to disabling chronic conditions and functional impairment.

WHAT IS PENNSYLVANIA DOING NOW?

The Commonwealth is undertaking several major initiatives to address the wellness of its population and management of chronic conditions. In addition to the State Health Improvement Plan, and Healthy People 2010, Governor Rendell has made health care a priority through his administration's *Prescription for Pennsylvania* strategies. In fact, Governor Rendell recently received the 2010 Health Quality Award from the National Committee for Quality Assurance for his health reform efforts.[156] Some major accomplishments are: legislation requiring the tracking of healthcare associated acquired infections; the Chronic Care Initiative (described in Section 5); expansion of coverage for children under the State's Children's Health Insurance Program; expansion of coverage for adult children up to age 30 under their parents' employer-based health plans; and, the launch of the Pennsylvania Health Information Exchange to improve statewide access to electronic health record information. In addition to these, the Pennsylvania Department of Health (DOH) and other state agencies have implemented numerous wellness, physical activity, and nutrition programs aimed at various age groups and populations. Other entities sponsor these activities as well such as hospitals and health care systems, faith-based organizations, YMCAs, local community centers, and independent living centers. Some of these programs are described below.

Based on the Commission's analysis of Medical Expenditure Panel Survey data specific to Pennsylvania for the years 2004 to 2006, older Pennsylvanians appear to have very good access to health care, dental care, and prescription drugs. Over 90 percent of this age group reported having a usual source of care and less than one percent reported being unable to get necessary medical care. Less than one percent reported being unable to get necessary dental care and slightly over one percent reported being unable to get necessary prescription drugs. When we compared access to prescription drugs in the pre- and post-implementation periods for Medicare Part D, we found a reduction in older Pennsylvanians reporting an inability to get necessary prescription drugs from 1.9 percent in the 2004–2005 period to 0.4 percent in 2006. See Technical Notes and Table 4 for details on this analysis.

PROGRAMS FOR OLDER PENNSYLVANIANS

Older Pennsylvanians can avail themselves of many wellness and physical activity programs. AAAs offer PrimeTime Health and Healthy Steps in Motion exercise programs at senior centers and other settings. PrimeTime Health programs include a wide array of activities including chronic condition management, nutrition, injury prevention, and exercise classes (though Healthy Steps in Motion classes have replaced PrimeTime Health exercise classes in most counties). In SFY 08–09, there were over 366,000 PrimeTime events in the Commonwealth with participation of 2.3 million older adults (duplicated count). In SFY 08–09, nearly 7,400 older adults participated in Healthy Steps for Older Adults programs (unduplicated count). Further, senior centers provide opportunities for older adults to socialize which is critical to reducing isolation and associated depression. The Department of Aging's 2008–2012 State Plan on Aging outlines a number of strategies designed to promote the health and wellness of older adults with accompanying performance measures and target dates.[157] AAAs do not report having waiting lists for the fitness and health promotion activities they sponsor.[158] However, older adults may lack knowledge about the options available.

Older adults who are enrolled in certain health plans can also participate in the SilverSneakers® program, a blend of physical activity, healthy lifestyle and social programming.[159] The program is offered by a number of Medicare Advantage and Medigap plans in Pennsylvania. Bravo Health, Geisinger Health Plan, Highmark, and Independence Blue Cross all offer SilverSneakers® in some of their products. Older adults who are not enrolled in these products can also participate in SilverSneakers® by purchasing a membership at a participating fitness center. YMCAs are also good low-cost sources for fitness programming geared toward older adults.[160]

The Commonwealth is undertaking some promising programs to better serve older adults with mental illness, including enhancement of community supports. The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) added an older adult behavioral health advisory committee as part of its Mental Health Planning Council. This committee, in partnership with the Office of Long Term Living and OMHSAS, implemented a Share the Care Initiative which trains county behavioral health professionals and county area agency on aging staff in cross-systems collaboration (e.g., aging, behavioral health, and medical services) and case review.[161] Fifty-three counties have participated in Share the Care trainings.[162] In Delaware County, the Gateway Program (Giving Assessment, Treatment and Empowerment in the Aging Years) identifies and assists older adults with behavioral health issues, linking them with community-based services and monitoring their progress.[163] For example, the program has placed geripsychiatric nurses in senior housing. Behavioral Health Connection is a collaboration between the Pennsylvania Department of Aging APPRISE program and the Pennsylvania Behavioral Health and Aging Coalition which enhances the APPRISE program's ability to assist consumers with behavioral health issues.[164]

PROGRAMS FOR CHILDREN AND TEENS

Pennsylvania is at the forefront of implementing nutrition and physical activity programs for children and teens.[165] In fact, the Childhood Obesity Action Network gave Pennsylvania an "A" on its childhood obesity report card based on factors such as obesity-related state initiatives, school standards, and policy options.[166] The Commonwealth was funded by the Centers for Disease Control and Prevention to develop a State Nutrition and Physical Activity

Program to Prevent Obesity and Related Chronic Conditions in 2001. These funds were used to support staff positions, convene stakeholders to develop the Pennsylvania Nutrition and Physical Activity Plan, and to implement statewide policy and environmental changes in schools and communities.[167] However, Pennsylvania was not awarded CDC funding in the 2008 contract cycle and the lack of funding has weakened the Commonwealth's programs.[168] In the spring of 2009, the Department of Health launched the Active Schools Grant program which provided $5,000 grants to 40 middle schools throughout the Commonwealth to achieve physical activity targets.

The Department of Health (DOH) created a Division of Nutrition and Physical Activity in 2006 to recognize the importance of these factors. Despite this commitment, the Commonwealth currently provides no state funding for nutrition and physical activity initiatives.[169] The programs which are in place are funded by federal grants and other sources.

IMPROVING ACCESS TO AFFORDABLE AND HEALTHFUL FOOD

The Fresh Food Financing Initiative (FFFI) is a model program which aims to increase the number of supermarkets or other grocery stores in underserved communities through grant and loan programs. The program started in Philadelphia with $30 million in funds appropriated by the Pennsylvania Legislature and an additional $90 million leveraged by The Reinvestment Fund. Managed through a partnership of The Food Trust, The Reinvestment Fund and the Greater Philadelphia Urban Affairs Coalition, the FFFI has committed $57.9 million in grants and loans to 74 supermarket projects in 27 Pennsylvania counties, ranging in size from 900 to 69,000 square feet. In total, these projects are expected to create or retain 4,854 jobs and more than 1.5 million square feet of food retail. The FFFI has received considerable recognition nationally, including a provision in President Obama's FY 2011 budget which provides over $400 million for a national campaign.[170]

WORKSITE WELLNESS PROGRAMS

An increasing number of employers in the United States are offering wellness programs and research has shown that these programs produce a good return on investment. MetLife's recent *Study of Employee Benefit Trends* found the percentage of employers offering wellness programs, on average, increased from 27 percent in 2005 to 33 percent in 2008.[171] There is large variation in the percentage of employers offering wellness programs by size of employer: 61 percent of large companies (over 10,000 employees) offer such programs compared to 13 percent of small companies (under 50 employees). According to health and productivity researcher Ron Goetzel of Thomson Reuters and Emory University, employers can expect to get a return on investment of about $3 for every $1 invested in health promotion programs.[172] However, it may take a few years for them to realize these savings. Federal health care reform includes some grant funding for worksite wellness programs.

Several companies in Pennsylvania have been acknowledged for their worksite wellness programs. Highmark Inc., the State's largest insurer with 11,000 employees, was recognized as one of "America's Healthiest Companies" when it received a "gold-level" 2009 *Well Workplace Award* by the Wellness Councils of America for its comprehensive wellness program.[173] Highmark conducted a robust scientific study of its program which found a $1.65 return on investment over a four-year period.[174] Three other Pennsylvania companies received the award in 2009 out of a total of 95 companies (up

from one in 2008 and none in 2007). And, employees at Berk-Tec, a small manufacturing company in Lancaster County, learned self-care techniques and lowered their own health care costs by nearly 18 percent and their company's by over 24 percent in one year.[175]

In 2005, the Pennsylvania Employees Benefit Trust Fund implemented the *Get Healthy* program for state employees and their spouses or domestic partners to encourage health improvements. As of July 2009, enrollees and covered spouses who complete a *Get Healthy* Health Assessment will save half of the employee share of their health insurance premiums through a health care contribution waiver.[176] In addition to the *Get Healthy* program, the DOH has a worksite wellness program for employees working in the Health & Welfare building which features activities such as lunch and learn programs, fitness seminars and walks, and information on how to access wellness and disease management programs.

WHAT BARRIERS AND SYSTEM CONSTRAINTS DOES PENNSYLVANIA FACE?

In addition to the constraints of limited funding, the Commonwealth's progress in the area of wellness may be hampered by a lack of coordination at the state level.

POLICY RECOMMENDATIONS

POLICY RECOMMENDATION #6:

Develop a cross-agency collaborative approach to promote better nutritional choices and physical activity in schools, workplaces, and senior centers.

POLICY RECOMMENDATION #7:

Develop statewide strategies to promote a greater emphasis on wellness principles into business practices.

While there are many excellent programs and initiatives, some of which are described above, Pennsylvania does not have an overarching strategy to promote a "culture of wellness" which would transcend population differences and leverage public-private synergies. The *Prescription for Pennsylvania*, its achievements notwithstanding, focuses mainly on the health care system and containing costs.

POLICY RECOMMENDATION #8:

Examine the feasibility of defining and requiring a minimum level of wellness coverage and chronic care management (including self care management) for all health insurance providers conducting business in the Commonwealth. The feasibility review shall include an assessment of the Commonwealth's legal authority to implement this requirement.

Another way to increase the use of wellness services is to require health insurance carriers selling policies in Pennsylvania to cover a minimum set of such services. Currently, the Pennsylvania Department of Insurance requires carriers to cover a number of preventive services (such as mammograms), but does not require coverage for wellness services with the exception of diabetes education.[177] Notably, federal health care reform requires Medicare and health plans to cover preventive services rated A or B by the U.S. Preventive Services Task Force, and to eliminate copayments for these services.

Section 7.
Workforce/Caregivers

Commission's Long-view Resolution for 2025: *The professional and direct care workforce, and informal caregivers, must be prepared to care for older adults and of sufficient capacity to meet their needs.*

WHY IS THIS IMPORTANT?

A larger health care workforce is needed to care for a population that is increasingly aged and chronically ill. Unfortunately, this heightened demand is coinciding with the aging of the health care workforce: the overall decline of workers in the 18–30 age range further increases concerns about the ability to attract enough workers to health care.[178]

HEALTH AND DIRECT CARE WORKFORCE SHORTAGES

National shortages of health care workers are expected to grow, which will continue to impact Pennsylvania. The Association of American Medical Colleges estimates that, by 2025, there will be a national shortage of physicians ranging from 124,400 to 159,300.[179] In Pennsylvania, the number of physician and surgeon openings is expected to increase 13 percent, with 950 average annual openings between 2006 and 2016.[180] A shortage of approximately 260,000 registered nurses (RNs) is expected, more than twice the size of any shortage experienced since the 1960s.[181] In Pennsylvania, between 2006 and 2016, RN openings are expected to increase 20 percent, with average annual openings of 4,800.[182]

By 2014, roughly 24,600 additional direct care workers will be needed, a rate of growth that is nearly three times larger than the state average for all occupations.[183] This is supported by findings from national data that indicate home health aide jobs in Pennsylvania are expected to increase 40 percent between 2006 and 2016, with 2,300 average annual openings.[184] Positions for nurse aides, orderlies, and attendants are expected to increase 14 percent during the same timeframe, with 1,850 average annual openings.[185]

On the positive side, despite difficult economic conditions, health care employment continues to add jobs at a time when many other sectors are cutting workers. In October 2009, 29,000 health care jobs were added nationally.[186] The Bureau of Labor Statistics reports that the health care industry has added 597,000 positions since the start of the economic downturn.[187]

Despite this strong employment outlook, health care workers who are needed most are facing some of the most significant disincentives within the system. Few doctors and nurses are acquiring specialty training in geriatrics. By specializing in geriatrics, physicians lose about $7,000 income annually when compared to general internists.[188] Among RNs, less than one percent are certified in geriatrics, and only one-third of BA programs even require geriatric exposure. The situation is similar for physician assistants, with less than one percent specializing in geriatrics and no aging-specific advanced training programs offered.

CHALLENGES FACED BY DIRECT CARE WORKERS AND INFORMAL CAREGIVERS

The problems the direct care workforce faces have been well-documented. They provide the most hands-on care to patients and are entrusted to provide quality care, yet are often paid wages comparable to those of fast food

"Sometimes attendants are forced to leave their consumers because this job is not a career. It's just a job without hope. Our consumers suffer when we are not valued and treated with quality, self respect, honor, sense of worth, and human decency...We will never have a good, sufficient, and necessary, rebalanced system when we as home care workers make poverty-level wages, have no health insurance, and only see a ceiling with the words of 'no opportunity' painted on it."

—Public testimony (Philadelphia)

workers. This devaluation is reflected in turnover rates. Nationally, nurse aide turnover is around 71 percent. Forty to 60 percent of home health aides leave within the first year and 80 to 90 percent are gone within two years. Turnover costs are estimated to cost employers roughly $4.1 billion annually.

As noted in the Commission's interim report, demographics for informal caregivers, who provide most LTC, are changing as well. The Congressional Budget Office estimates that private funding sources comprise 60 percent of LTC spending for people age 65 and older, with informal care being the largest portion (36 percent).[189] Nationally, up to 75 percent of caregivers are female, with the majority being 35 – 64 years old.[190] Informal caregivers are increasingly likely to be juggling care for a loved one with a full- or part-time paying job and their own personal and family care needs. As a result, the aging of the baby boom generation is expected to coincide with a decline in the number of people available for caregiving.

WHAT IS PENNSYLVANIA DOING NOW?

STATE GOVERNMENT WORKFORCE EFFORTS

Governor Rendell's administration has taken several important steps to boost the healthcare workforce in the Commonwealth. In 2008, the Governor signed three bills into law that expanded scopes of practice for physician assistants, physical therapy assistants, and respiratory care therapists.[191] In addition, the Governor established the Pennsylvania Center for Health Careers (PCHC) as well as the Health Careers Leadership Council (the latter being a Workforce Investment Board initiative).[192] For the past few years, the PCHC has held annual Best Practices conferences which provide opportunities to learn about the latest successes in such areas as training and retention of healthcare workers.[193] In addition, the PCHC issued a 2006 report with strategies aimed at boosting retention, among them: enhanced training for new workers to help them adjust more quickly, ongoing education of staff to promote career development and advancement, and providing information to employers about retention research and best practices.[194]

Some state legislators have also become more attuned to the role of healthcare workers and the challenges in their day-to-day jobs. In 2009, a handful of legislators participated in the "Come Care with Me" program, sponsored by the Paraprofessional Healthcare Institute.[195] During this program, legislators followed direct-care workers to get a first-hand view of their duties and to hear about their struggles to make ends meet.[196] As Representative Dan Frankel commented, "It's ironic that health care benefits have never been part of the compensation package for direct-care workers who provide much-needed health services."[197]

PRIVATE PROVIDERS' WORKFORCE EFFORTS

Private providers have also been acknowledged for innovative efforts to improve recruitment and retention. In 2003, Gettysburg Hospital partnered with a local community college to offer a nursing program in the area, thus expanding access to a nursing education and working to ensure a supply of nurses for the area.[198] HealthSouth Rehabilitation Hospital in Altoona invested in retaining its staff. In 2005, as a response to surveys of various health care employees, HealthSouth improved how it trains workers in various specialty practice areas, eliminated contract labor, developed a career advancement program, and placed workers in patient programs they asked to work in.[199]

Furthermore, HealthSouth strengthened its ties with local colleges to increase clinical rotation placement sites and create a pipeline of workers.[200]

WHAT BARRIERS AND SYSTEM CONSTRAINTS DOES PENNSYLVANIA FACE?

Clearly, the Commonwealth's financial situation poses significant challenges to investing in future healthcare workforce needs. Yet, given the all-but-certain increased future demand for health and LTC services and the workforce and caregiver trends discussed above, the question becomes how the state can afford not to be proactive in furthering efforts to boost its healthcare workforce and support caregivers. These challenges are not unique to the Commonwealth, as recognized in the PPACA which includes many provisions aimed at strengthening the healthcare and direct care workforce.

POLICY RECOMMENDATIONS

POLICY RECOMMENDATION #9:

Assess the feasibility of providing access to basic health coverage to direct care workers through public and private low-cost programs to enhance recruitment and retention.

It is particularly difficult to hire and retain direct care workers due to poor pay and, often, lack of benefits. Pennsylvania direct care workers average about $10.50 an hour, making it difficult to afford health insurance. Roughly 40 percent of Pennsylvania direct care workers do not have health insurance and less than a third of LTC employers in Pennsylvania contribute to family coverage for their employees.[201] Consequently, it is estimated that 30–35 percent of direct care workers in Pennsylvania subsidize their income with some form of public assistance.[202] Finally, given the fact that many direct care workers have health problems of their own and a high rate of on-the-job injuries, they are often classified as high risk by insurance companies, further adding to the difficulty in obtaining health insurance.[203]

One possibility for providing health insurance to more direct care workers is to work with the insurance industry, in a joint effort, to develop an affordable, limited benefit package that can be purchased by adults ages 19–65. The benefit package could include preventive care, physician services, and emergency care. While options for subsidized and low-cost health insurance will expand greatly under health care reform, these provisions will not be completely implemented until 2014.

POLICY RECOMMENDATION #10:

Promote employer initiatives to support elder care such as offering flexible work schedules and elder care information and referral services through a statewide campaign educating employers on the economic and other impacts of caregiving on businesses.

In 2007, an estimated 1.4 to 2.1 million informal caregivers in Pennsylvania provided care to loved ones at an economic value of $15.6 billion.[204] For people age 85 and older (the fastest growing segment of the population), 80 percent of their care is provided by friends and family.[205] For caregivers who are also employed, trying to balance the responsibilities of work and personal life can be extremely challenging.

Increasingly, employers are feeling the effects of employees who also serve as caregivers. Employees caring for an older loved one are more likely to report health problems such as depression and heart disease, resulting in additional health care costs of $13.4 billion, on average, each year.[206] The MetLife Mature Market Institute in 2006 estimated that, based on such factors as absenteeism and workday interruptions, employers incurred $33.6 billion in costs for full-time employed caregivers.[207] However, the single most costly expense was replacing employees altogether ($6.6 billion).[208] Thus, employers are increasingly recognizing that it benefits their bottom line to provide services and supports for employees who are caregivers. As MetLife notes, "[C]oordination of eldercare services and wellness initiatives may open new avenues of innovation to benefit both employees and employers. Employers can provide support to their employees and, at the same time, reduce their health care costs by anticipating and responding to the challenges of eldercare."[209]

Currently, it is estimated that about 33 percent of large employers have eldercare programs of some sort in place for their employees.[210] The Bon Secours Richmond Health System offers a program in which it provides a 50 percent subsidy to its CNAs, LPNs, and RNs for elder care.[211] Furthermore, employees can receive home health care assistance for dependents up to ten days per year.[212] Likewise, General Mills, in order to retain crucial talent and strike a better work-life balance, began funding an Employee Assistance Program (EAP) over twenty years ago.[213] Through EAP, employees receive confidential support to access elder care providers, obtain customized referrals for senior housing and service options, and receive support in coping with aging loved ones.[214]

Numerous options for better eldercare practices exist. The Equal Opportunity Commission (EEOC) has issued best practices guidelines for employers regarding employees as caregivers. Along with suggestions of flexible work hours, telecommuting, and part-time or job share arrangements, the EEOC also suggests: incentives for managers to ensure employees know about work-life balance options, making certain that open positions are publicized to all eligible employees regardless of caregiving duties, removing any barriers for caregivers seeking to re-enter the workforce, and making required overtime as family-friendly as possible (i.e., advance notice and adjusted start or end times, if possible).[215]

POLICY RECOMMENDATION #11:

Leveraging new federal funding, develop and implement curricula for health care professionals and direct care workers in gerontology, chronic care management, long-term care, and senior and family-centered interdisciplinary care to maintain a quality care workforce.

The Commonwealth's ability to provide effective and high-quality care to older adults is constrained by widespread lack of geriatric training. In April 2008, the Institute of Medicine (IoM) issued recommendations to prepare for the anticipated health care needs of aging Americans. Key among them were enhancing geriatric competence and increasing recruitment and retention of geriatric specialists.[216] As stated earlier, few health care workers (professional and paraprofessional) receive geriatric training, even though many of them will almost surely come into contact with older adults at some time in their careers. The IoM recommended that licensure and certification of health care professionals be contingent on demonstrating competence

in caring for older adults.[217] For paraprofessionals who have extensive day-to-day contact in caring for older adults, the IoM recommends more stringent federal and state requirements for training.[218] Even for caregivers, the IoM recommends that more local training opportunities be available so they are better equipped to help meet complex health needs.[219] To boost recruitment and retention, the IoM recommends pay increases to health care workers obtaining geriatric specialty training, as well as loan forgiveness and scholarship opportunities for workers pursuing such training.[220] Additional recommendations include financial incentives to faculty trained in geriatrics and more relationship building and mentoring for direct care workers.[221] The need for expanded opportunities for training in geriatrics was recognized in the PPACA which earmarked nearly $11 million in funds for geriatric training and education and another $10 million for advanced training for direct care workers.

In rural Minnesota, an innovative model has revamped traditional views on training health care workers. Like many nursing facilities, Good Shepherd Lutheran Home in Sauk Rapids had great difficulty finding LPNs and was also losing nursing assistants who saw no opportunities for career progression. Good Shepherd partnered with a local technical college in 2001 to create the Long-Term Care Connection, a customized LPN curriculum operating at Good Shepherd with faculty from the technical college training CNAs who work at facilities in the area.[222] The benefits of such a model are many: first, CNAs are able to "learn while they earn." Also, nursing assistants "become loyal employees who provide great care for our residents. Everybody benefits."[223] Good Shepherd's president and CEO, Bruce Glanzer, believes that tailoring the curriculum to LTC was also instrumental to the program's success.[224] He notes that many health care workers try to work in acute care settings because that is what they are best trained for by traditional curricula.[225] By creating a curriculum that concentrates more on LTC, workers feel more confident and capable of working in LTC settings.

Another evolving mindset is the need for person-centered principles when providing LTC. The Southwest Pennsylvania Partnership for Aging convened a workgroup and identified nine core elements.[226] First and foremost, the person must be at the center of care. The additional elements that should exist for places where seniors receive LTC are:

- Balancing risk while promoting independence;
- Quality of life and quality of care;
- Easy to understand and access;
- Coordinated with smooth transitions between services;
- Prevention, wellness, and early connections to home and community-based services;
- Viable and well-trained direct care workforce;
- Continuing education and quality improvement and
- Financially feasible model.[227]

It is not only person-centered principles that are gaining acceptance. Pennsylvania's LIFE program is driven by the belief that older adults and *their families* benefit more when chronic care needs are met in the community as much as possible. This model puts supports for the individual and the

family at the center of care. An interdisciplinary team of healthcare workers, many of whom are nurses trained in geriatrics and home care, coordinates transportation, rehabilitative services, specialty care (such as dentists and podiatrists), and other services based on the individual's needs.[228] At the University of Pennsylvania's LIFE program, staff turnover was just 3–9 percent, compared to 30–50 percent turnover rates in nursing facilities between 2000 and 2001.[229]

POLICY RECOMMENDATION #12:

Promote cross-training or blended job roles for long-term care workers to achieve greater efficiencies in service delivery and coordinated career progression to attract frontline workers to the field.

Federal and state training requirements for direct care workers can vary by population being served and core competencies do not even exist. A number of states and national groups have offered recommendations to ensure more consistent training of direct care workers. Many recommend a comprehensive assessment of the jobs in which they work and the core competencies that should be required in these positions.[230] Pennsylvania's own Direct Care Workforce Workgroup recommended this as well in 2007, along with supporting career development and offering specialized training.[231] Perhaps no state is further along with these efforts than Iowa, which recommends, among other things, a 3-tiered certification system, with each tier adding new job duties and education requirements.[232] Other recommendations from Iowa include creating a standardized curriculum for direct care workers and providing endorsements for those who acquire specialty skills in areas such as dementia care and mental health.[233] At the federal level, health reform has established a pilot program to test the efficacy of developing and implementing core competencies for direct care workers.

Another promising endeavor offers uniform training and job advancement to direct care workers. In 2004, North Central Kansas Technical College (NCKTC) began a Health Support Specialist (HSS) program. Since that time, it has become a national Registered Apprenticeship Program overseen by the U.S. Department of Labor. Under this program, NCKTC has worked with roughly ten states to implement a new, nationally recognized type of health care worker for older adults, the Health Support Specialist (HSS). This new occupation provides pay scale increases as additional certifications are obtained (in areas such as dementia care) and provides a career ladder for frontline workers, who can progress to a Universal Worker (trained as a CNA, a Trained Medication Aide, and has additional certifications, such as for dementia care).[234] The HSS apprenticeship program combines school training with on-the-job learning, and can enhance mobility of workers who have met more recognizable training standards.[235]

Section 8.
Conclusion

"As we look ahead, we know that government efforts in the field of long-term care cannot be all things to all people. Faced with finite resources, it is inevitable that Pennsylvania will need to make some hard choices, but our guiding principle must always be prioritizing our programs to assist those with the greatest social and economic needs.

Even so, recent passage of the CLASS Act by Congress is tremendously encouraging and confirms what many of us have been saying: that a social insurance model, incorporating the concept of personal responsibility on the part of our citizens, is essential to meeting the demands of the future. CLASS Act payroll deductions—much like Social Security or Medicare—will provide seniors and adults with disabilities with security, certainty and affordable access to long-term living services in the hour of their greatest need. At the same time, the CLASS Act ratifies the work Pennsylvania has underway to build a long-term living system that emphasizes independence, dignity, community integration and consumer choice and control."

—John Michael Hall, Secretary, Pennsylvania Department of Aging

As a Commission, we have taken an honest accounting of where we are in providing care, services, and resources for older Pennsylvanians and considered what is necessary to ensure we can meet the needs of the future older adult population. In examining these issues and the available data, we have proposed what we believe are realistic, "doable" action steps to move us closer to a sustainable and flexible array of supports and services for older Pennsylvanians. Given the many promising efforts which are already in place, we are confident in the Commonwealth's potential to make these changes.

Despite Pennsylvania's tremendous investment, our review has identified many inadequacies of the current system. In the absence of action, the direct care workforce and unpaid caregivers will be severely strained in providing adequate care for older Pennsylvanians with impairments. Lack of care coordination currently results in unnecessary hospitalizations and adverse outcomes for our citizens. Given the projected demographic, health risk, and economic trends discussed, the system is not sustainable in the long-run. It is imperative that we not be complacent and unfocused under the pretext that this is a "future" issue which we still have time to address.

Although we must acknowledge and face these challenges, we are encouraged by the progress the Commonwealth has already made in addressing many of the issues we describe. And, we are certain that Pennsylvania can achieve a more sustainable system of care and services for its older population with additional strategic interventions. Finally, we cannot underestimate the assets older adults bring to our society and the potential of the baby boom and subsequent cohorts of older adults to actively engage in developing new ways to meet the challenges we describe in this report.

"You, as a commission, have been charged with looking into the future and finding a solution for this very serious dilemma. My comment is, unfortunately, the future is now. It's not 2025. The future is right now."

—Public testimony (Harrisburg)

Policy Recommendations and Lead State Agencies

Theme	Recommendation	Lead Agencies	Other Agencies
Finance	1. Develop strategies to educate Pennsylvanians about the need to plan for long-term care needs and increase self-funding of long-term care through various mechanisms, such as: improving incentives for purchasing long-term care insurance and/or participating in the Long-Term Care Partnership under Act 40.	Aging	Insurance, Public Welfare
	2. Provide additional incentives for self-funding of long-term care through implementation of a social insurance program modeled on the CLASS Act as enacted either through federal or state legislation.	Aging; Insurance	
	3. Assess the feasibility of developing and implementing an integrated financing system (Medicare, Medicaid, state funding) across the care continuum to eliminate care silos and delay or prevent nursing facility admission through better care coordination and timely interventions.	Aging, Public Welfare	
Care Coordination	4. Review gaps, barriers, and redundancies in current information systems, reimbursement, and service delivery as they relate to care coordination and care transitions across the care continuum and utilize funding initiatives under the American Reinvestment and Recovery Act of 2009 and the Patient Protection and Affordable Care Act of 2010 when available to fill identified gaps and barriers.	Public Welfare; Aging	N/A
	5. Maximize use of technology such as telehealth and assistive devices to improve outreach, care coordination, accessibility, and safety for older adults living in the community.	Public Welfare	Health, Aging
Improving Wellness	6. Develop a cross-agency collaborative approach to promote better nutritional choices and physical activity in schools, workplaces, and senior centers.	Health, Education, Aging, Labor and Industry	
	7. Develop statewide strategies to promote a greater emphasis on wellness principles into business practices.	Administration	
	8. Examine the feasibility of defining and requiring a minimum level of wellness coverage and chronic care management (including self care management) for all health insurance providers conducting business in the Commonwealth. The feasibility review shall include an assessment of the Commonwealth's legal authority to implement this requirement.	Insurance	

Theme	Recommendation	Lead Agencies	Other Agencies
Workforce/ Caregivers	9. Assess the feasibility of providing access to basic health coverage to direct care workers through public and private low-cost programs to enhance recruitment and retention.	Public Welfare	Health, Labor, Industry
	10. Promote employer initiatives to support elder care such as offering flexible work schedules and elder care information and referral services through a statewide campaign educating employers on the economic and other impacts of caregiving on businesses.	Labor; Industry	Aging, Industry, Chamber of Business
	11. Leveraging new federal funding, develop and implement curricula for health care professionals and direct care workers in gerontology, chronic care management, long-term care, and senior and family-centered interdisciplinary care to maintain a quality care workforce.	Health	State
	12. Promote cross-training or blended job roles for long-term care workers to achieve greater efficiencies in service delivery and coordinated career progression to attract frontline workers to the field.	Health; Public Welfare; Aging	N/A

Technical Notes

PENN STATE UNIVERSITY ECONOMETRIC MODEL

As part of a Fiscal Impact Study PSU conducted for the Office of Long Term Living, PSU developed a statistical model to estimate future Medical Assistance (MA) long term living expenditures through 2030. The model utilized the Penn State Data Center's population projections and historical cost and utilization data. There are numerous parameters within the model which can be manipulated to produce estimates reflecting a variety of scenarios. These inputs are: nursing home costs (using average daily rate); projection time period; growth rate of the MA nursing home population; shares of consumers using nursing home versus community-based services waivers; capacity of nursing homes; nursing home bed turnover rate; number of MA beds per nursing home; "reconciliation" of consumers once MA beds are filled (four levels which determine where the model places the consumer); allocation of people on a waiting list; mix of types of waivers by AAA service area; mix of waiver services with types of waivers by AAA service area; and costs of waiver services.

As noted in the report, the Commission requested a few simple analyses which would project future MA long term living expenditures in 2025 based on three assumptions about inflation. We further asked PSU to run these analyses based on two different assumptions about the mix of consumers by LTC setting (nursing home versus community-based waivers). One parameter was set at the current mix (roughly 65 percent of consumers served in nursing homes and 35 percent served in waivers) and one at a 50/50 mix.

The PSU model has some significant limitations: it cannot phase in changes to the mix of consumers by LTC setting over time; and it cannot limit analyses by consumer characteristics such as age or acuity. Thus, the usefulness of the 50/50 mix scenario was undercut by the model's constraint which forced the change from the start of the projection time period (rather than incrementally increasing the share of people receiving waiver services over a certain period of time). Further, the base expenditure data exclude certain LTC expenditures which are made outside of the claims processing system and exclude two waivers serving people with intellectual and developmental disabilities.

ANALYSIS OF MEDICAL EXPENDITURE PANEL SURVEY (MEPS) DATA

On behalf of the Commission, a State contractor, Thomson Reuters, submitted a research request to the Agency of Healthcare Research and Quality (AHRQ) to use state-specific MEPS data to fill in some gaps in our knowledge, especially pertaining to functional impairment and adequacy of health care resources. MEPS is a national longitudinal survey which measures health care service use and expenditures, and characteristics of those using health care services including prevalence of medical conditions and health insurance coverage. MEPS is limited to the noninstitutional civilian population; thus nursing home residents are excluded. For states with large populations, MEPS can produce state-level estimates. AHRQ approved the research request and provided Thomson Reuters with three years of data (2006 – 2008) limited to Pennsylvanians age 50 and older. The main types of information the Commission analyzed were: access to medical care, dental care, and prescription drugs (including a comparison for the 65 and older group of pre- and post-implementation of Medicare Part D); prevalence of functional impairment (IADL, ADL, and cognitive); mental health status; insurance coverage; and out-of-pocket costs. We compared estimates for two age groups: people ages 50 to 64 and people ages 65 and older. The purpose of including people ages 50 to 64 was to glean some knowledge about the age cohort that would make up the 65 and older population by 2025.

All data are self-reported by survey respondents. However, AHRQ makes efforts to validate the health care service use and expenditures through corresponding MEPS provider surveys.

For most analyses, we pooled the three survey years together to increase sample size and yield stronger estimates. Although MEPS has an overlapping panel design with survey cohorts spanning two years, each year's sample is statistically independent. We used person-level survey weights designed for use with the state-specific file.

Table 4 provides the estimates produced by the MEPS analyses and associated confidence intervals based on a 95 percent degree of confidence.

Table 4. Results from Analysis of Pennsylvania Medical Expenditure Panel Survey Data: 2004 – 2006

	Ages 50 to 64			Ages 65 and Older		
Survey Topic	**Estimate**	**Low**	**High**	**Estimate**	**Low**	**High**
% male	48.2%	46.1	50.3%	41.2%	39.7	42.7
% female	51.8%	49.7%	53.9%	58.8%	60.3%	57.3
Average annual income ($2006)	$37,696	$32,910	$42,482	$22,502	$19,441	$25,563
% need help with ADLs expected to last at least 3 months	0.5%	0.14%	0.84%	3%	1.75%	4.25%
% need help with IADLs expected to last at least 3 months	0.9%	0.4%	1.2%	6%	4.2%	7.8%
% with any cognitive limitations	2.4%	1.5%	3.3%	5.9%	4%	7.8%
% reporting mental health status:						
Excellent	31%	27.7%	34.3%	23.9%	20.6%	27.2%
Very Good	30.6%	26%	35.2%	29.2%	25.1%	33.3%
Good	27.6%	23.3%	31.8%	31.9%	27.7%	36.1%
Fair	7.4%	5.6%	8.8%	7.3%	5.6%	9%
Poor	2.3%	1.1%	3.5%	2.6%	1%	4.2%
Inapplicable or don't know	1.2%	0.53%	1.9%	5%	3.6%	6.4%
Total health care expenditures for year ($2006)	$7,440.52	$5,429.38	$9,451.66	$8,446.12	$7,487.84	$9,404.40
Total out-of-pocket cost for year ($2006)	$1,470.75	$933.24	$2,008.26	$1,462.33	$1,373.58	$1,551.08
Has ever had Medicaid during the year	10.7%	8%	13.4%	9%	7.7%	10.3%
% have usual source of care	87.5%	85.9%	89.1%	91%	89.4%	92.6%
% unable to get necessary medical care	1.7%	0.96%	2.4%	0.33%	0.1%	0.56%

Table 4. Results from Analysis of Pennsylvania Medical Expenditure Panel Survey Data: 2004 – 2006

	Ages 50 to 64			Ages 65 and Older		
Survey Topic	**Estimate**	**Low**	**High**	**Estimate**	**Low**	**High**
% unable to get necessary dental care	1.9%	1.1%	2.7%	0.84%	0.5%	1.1%
% unable to get necessary prescription medicines (2004 – 2006)	2.5%	1.1%	3.9%	1.4%	0.7%	2.1%
% unable to get necessary prescription medicines (2004 – 2005)	n/a	n/a	n/a	1.9%	0.9%	2.9%
% unable to get necessary prescription medicines (2006—Part D implemented)	n/a	n/a	n/a	0.4%	0%	0.83%

Endnotes

1 Act 16, Article VIII-D, Section 802-D. See Appendix A for the full text of the legislation.

2 Ibid.

3 Public Law No. 111-148, amended by the Health Care and Education Reconciliation Act of 2010 (H.R. 4872).

4 Pennsylvania Office of Long Term Living, Public Input Meeting Summary: Overview, undated.

5 Ibid.

6 Ibid.

7 Ibid.

8 Thomson Reuters analysis of *Pennsylvania Population Projections Final Report 2000 – 2030*, Pennsylvania State University State Data Center prepared for the Office of Long Term Living, June 2008.

9 The baby boom cohort includes people born between 1946 and 1964. The group is often divided into two age cohorts based on year of birth: older boomers (1946 – 1954) and younger boomers (1956 – 1964).

10 See *Facts and Fictions About an Aging America*, MacArthur Foundation Research Network on an Aging Society, Fall 2009.

11 U.S. Census, GCT-T8-R Old-Age Dependence Ratio of the Total Population, 2008 Population estimates.

12 Thomson Reuters analysis of *Penn State Population Projections: Final Report*, Table 3.

13 *Health, United States: 2008*, Table 26. Life expectancy at birth, at 65 years of age, and at 75 years of age by age, race and sex, Centers for Disease Control and Prevention, accessed on February 2, 2010 at http://www.cdc.gov/nchs/data/hus/hus08.pdf#026.

14 U.S. Census, Table 102, Expectation of Life at Birth, 1970 to 2006, and Projections, 2010 to 2020 accessed on February 2, 2010 at http://www.census.gov/compendia/statab/2010/tables/10s0102.pdf.

15 Penn State University, Pennsylvania State Data Center, 2006 Final Population Estimates Table.

16 Penn State University, Pennsylvania State Data Center, *Pennsylvania Population Projections Final Report 2000 – 2030*, Appendix D Pennsylvania Population Projections by County, Race, Gender, and Age, June 2008.

17 U.S. Census, 2006 – 2008 American Community Survey.

18 Pennsylvania Office of Long Term Living, analysis of SAMS data.

19 *Out and Aging: The MetLife Study of Lesbian and Gay Baby Boomers*, MetLife Mature Market Institute, Lesbian and Gay Aging Issues Network of the American Society on Aging, and Zogby International, November 2006, accessed on February 7, 2010 at http://www.asaging.org/networks/LGAIN/OutandAging.pdf.

20 J. Bennett, *Invisible and Overlooked*, Newsweek Web Exclusive, September 18, 2008, accessed on February 3, 2010 at http://www.newsweek.com/id/159509. The estimate of the percentage LGBT comprise of the older population comes from J. M. Grant, Outing Age 2010: Public Policy Issues Affecting Lesbian, Gay, Bisexual and Transgender Elders, National Gay and Lesbian Task Force, November 2009, accessed on February 2, 2010 at http://www.thetaskforce.org/downloads/reports/reports/outingage_final.pdf. This is a comprehensive source on the issues facing the LGBT community as they age.

21 Thomson Reuters analysis of *2007 Nursing Home Data Compendium*, Table 3.3(a), Distribution of Activity of Daily Living (ADL) Impairments in Nursing Home Residents: 2002, Centers for Medicare & Medicaid Services (based on Minimum Data Set). 2008 data from analysis of the same table in the 2009 edition of the Nursing Home Data Compendium.

22 See *Volume II: The Future of Long Term Care Services in the Commonwealth of Pennsylvania, Final Report*, Prepared for The Pennsylvania Health Care Association, The Lewin Group, April 25, 2006.

23 *When I'm 64: How Boomers will Change Health Care*, American Hospital Association and First Consulting Group, May 2007 accessed on February 6, 2010 at http://odpagewaveresources.org/uploads/When_I%27m_64.pdf. Also, see Pennsylvania 2020 Vision Report, Part II Trends and Issues based on Lifestage Matrix Marketing.

24 *2009 Economic Report of the President.*

25 At the time this was written (May 2010), there was debate about whether the recession had ended.

26 Bureau of Labor Statistics, Local Area Unemployment Statistics, Regional and State Unemployment Rates (seasonally adjusted), accessed at http://www.bls.gov/lau/ on May 6, 2010. http://www.bls.gov/lau/home.htmUnemployment in Pennsylvania varies regionally between a low of 7.2 percent in State College to 10.9 percent in Williamsport (January 2010 preliminary, not seasonally adjusted).

27 Mortgage Bankers Association, *Delinquencies Continue to Climb in Latest MBA National Delinquency Survey*, 11/19/2009, and First American CoreLogic, *Negative Equity Report, Q3 2009.* Negative equity exists when the loan amount exceeds the value of the home. This analysis is based on the company's database which represents over 90 percent of all mortgages.

28 *State Coincident Indexes: December 2009*, Research Department, Federal Reserve Bank of Philadelphia, accessed on February 10, 2010 at http://www.philadelphiafed.org/research%2Dand%2Ddata/regional%2Deconomy/indexes/coincident/2009/CoincidentIndexes1209.pdf. This index is based on a blend of the following four variables: nonfarm payroll employment, average hours worked in manufacturing, the unemployment rate, and wage and salary disbursements deflated by the consumer price index. The trend for each state's index is set to the trend of its gross domestic product (GDP) so long-term growth in its index matches long-term growth in its GDP.

29 Governor's Budget Office.

30 M. Soto, *How is the Financial Crisis Affecting Retirement Savings? May 2009, Update*, The Urban Institute Retirement Policy Program.

31 B. A. Butrica and P. Issa, *Retirement Account Balances, January 2010*, Urban Institute Fact Sheet on Retirement Policy accessed on January 22, 2010 at http://www.urban.org/uploadedpdf/411976_retirement_account_balances.pdf.

32 Ibid. The rebound is measured between the end of the 1st and 4th quarters of 2009.

33 A. Rappaport and S. Siegel, *Overview of Housing Wealth, Options, and Spending Issues in Retirement Monograph*, Society of Actuaries, 2009, accessed on January 21, 2010 at http://www.soa.org/library/monographs/finance/housing-wealth/2009/september/mono-2009-mfi09-rappaport.pdf.

34 *2007 SCF Chartbook*, The Federal Reserve Board, accessed on January 21, 2010 at http://www.federalreserve.gov/pubs/oss/oss2/2007/2007%20SCF%20Chartbook.pdf.

35 The median value of a primary residence (for those with a primary residence) comprises 66 percent of the median value of assets for households with assets headed by someone age 65 to 74, and 72 percent for a household head age 75 or older.

36 J. R. Gist, C. Figueiredo and S. Verma, *Housing Wealth Affects, Boomer Refinancing, Housing Debt, and Retirement Saving Adequacy 1989 – 2007*, Society of Actuaries, 2009 accessed on December 12, 2009 at http://www.soa.org/library/monographs/finance/housing-wealth/2009/september/mono-2009-mfi09-gist.pdf.

37 Ibid.

38 R.W. Johnson and C. Mommaerts, *Unemployment Statistics on Older Americans*, Updated August 6 2010, Urban Institute Retirement Policy Program accessed on January 22, 2010 at http://www.urban.org/UploadedPDF/411904_unemploymentstatistics.pdf.

39 Retirement Confidence Survey, Employee Benefit Research Institute, accessed on December 8, 2009 at http://www.ebri.org/surveys/rcs/.

40 R. Helman, Mathew Greenwald & Associates, C. Copeland and J. VanDerhei, *The 2009 Retirement Confidence Survey: Economy Drives Confidence to Record Lows; Many Looking to Work Longer*, Issue Brief, April 2009, No. 328, accessed on December 8, 2009 at http://www.ebri.org/pdf/briefspdf/EBRI_IB_4-2009_RCS2.pdf. See also results from a 2008 survey of retirees with assets of $100,000 or more jointly sponsored by LIMRA, International Foundation for Retirement Education, and the Society of Actuaries published in the report *Will Retirement Assets Last a Lifetime* and a 2009 supplement *What a Difference A Year Makes*. These show dramatic erosion of retirees' confidence in their financial security between early 2008 and spring 2009.

41 The worker response was the lowest since the survey started asking the question in 1993.

42 C. Mara, A. D. Thomas and S. L. Hintz (all of Penn State Harrisburg), *Long-Term Care 50+ Survey, Final Report*, submitted to the Office of Long Term Living, Pennsylvania Department of Public Welfare, September 2008.

43 While it would be understandable that survey respondents under age 65, most of whom would not yet have Medicare, might not be aware of Medicare's coverage policies, the same percentage of people age 65 and older thought Medicare would pay for LTC.

44 Thomson Reuters analysis of MSIS State Summary Datamart, 2008 Quarterly Medicaid State Summary. Note that the Governor's recent 2010 – 2011 budget summary showed total Medical Assistance spending of $15.4 billion with the elderly comprising 32 percent of that amount ($4.9 billion). The time period was not stated, but we assume it was 2008 – 2009. The discrepancy between the State's spending figure of $15.4 and the MSIS total of $12.5 billion could be explained by payments made outside of the claims processing system.

45 Ibid.

46 R. L. Mollica and K. Simms-Kastelein (National Academy for State Health Policy) and E. Kassner (AARP Public Policy Institute), *State-Funded Home and Community-Based Services Programs for Older Adults*, AARP Public Policy Institute, April, 2009. Per capita figures were derived by dividing expenditures for programs serving older people (from Mollica et al Table 2) by population estimates for people ages 60 and older (U.S. Census state population estimates by single year of age as of July 2007).

47 Pennsylvania Lottery web site accessed on January 21, 2010 at http://www.palottery.state.pa.us/content.aspx?id=60.

48 P. Kemper, H. L. Komisar, and L. Alecxih, Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect? *Inquiry* 42: 335-350 (Winter 2005/2006).

49 Forty-two percent of people would have no LTC expenditures either because they do not have LTC needs or because they use only informal care.

50 This figure is based on a combination of $179,000 for maintaining a nursing home resident in the community and $174,000 for maintaining a disabled older adult at home.

51 This applies only to people who had not resided in a nursing facility.

52 This is roughly the average annual inflation rate over the past ten years (based on CPI-U).

53 Pennsylvania Department of Aging. This model was not limited to Medicaid LTC spending on older adults. It excluded expenditures for the Consolidated and PFDS waivers.

54 The lower range reflects zero inflation and the upper range reflects three percent inflation.

55 The Commission also requested projections of spending assuming an incremental increase in the share of consumers served in the community up to a 50 percent share by a target year, but the model does not have this capability.

56 R. W. Johnson and C. Mommaerts, *Are Health Care Costs a Burden for Older Americans?* The Urban Institute, July 2009.

57 E. Brando, "Fidelity: Retired Couples Need $240,000 for Medical Expenses," *U.S. News and World Report Money*, March 27, 2009.

58 The Chief Actuary of the Centers for Medicare & Medicaid Services estimates national health care spending will be slightly higher under health care reform over a ten-year projection period compared to baseline (January 8, 2010 memorandum by Richard S. Foster, Estimated Financial Effects of the 59 Patient Protection and Affordable Care Act Passed by the Senate on December 24, 2009).

59 *2009 Economic Report of the President*, Table B-64: Changes in consumer price indexes for commodities and services, 1929 – 2007 and Table B-4: Percent changes in real gross domestic product, 1959 – 2008.

60 *Social Security: 2008 Pennsylvania Quick Facts*, AARP.

61 2009 OASDI (Social Security) Trustees Report, accessed January 28, 2010 at http://www.ssa.gov/OACT/TR/2009/tr09.pdf.

62 2010 Medicare Trustees Report, accessed on August 13, 2010 at http://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf. Note that CMS's chief actuary disputes the Trustees' assumptions regarding the PPACA's positive impact on the Medicare Trust Fund.

63 C.J. Truffer et al, Health Spending Projections Through 2019: The Recession's Impact Continues, forthcoming in *Health Affairs*, Volume 29, Number 2, March 2010.

64 E. Fisher, D. Goodman, J. Skinner and K. Bronner, *Health Care Spending and Quality Outcomes: More Isn't Always Better*, February 27, 2009, Dartmouth Institute for Health Policy & Clinical Practice, accessed on March 9, 2010 at http://www.dartmouthatlas.org/atlases/Spending_Brief_022709.pdf.

65 *Final Report on the Own Your Future Consumer Survey*, November 2006, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy Group, U.S. Department of Health and Human Services, accessed o February 5, 2010 at http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Campaign/Reports/Documents/2006/Phase%201%20Consumer%20Survey.pdf.

66 *Long-Term Care Partnership Registry*, developed by Thomson Reuters under contract to the Office of the Assistant Secretary for Planning and Evaluation, HHS. Data on active LTC Partnership policies in force may be found at: http://www.dehpg.net/LTCPartnership/map.aspx. The number of policies purchased represents the number currently in force as of December 31, 2009.

67 Pennsylvania Governor's Office of Administration. State agencies which do not use the Commonwealth's payroll system can't offer this benefit because payment of premiums is administered through the payroll system.

68 We do not have an estimate of the number of state employees and family members who would meet eligibility criteria for the long-term care insurance.

69 Pennsylvania Office of Long Term Living.

70 Workforce is, of course, another important constraint. But, presumably if there were sufficient resources to increase pay and benefits, more people would choose this line of work.

71 Kaiser Commission on Medicaid and the Uninsured, *Paying for Nursing Home Care: Asset Transfer and Qualifying for Medicaid*, January 2006.

72 Thomson Reuters analysis of *National Association of Insurance Commissioners 2007 Long-Term Care Insurance Experience Reports*, Form C, and American Community Survey population estimate of Pennsylvanians ages 45 and older, 3-year average, 2006 – 2008. The population estimate was further limited to those with income at or above poverty (who could afford premiums) and then reduced by 15 percent to account for the share of people who would be declined coverage due to underlying health issues. This estimate is consistent with a 2002 estimate of Pennsylvania's LTCI market penetration of six to nine percent in 2002 published in *Long-Term Care Insurance in 2002, Research Findings*, by America's Health Insurance Plans (based on the population age 50 and older, but with no adjustments for income or share of people who might be declined coverage).

73 *National Spending for Long-Term Care*, Fact Sheet, Georgetown University Long-Term Care Financing Project, updated February 2007, accessed on April 14, 2010 at http://ltc.georgetown.edu/pdfs/natspendfeb07.pdf.

74 D. G. Stevenson, M.A. Cohen, E.J. Tell and B. Burwell, The Complementarity of Public and Private Long-Term Care Coverage, *Health Affairs*, Volume 29, Number 1, January 2010.

75 The Congressional Budget Office estimated monthly premiums would be $123 whereas the CMS Office of the Actuary estimated they would be $240.

76 See P. Saucier and B. Burwell, *The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care*, submitted to CMS on January 2007, and J. G. Folkemer, *Seven Reasons Why Managed Long-Term Care Won't Work*, presented at the National Association of State Medicaid Directors, November 14, 2007.

77 H.S. Kaye, C. Harrington and M.P. LaPlante, Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much? *Health Affairs*, Volume 29, No. 1, 2010. This is true both for older adults and people under the age of 65, though the share living in the community is higher among the latter group.

78 Y. Chen and E. A. Thompson, Understanding Factors that Influence Success of Home-and Community-Based Services in Keeping Older Adults Living in the Community, *Journal of Aging and Health*, OnLineFirst, January 26, 2010.

79 J. Feder, H. L. Komisar, R. B. Friedland, *Long-Term Care Financing: Policy Options for the Future*, Georgetown University Long-Term Care Financing Project, June 2007.

80 H. L. Komisar, J. Feder, J.D. Kasper, S. Mathieu, *Unmet Long-Term Care Needs of Medicare-Medicaid Dual Eligibles*, Chartpack, The Commonwealth Fund, October 2005.

81 Pennsylvania Department of Aging, *Waiting List by Care Program Report Period Between 7/1/2009 and 7/31/2009 as of August 12, 2009.*

82 Pennsylvania Department of Aging, *Count by AAA of Consumers with Active Care Program Enrollment with Care Plan End Dates after 7/31/2009 Waiting for Services as of 8/12/2009.*

83 Pennsylvania Office of Developmental Programs, PUNS snapshot 12/31/09. Over 70 percent of older adults on the waiting list are currently served by the Family, Person Directed Waiver but are waiting to receive more comprehsensive services through the Consolidated Waiver.

84 U.S. Census, 2006 – 2008 American Community Survey 3-Year Estimates, Table B25093.

85 Ibid, Table B25072.

86 *Affordable Housing Needs 2005: Report to Congress*, U.S. Department of Housing and Urban Development, Office of Policy Development and Research, accessed on January 29, 2010 at http://www.huduser.org/Publications/pdf/AffHsgNeeds.pdf. Note that HUD's definition of elderly household for this analysis undercounts these households because they exclude households with children under the age of 18. These comprise roughly 4 percent of very low income elderly households according to HUD analyses of the 2005 American Housing Survey.

87 Ibid. Very low income is defined as 50 percent or less of the area median income.

88 This includes severe (e.g. worst case) and non-severe problems (e.g. paying 30 to 50 percent of income in rent or moderately inadequate housing or overcrowding).

89 *A Report on Non-traditional Housing Options*, Intra-Governmental Council on Long Term Care, Housing Alternatives Workgroup, December 2007.

90 Thomson Reuters analysis of 2006 – 2008 American Community Survey 3-Year Estimates via DataFerret.

91 *Looking Ahead: Philadelphia's Aging Population in 2015*, Philadelphia Corporation for Aging, January 2006.

92 *The State of Housing in American in the 21st Century: A Disability Perspective*, Table 9. HUD Multifamily Housing Inventory Survey of Units for the Elderly and Disabled, 2008. National Council on disability, January 2010.

93 Ibid. Table 8. Disability Status of households in Public Housing and Using Housing Choice Vouchers, 2008.

94 *Aging Services: The Facts*, American Association of Homes and Services for the Aging accessed on February 5, 2010 at http://www.aahsa.org/print.aspx?id=74. These are national average costs and are based only on non-profit continuing care retirement communities.

95 Individuals who testified were mainly focused on needs in south-central Pennsylvania. They identified one 45-unit assisted living facility for the deaf and hard of hearing in this area (Valley View at Elwyn in Media, PA).

96 *Human Service Transportation Coordination Study: Summary Report*, Pennsylvania Departments of Transportation, Public Welfare, Aging, and Budget, July 17, 2009, accessed on February 16, 2010 at

97 Ibid.

98 See Agency for Healthcare Quality and Research, *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination* accessed on February 16, 2010 at http://www.ahrq.gov/downloads/pub/evidence/pdf/caregap/caregap.pdf.

99 *Preliminary Analysis of Preventable Hospitalizations: Discussion Draft*, February 13, 2007, Pennsylvania Department of Public Welfare.

100 *Chronic Health Conditions in Pennsylvania: Diabetes "Asthma "COPD "Heart Failure*, A State of Health Care in Pennsylvania Report, Pennsylvania Health Care Cost Containment Council, June 2010.

101 R. Kelley, *Where Can $700 Billion in Waste Be Cut Annually from the U.S. Healthcare System*, White Paper, October 2009, Thomson Reuters.

102 The report cites another $25 to $50 billion in waste attributable to preventable conditions and avoidable care (mainly hospitalizations). As these are also referenced as costs resulting from lack of care coordination, it seems reasonable to add them together which comprises roughly 12 percent of $700 billion.

103 *Promoting VisitAbility in Pennsylvania*, brochure, the Self-Determination Housing Project of Pennsylvania, Inc. accessed on February 17, 2010 at http://www.sdhp.org/Visitability%20bookletfinal.pdf

104 Stanford University School of Medicine, Patient Education, Stanford Self-Management Programs web site accessed on October 20, 1009 at http://patienteducation.stanford.edu/programs/. And, a presentation by Katie Lorig at the National Health Policy Forum meeting on patient engagement on October 2, 2009 in Washington DC.

105 L. N. Gitlin, N. Chernett, L.F. Harris, D. Palmer, P. Hopkins, and M.P. Dennis, "Harvest Health: Translation of the Chronic Disease Self-Management Program for Older African Americans in a Senior Setting," *The Gerontologist*, Vol. 48, No. 5, 698-705, 2008.

106 *Secretary Sebelius Awards Funding for Chronic Disease Self-Management Programs for Older Americans*, News Release, March 30, 2010, U.S. Department of Health and Human Services, accessed on May 6, 2010 at http://www.hhs.gov/news/press/2010pres/03/20100330a.html

107 S. Lobron-Rabin, K. Preston and R. Seok, *Aging in the New Millenium: Meeting the Challenge Through Telehealth*, presentation to the Pennsylvania Senior Care and Services Study Commission in Harrisburg, June 9, 2009.

108 Pennsylvania Health Information Exchange Website accessed on February 17, 2010 at http://www.pahealthinfoexchange.com/.

109 U.S. Census, 2008 American Community Survey, Table S0103, Population 65 Years and Over in Pennsylvania. Note: the Census Bureau introduced an improved set of disability questions in the 2008 American Community Survey. Because the new questions are based on a different conceptual framework compared to the old questions, the 2008 disability prevalence rates cannot be compared to prior years. See Matthew W. Brault, *Review of Changes to the Measurement of Disability in the 2008 American Community Survey*, U.S. Census Bureau, at http://www.census.gov/hhes/www/disability/2008ACS_disability.pdf for a description of the changes.

110 Centers for Medicare & Medicaid Services Minimum Data Set Active Resident Report, 2nd Quarter 2008, RSaGE, Age of Resident, accessed at http://www.cms.hhs.gov/MDSPubQIandResRep/04_activeresreport.asp?isSubmitted=res3&var=RSaGE&date=23 on October 13, 2009.

111 Pennsylvania Senior Care and Services Study Commission *Initial Review: Current Care, Services, and Resources for Pennsylvanians Age 65 and Older*. This figure is based on State Fiscal Year 2006 – 2007.

112 Ibid.

113 U.S. Census, 2005 – 2007 American Community Survey, 3-Year Estimates, Table B18001 Sex by Age by Number of Disabilities for the Civilian Noninstitutionalized Population Age Five Years and Over.

114 U.S. Census, 2005 – 2007 American Community Survey, 3-Year Estimates, Table B18030 Disability Status by Age by Sex by Poverty Status for the Civilian Noninstitutionalized Population 5 Years and Over. The 3-year estimates were used because they have lower margins of error. Results using the 2008 1-year estimates were roughly the same (although the two time periods cannot be directly compared due to the changes in disability questions).

115 *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions*, Center for Health Care Strategies, Inc. October 2009, accessed on November 24, 2009 at http://www.chcs.org/usr_doc/Faces_of_Medicaid_III.pdf. The study is based on Medicaid Analytic eXtract (MAX) files. MAX files, maintained by the Centers for Medicare & Medicaid Services, include Medicaid data from almost all states. The study is based on a diagnostic classification system called Chronic Illness and Disability Payment System which was developed by Richard Kronick and other researchers at the University of California San Diego and used by many state Medicaid programs.

116 Ibid. These categories are not mutually exclusive.

117 T. Coughlin and T. Waidmann (the Urban Institute), and M. O'Malley Watts (Kaiser Commission on Medicaid and the Uninsured), *Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries*, April 2009, Kaiser Commission on Medicaid and the Uninsured, accessed on November 24 at http://www.kff.org/medicaid/upload/7895-2.pdf. Note that this study was based on 2003 data which was prior to the implementation of Medicare Part D. At that time, Medicaid covered prescription drugs, thus the Medicaid share of dual-eligibles' health care costs was higher than it is now. However, states still finance a large portion of prescription drug costs through the clawback provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This provision requires states to pay back the Medicare program for the majority of their estimated savings on dual-eligibles' drug costs. Pennsylvania's clawback payment in SFY 2008 – 09 was $418.6 million (Office of the Budget).

118 Ibid.

119 *Older Adults: Depression and Suicide Facts*, NIH Publication No. 4593, Revised April 2007, National Institute of Mental Health, National Institutes of Health, accessed on August 21, 2009 at http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts-fact-sheet/index.shtml.

120 *Older Adults and Mental Health*, National Institute of Mental Health, accessed on December 7, 2009 at http://www.nimh.nih.gov/health/topics/older-adults-and-mental-health/index.shtml

121 *Health Care Costs Much Higher for Older Adults with Depression Plus Other Medical Conditions*, Science Update, February 13, 2009, National Institute of Mental Health, accessed on December 7, 2009 at http://www.nimh.nih.gov/science-news/2009/health-care-costs-much-higher-for-older-adults-with-depression-plus-other-medical-conditions.shtml.

122 Thomson Reuters analysis of Medical Expenditure Panel Survey data for Pennsylvania, pooled 2004 – 2006.

123 American Health Care Association, *Medical Condition—Mental Status*, CMS OSCAR Data Current Surveys, June 2009, accessed on December 7, 2009 at http://www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/MC_mental_status_Jun2009.pdf. 50 percent are diagnosed with dementia, 22 percent with a psychiatric diagnosis, and 26 percent with behavior symptoms.

124 D. C. Grabowski, K. A. Aschbrenner, Z. Feng, and V. Mor, "Mental Illness In Nursing Homes: Variations Across States," *Health Affairs*, Vol. 28, No. 3, May/June 2009. The mental illness statistic cited is based on the authors' broad definition of mental illness: having schizophrenia, bipolar disorder, depression, or anxiety (as indicated on the Minimum Data Set assessment). The authors' estimates for Pennsylvania were quite similar to the U.S. average

125 Ibid.

126 Ibid. Grabowski et al note these factors as possible explanations for state variation in prevalence of mental illness among nursing home residents and percentage of mentally ill residents becoming long-stay.

127 Alzheimer's Association. *2010 Alzheimer's Disease Facts and Figures*, accessed on August 8, 2010 at http://www.alz.org/documents_custom/report_alzfactsfigures2010.pdf.

128 Ibid.

129 Ibid.

130 J. Kasper., M. O'Malley Watts and M. & Lyons, B. *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*. Kaiser Commission on Medicaid and the Uninsured. July 2010

131 Centers for Medicare & Medicaid Services, MDS Active Resident Information Reports, Second Quarter 2010.

132 Alzheimer's Association, *2010 Alzheimer's Disease Facts and Figures*.

133 Ibid.

134 *F as in Fat: How Obesity Policies are Failing in America, 2009*. Trust for America's Health. Robert Wood Johnson Foundation, July 2009, accessed on January 13, 2010 at http://healthyamericans.org/reports/obesity2009/ (citing Centers for Disease Control and Prevention data).

135 Centers for Disease Control and Prevention, *Overweight and Obesity* main page, accessed on January 12, 2010, at http://www.cdc.gov/obesity/index.html.

136 Trust for America's Health, July 2009 (based on a 2006–2008 3-year average).

137 2008 BRFSS. Adults are defined as those ages 18 and over since the data do not break out results for those ages 21 and over.

138 Trust for America's Health, July 2009. These rankings are based on 2006–2008 3-year averages of state-level BRFSS data.

139 U.S. Department of Health and Human Services, Office of the Surgeon General, *Overweight and Obesity: Health Consequences*, January 2007, accessed on November 30, 2009 at http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences.htm.

140 Trust for America's Health, July 2009 (based on a meta-analysis of 10 published studies).

141 *The Future Costs of Obesity: National and State Estimates of the Impact of Obesity on Direct Health Care Expenses*. A collaborative report from United Health Foundation, the American Public Health Association, and Partnership for Prevention. Updated November 2009.

142 E. A. Finkelstein, J. G. Trogdon, J. W. Cohen and W. Dietz, Annual Medical Spending Attributed to Obesity: Payer- and Service-Specific Estimates, *Health Affairs* 28, no. 5 (2009); w822-w831, published online 27 July 2009. Total health services and supplies spending estimate is from the National Health Expenditure Accounts Highlights at http://www.cms.gov/NationalHealthExpendData/downloads/highlights.pdf.

143 Trust for America's Health, July 2009.

144 Ibid. Dr. Thorpe and colleagues developed an econometric model which controlled for numerous population characteristics to develop these estimates.

145 Ibid. Lower to upper range estimates were $335–$450 for 2008 and $936–$1,974 for 2018.

146 Centers for Disease Control and Prevention, *Overweight and Obesity*, accessed on November 25, 2009 at http://www.cdc.gov/obesity/childhood/prevalence.html.

147 Ibid.

148 Trust for America's Health, 2009 (citing the American Diabetes Association for description of type 2 diabetes as epidemic).

149 Trust for America's Health, 2009 (based on a 3-year average to smooth data anomalies).

150 Centers for Disease Control and Prevention, 2009 Behavioral Risk Factor Surveillance Study. Note that the BRFSS question on disability is different than the Census Bureau's which yields a significantly lower disability prevalence rate among people age 65 and older of 30 percent compared to 37 percent in the ACS.

151 *Chronic Care: A Call to Action for Health Reform*, AARP Public Policy Institute beyond 50.09, accessed on November 24, 009 at http://assets.aarp.org/rgcenter/health/beyond_50_hcr.pdf.

152 See *National Healthcare Disparities Report* (Agency for Healthcare Research and Quality), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Institute of Medicine).

153 Pennsylvania Department of Health, Minority Health Disparities, accessed on January 28, 2010 at http://www.portal.state.pa.us/portal/server.pt?open=512&objID=2999&PageID=431162&mode=2&contentid=http://pubcontent.state.pa.us/publishedcontent/publish/global/news_releases/governor_s_office/news_releases/governor_rendell_ceremonially_signs_four_health_care_bills_that_will_reduce_costs__improve_access_and_quality.html.

154 Three sources were used for Pennsylvania-specific health care disparities: the Pennsylvania Profile on the Office of Women's Health Quick Health Data Online Health Disparities Profiles (U.S. Department of Health and Human Services); statehealthfacts.org *Key Health and Health Care Indicators by Race/Ethnicity and State, 2009 Update* (Kaiser Family Foundation); and *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level* (Kaiser Family Foundation).

155 R. B. Friedland, *Caregivers and long-term care needs in the 21st century: Will public policy meet the challenges?* Georgetown University Long-Term Care financing Project, Issue Brief, July 2004, accessed on October 13, 2009 at http://ltc.georgetown.edu/pdfs/caregiversfriedland.pdf.

156 *Governor Rendell Earns National Health Quality Award for Work to Expand Access to Health Care*, News Release, March 24, 2010, Commonwealth of Pennsylvania, Media in Pennsylvania.

157 *2008–2012 State Plan on Aging*, Pennsylvania Department of Health.

158 Pennsylvania Department of Aging. No waitlists were reported by AAAs when polled by the Pennsylvania Department of Aging.

159 SilverSneakers® web site accessed on October 20, 2009 at http://www.silversneakers.com/Default.aspx.

160 For example, according to its brochure, the YMCA of Northern Dauphin County has a Senior Wellness Center which is an exercise room devoted to older adults (.http://www.ymcaharrisburg.org/Programs/Brochures/NDYMCAFall2009.pdf).

161 Older Adult Advisory Committee, presentation on Share the Care and Share the Care survey results, presented at the November 2008 and January 2010 committee meetings, respectively.

162 Pennsylvania Office of Mental Health and Substance Abuse Services, Bureau of Policy, Planning and Program Development.

163 Delaware County Office of Services for the Aging Web site, accessed on January 25, 2010 at http://www.delcosa.org/site/375/community_services.aspx.

164 Pennsylvania Behavioral Health and Aging Coalition Web site, accessed on January 25, 2010 at http://www.olderpennsylvanians.org/?page_id=51.

165 Communication with Lisa Bailey-Davis, affiliate faculty of *nrgBalance* (sponsored by Pennsylvania Advocates for Nutrition and Activity, Penn State Hershey Children's Hospital).

166 Ibid. The types of legislation include: nutrition standards in schools, vending machine prohibition in schools, body mass index measured in schools, physical education and recess requirements, and obesity programs and education.

167 Pennsylvania Department of Health.

168 Communication with Lisa Bailey-Davis.

169 Pennsylvania Department of Health.

170 *Obama's Budget Funds National Healthy Food Financing Initiative*, PR Newswire, February 2, 2010.

171 *Annual MetLife Study of Employee Benefit Trends: Findings from the national survey of employers and employees, Seventh Annual*, 2009, MetLife Inc. This study is based on interviews with over 2,000 employers and employees, respectively.

172 *The Cost of Wellness*, A WELCOA Expert Interview, The Wellness Councils of America, interview with Ron Goetzel, PhD, May 5, 2004.

173 Blue Cross Blue Shield Association, Press Release, October 27, 2009, accessed on December 4, 2009 at http://www.bcbs.com/news/plans/highmark-recognized-as-one-of-healthiest-companies.html. The Gold level is the Wellness Councils of America's second highest award level and recognizes organizations developing comprehensive programs producing results.

174 B. L. Naydeck, J. A. Pearson, R. J. Ozminkowski, B. T. Day, R. Z. Goetzel, "The Impact of the Highmark Employee Wellness Programs on 4-Year Healthcare Costs," *Journal of Occupational and Environmental Medicine*, Volume 50, Number 2, February 2008.

175 The Wellness Councils of America, accessed on December 4, 2009 at http://www.welcoa.org/worksite_cost_benefit.html.

176 *Get Healthy* program brochure, Pennsylvania Employees Benefit Trust Fund accessed on May 6, 2010 at https://www.pebtf.org/Uploads/Publications/1263562767.pdf.

177 Commonwealth of Pennsylvania, Insurance Department, personal communication.

178 Pennsylvania Department of Aging, *Manual for the PA 2020 Vision Project*, http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616029&mode=2

179 Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections Through 2025*, undated.

180 State Occupational Projections, Long-Term, www.projectionscentral.com/lt_search.aspx.

181 *Recession is Easing Nurse Shortage, but Longer-Term Shortage Still Looms*, Health Affairs press release June 12, 2009, www.healthaffairs.org/press/mayjun0912.htm

182 State Occupational Projections, Long-Term, www.projectionscentral.com/lt_search.aspx.

183 Governor's Office of Health Care Reform, *Addressing Pennsylvania's Direct Care Workforce Capacity: Primary Recommendations for Quality Jobs and Quality Care*, December 7, 2007.

184 State Occupational Projections, Long-Term, www.projectionscentral.com/lt_search.aspx.

185 Ibid.

186 Bureau of Labor Statistics News Release, *The Employment Situation—October 2009*, released November 6, 2009.

187 Ibid.

188 Institute of Medicine, *Retooling for an Aging America: Building the Health Care Workforce*, PowerPoint presentation, undated. This is the source for the remaining facts presented in this paragraph and the next.

189 Congressional Budget Office, *Financing Long-Term Care for the Elderly*, April 2004.

190 B. Spillman, *Trends in Family Caregiving and Why It Matters*, the Urban Institute, September 21, 2007, http://www.nhpf.org/index.cfm?fuseaction=Details&key=669.

191 Prescription for Pennsylvania Related Legislation: 2006 – 2008 Session, http://www.rxforpa.com/legislation.html

192 Rx for PA website, www.rxforpa.com

193 Pennsylvania Center for Health Careers, 2010 *Best Practices Conference*, http://www.portal.state.pa.us/portal/server.pt/community/pa_center_for_health_careers/12946/best_practices_conference/602228 ; Pennsylvania Center for Health Careers, Redefining Excellence, same cite.

194 Pennsylvania Center for Health Careers, *The Retention of Health Care Workers in the Commonwealth*, http://www.portal.state.pa.us/portal/server.pt/community/pa_center_for_health_careers/12946/retention_of_health_care_workers_in_the_commonwealth/575519

195 Paraprofessional Healthcare Institute, http://phinational.org/archives/come-care-with-me-days-influence-pa-legislators/#more-3651

196 Ibid.

197 Ibid.

198 Health Care Workforce, *Ideas in Action*, http://www.healthcareworkforce.org/healthcareworkforce_app/jsp/cedisplay.jsp?dcrpath=HEALTHCAREWORKFORCE/Case_Example/data/gettysburg&domain=HEALTHCAREWORKFORCE

199 Health Care Workforce, *Ideas in Action*, http://www.healthcareworkforce.org/healthcareworkforce_app/jsp/cedisplay.jsp?dcrpath=HEALTHCAREWORKFORCE/Case_Example/data/healthsouthrehabaltoona&domain=HEALTHCAREWORKFORCE

200 Ibid.

201 Paraprofessional Healthcare Institute, Health Care for Health Care Workers, *Fact Sheet: Pennsylvania, Caregivers without Health Care*, 2006.

202 Ibid.

203 Ibid.

204 A. N. Houser and M. J. Gibson, AARP Public Policy Institute, *Valuing the Invaluable: the Economic Value of Family, 2008 Update*, November 2008, http://assets.aarp.org/rgcenter/il/i13_caregiving.pdf. The state-level estimates on the economic value of informal care are based on a national survey that provides data on the number of caregivers at the state level, and assumptions taken from national estimates of caregiving hours (1,080 hours per caregiver per year) and value (see http://assets.aarp.org/rgcenter/il/dd158r_caregiving.pdf for technical notes). The lower estimate of the number of informal caregivers is based on the provision of care at any given time during the year, whereas the higher estimate is based on the provision of care at any time during the year.

205 Corporation for a Skilled Workforce, Experience Works, and Pennsylvania Department of Aging, *Healthcare Employer Toolkit: a Guide to Recruiting and Retaining Older Healthcare Workers*, undated (citing a 2004 U.S. Department of Health and Human Services report, *When Employees Become Caregivers: A Manager's Workbook*).

206 MetLife, *Caregiving Employees' Health Problems Can Cost U.S. Companies a Potential $13.4 Billion Yearly*, February 2, 2010.

207 MetLife Mature Market Institute, *The MetLife Caregiving Cost Study: Productivity Losses to U.S. Businesses*, July 2006.

208 Ibid.

209 Met Life, *Caregiving Employees' Health Problems Can Cost U.S. Companies a Potential $13.4 Billion*, full cite above (quoting Sandra Timmermann, Director of MetLife Mature Market Institute).

210 Corporation for a Skilled Workforce, Experience Works, and Pennsylvania Department of Aging, *Healthcare Employer Toolkit: a Guide to Recruiting and Retaining Older Healthcare Workers*, undated.

211 Ibid. and Bon Secours Richmond Health System benefits guide, http://www.bonsecours.com/physrecruit/guide.asp

212 Ibid.

213 S. A. Weisberg, *The Economic Impact of Elder Care The Employer Perspective*, Testimony to the Joint Economic Committee, May 16, 2007.

214 Ibid.

215 United States Equal Employment Opportunity Commission, *Employer Best Practices for Workers with Caregiving Responsibilities*, undated.

216 Institute of Medicine, *Retooling for an Aging America: Building the Health Care Workforce*, Report Brief, April 2008.

217 Ibid.

218 Ibid.

219 Ibid.

220 Ibid.

221 Ibid.

222 N. Giguere, "From Nursing Assistant to LPN," *Star Tribune*, July 8, 2009; Diane Hageman, "Lifelong Learning: Companies that support staff development find the benefits range from improved problem solving skills to higher employee retention," *Business Central Magazine* (undated).

223 Ibid (quoting Bruce Glanzer, president and CEO of Good Shepherd).

224 Communication with Bruce Glanzer, January 7, 2010.

225 Ibid.

226 Paraprofessional Healthcare Institute, *PA Group Publishes Principles for Ideal LTC System*, August 25, 2009.

227 Ibid.

228 E. M. Sullivan-Marx, *The Social Marketing of Long-Term Care and Nursing Home Careers*, presented at Massachusetts Department of Higher Education Symposium, June 16, 2009.

229 Ibid.

230 L. O'Reilly, *Direct Service Workforce Core Competencies Annotated Bibliography*, CMS National Direct Service Workforce Resource Center and The Lewin Group, September 2009.

231 Governor's Office of Health Care Reform and Pennsylvania Center for Health Careers, *Addressing Pennsylvania's Direct Care Workforce Capacity*, December 7, 2007.

232 Iowa Direct Care Worker Task Force, *Recommendations for Establishing a Credentialing System for Iowa's Direct Care Workforce*, May 2008.

233 Ibid.

234 Department of Labor website, *Health Support Specialist*, http://www.doleta.gov/oa/bul06/Bulletin%202006-18-att.pdf; Aging Services of Minnesota, *Health Support Specialist: An Innovative Concept to Transform Care and Elevate our Workforce*, undated.

235 Aging Services of Minnesota, *Health Support Specialist*, full cite above.

Appendix A.
Pennsylvania General Assembly House Bill 1367

SENATE AMENDED

PRIOR PRINTER'S NO. 1632 PRINTER'S NO. 2087

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1367 Session of 2007

INTRODUCED BY DeWEESE, McCALL, COHEN, SURRA, DERMODY, EACHUS, D. EVANS, MUNDY AND CALTAGIRONE, MAY 21, 2007

SENATOR ERICKSON, PUBLIC HEALTH AND WELFARE, IN SENATE, AS AMENDED, JUNE 26, 2007

Section 815-A. Time periods.--The assessment authorized in this article shall not be imposed prior to July 1, 2003, or after June 30, [2007] 2012.

Section ~~3~~ 4. The act is amended by adding an article to read: <—

ARTICLE VIII-D

SENIOR CARE AND SERVICES STUDY COMMISSION

Section 801-D. Definitions.

The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Commission." The Senior Care and Services Study Commission.

Section 802-D. Senior Care and Services Study Commission.

(a) Declaration of policy.--The General Assembly recognizes that the health care needs of Pennsylvania's current and future senior population should be assessed.

(b) Establishment.--There is established a Senior Care and Services Study Commission.

(c) Purpose.--The purpose of the commission shall be all of the following:

(1) Reviewing the current care and service offerings and resources available for Commonwealth residents over the age of 65 years.

(2) Projecting future need for the various levels of senior care and services through 2025.

(3) Evaluating the ability of the current assessment and delivery systems to meet the projected service needs.

(4) Projecting the resources necessary to meet the projected need and making policy recommendations as to how the projected need can best be met considering the resource

limitations that may exist at the time the commission completes its work under this article.

(d) Composition.--

(1) The commission shall consist of all of the following members:

(i) The Secretary of the Budget or a designee.

(ii) The Secretary of Health or a designee.

(iii) The Secretary or a designee.

(iv) The Secretary of Aging or a designee.

(v) One member appointed by the President pro tempore of the Senate.

(vi) One member appointed by the Minority Leader of the Senate.

(vii) One member appointed by the Speaker of the House of Representatives.

(viii) One member appointed by the Minority Leader of the House of Representatives.

(ix) The following members appointed by the Governor:

(A) Two Commonwealth residents age 65 or older who use long-term living services.

(B) One individual representing non-profit nursing facilities.

(C) One individual representing for-profit nursing facilities.

(D) One individual representing county nursing facilities.

(E) One individual representing hospital-based nursing facilities.

(F) One individual representing home and

community-based service providers.

(G) One individual representing area agencies on aging.

(H) One representative of an organized labor group representing employees providing long-term living services.

(I) One physician whose practice is focused in long-term care settings.

(J) One individual representing other long-term living stakeholders as may be determined by the Governor.

(2) Appointments under paragraphs (1)(v), (vi), (vii), (viii) and (ix) shall be made within 60 days of the effective date of this section.

(3) Upon appointment of the last member under paragraph (2), the commission shall transmit notice to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin of the date of the last appointment. The date of the last appointment shall be considered the date of the establishment of the commission.

(e) Election of chairperson.--The members of the commission shall elect a chairperson of the commission from among themselves.

(f) Terms of members.--

(1) The terms of those members who serve by virtue of the public office they hold shall be concurrent with their service in the office from which they derive their membership.

(2) Except as provided in paragraph (1), members shall serve until their successors are appointed, if they represent

the interest of the membership class for which they were appointed.

(g) Meetings.--The first meeting of the commission shall be held within 30 days of establishment of the commission. Subsequent meetings shall be held at least quarterly but more frequent meetings may be convened either at the call of the chairperson or by request of a simple majority of the commission members.

(h) Initial review.--The commission shall complete the initial review required under subsection (c)(1) within three months of its establishment.

(i) Public input sessions.--Within three months of issuing the findings under subsection (h), the commission shall hold no fewer than three public input sessions across the Commonwealth for the purpose of receiving public comment on current or proposed programs serving seniors.

(j) Projections.--The commission shall obtain the projections under subsection (c)(2) and (4) no later than one year from its establishment. Nothing in this subsection shall prohibit the commission, if a majority of the members agree, from using a Commonwealth procured study initiated prior to the establishment of the commission to obtain this information.

(k) Final report.--The commission shall publish a final report as required under subsection (c)(1), (2), (3) and (4) no later than 18 months following its establishment and shall submit the report to the Governor and the General Assembly. The final report of the commission and any information and data compiled by the commission in accordance with this article shall be made available on the publicly accessible Internet website operated by the Department of Aging when the commission submits

its final report to the Governor and the General Assembly.

(1) Expenses.--The commission is authorized to incur expenses deemed necessary to implement this article.

Section 803-D. Expiration.

The commission shall expire following issuance of its report under ~~subsection (k)~~ SECTION 802-D(K) or three years after the establishment of the commission, whichever occurs sooner. <—

Section ~~4~~ 5. This act shall take effect immediately. <—

Appendix B.
Senior Care and Services Study Commission

Eileen Sullivan-Marx, Ph.D., R.N., FAAN, *Chair*
Shearer Term Associate Professor for Healthy Community Practices,
and Associate Dean for Practice and Community Affairs
University of Pennsylvania School of Nursing
Room 448 Fagin Hall
418 Curie Blvd.
Philadelphia, PA 19104-4217

Stuart H. Shapiro, M.D, *Vice-Chair*
President and CEO
Pennsylvania Health Care Association
315 North 2nd Street
Harrisburg, PA 17101

• • •

John Michael Hall
Secretary
Pennsylvania Department of Aging
555 Walnut Street, 5th floor
Harrisburg, PA 17101

Michael K. Huff
Acting Secretary
Pennsylvania Department of Health
Health & Welfare Building
7th & Forster Streets
Harrisburg, PA 17120

Michael Nardone
Acting Secretary
Pennsylvania Department of Public Welfare
Health & Welfare Building
7th & Forster Streets
Harrisburg, PA 17120

Mary Soderberg
Secretary of the Budget
Office of the Governor
238 Main Capitol Bldg
Harrisburg, PA 17120

• • •

Louis Capozzi, Jr.
Founder
Capozzi & Associates
2933 North Front Street
Harrisburg, PA 17110

J. Mark Greene
Director of Reimbursement Policy
Extendicare Health Services
111 West Michigan Street
Milwaukee, WI 53203

Kevin Hefty
Vice President for Long-term Care
SEIU District 1199P
1500 N 2nd Street
Harrisburg, PA 17102

Vicki Hoak
Executive Director
PA Home Care Association
20 Erford Road, Suite 115
Lemoyne, PA 17043

Shikha Iyengar
Vice President of Geriatric Services
University of Pittsburgh Institute on Aging
Kauffman Medical Building
3471 Fifth Avenue, Suite 500
Pittsburgh, PA 15213

Crystal Lowe
Executive Director
PA Assoc. of Area Agencies on Aging
525 South 29th Street
Harrisburg, PA 17104

Joseph Murphy
Chief Executive Officer
Masonic Villages
1 Masonic Drive
Elizabethtown, PA 17022

Emmanuel Okolo, M.D.
Medical Director
Wesley Enhanced Living at Stapeley
6300 Greene Street
Philadelphia, PA 19144

Marlin Peck
Administrator
Pleasant Acre Nursing and Rehab
118 Pleasant Acre Road
York, PA 17402

Alvin Poppen
Consumer Representative

Steven E. Proctor
President and CEO
Presbyterian Homes, Inc.
1217 Slate Hill Road
Camp Hill, PA 17011-8012

Florence Reed
Consumer Representative

Daneen Reese
Executive Director
Pennsylvania Assisted Living Association
336 South State Street
Clarks Summit, PA 18411

Appendix C.
Senior Care and Services Study Commission Notice of Public Input Meetings

MARK YOUR CALENDARS!

The Senior Care and Services Study Commission was established pursuant to Pennsylvania Act 16 for the purpose of reviewing the current care and service options available for Pennsylvanians 65 years of age and older. Additionally, the Commission has been tasked with projecting future needs for the various levels of senior care through the year 2025. This would include evaluating the ability of the current assessment and delivery systems to meet projected future needs.

Public Input Meetings will soon be held throughout the Commonwealth. Your feedback is needed regarding:

- Current long-term care, services, and resources for Pennsylvanians 65 and older
- Long-term care, services, and resources needed through 2025

Some questions that may facilitate discussion include:

- What have you (or a loved one) experienced regarding current long-term care, services, and resources for older Pennsylvanians?
- What long-term care, services, and resources do you think will be needed through 2025?

WHO SHOULD ATTEND?

Individuals, Service providers, Employers, Community leaders and Elected officials

WHY ATTEND?

Your comments could help shape the reports and recommendations made by the Senior Care and Services Study Commission.

LOCATION DATES AND TIMES

STATE COLLEGE—WEDNESDAY, OCTOBER 15

The Oaks Community Room; 200 Rachael Drive, Pleasant Gap, PA 16823; 9:00 am–12 noon

MEADVILLE—THURSDAY, OCTOBER 16

Lew Davies Community Building; 1034 Park Avenue, Meadville, PA 16335; 9:00 am–12 noon

YOUNGWOOD—TUESDAY, OCTOBER 21

Westmoreland County Community College; 145 Pavilion Lane (Founders Hall), Youngwood, PA 15697; 9:00 am–12:00 noon

PITTSBURGH—TUESDAY, OCTOBER 21

Three Rivers Center for Independent Living; 900 Rebecca Avenue, Pittsburgh, PA 15221; 5:00 pm–8:00 pm

HARRISBURG—THURSDAY, OCTOBER 23

The Rutherford House; 3300 Parkview Lane, Harrisburg, PA 17111; 9:00 am–12 noon

PHILADELPHIA—WEDNESDAY, OCTOBER 29

The Center in the Park; 5818 Germantown Avenue, Philadelphia, PA 9:00 am–12 noon

NANTICOKE—WEDNESDAY, NOVEMBER 5

Luzerne County Community College; Educational Conference Center; Building #10—Auditorium; 1333 S. Prospect Street, Nanticoke, PA 18634; 9:00 am–12 noon

PLEASE PLAN TO ATTEND A SESSION

We recommend that all please register. If you would like to comment, please let us know at least two days before the date of the meeting you are planning to attend—for scheduling purposes. Please notify us by sending an email to our email address at RA-LTLCommission@state.pa.us or by phone at (717) 705-3705. Please provide the following information upon registration:

- Name
- Address
- Telephone Number
- The location, date and time of the session you are attending
- A full copy of your comments, if available

There will also be time on the agenda for people to speak who did not pre-register. For those who cannot attend but still would like to comment we will be accepting comments through November 14, 2008. Please feel free to submit your comments via email at: RA-LTL-Commission@state.pa.us or via US mail at PO BOX 2675, Attn OLTL POLICY Harrisburg PA 17105.

Senior Care and Services Study Commission
Office of Long Term Living
Pennsylvania Department of Aging
Pennsylvania Department of Public Welfare

Contact for more information or questions: Robert McNamara, 717-787-8091

NOVEMBER 2010