House Enrolled Act No. 1391, of the 2014 Indiana General Assembly requires the Division of Aging (DA), the Indiana State Department of Health (ISDH), and the Office of Management and Budget (OMB) submit a report to the Indiana General Assembly on or before October 1, 2015, regarding the following:

1) a review of all current long-term care services available in Indiana, including regulated and unregulated methods of service delivery.

2) an analysis of

A) past policies implemented in Indiana; and

B) other states’ approaches;

To serve individuals in a home and community-based setting and in an institutional care setting more efficiently and cost-effectively through the use of emerging technologies, including telemedicine and remote patient monitoring

3) An analysis of demographic trends by:

A) payor sources; and

B) demand and utilization of long-term care services options;

4) An analysis of program and policy options for long-term care services where demand exceeds current capacity for providing the services.

5) A review of Medicaid reimbursement for skilled nursing facility care, and a determination concerning whether;

A) the reimbursement methodology should be modified to reflect current and future care models; and

B) incentives should be included in reimbursement for quality care and quality outcomes.

6) An analysis of past policies in Indiana and other states’ approaches to manage construction of additional skilled nursing facilities, including certificates of need and moratoriums. The analysis must include the following:

A) the costs and benefits to Indiana’s budget and the Medicaid program in whether or not additional skilled nursing facilities are built, including the impact on Medicaid utilization for skilled nursing services.

B) the impact of additional skilled nursing facilities on the availability and cost of capital for the renovation and new construction of skilled nursing facilities, residential care facilities, assisted living facilities, and other senior housing options.

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# Executive Summary

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# The Basics

The Older Americans Act (OAA) of 1965 established a foundation for each state to develop an aging network based upon the development of Area Agencies on Aging (AAAs) that would direct OAA funds to individuals ages sixty and older to meet needs as determined by their local communities.

**Milestones**

1965—Older Americans Act established the Administration on Aging and created State Units on Aging.

1973—Older Americans Act amendments established Area Agencies on Aging.

1984—Reauthorization of the Older Americans Act clarified roles of State and Area Agencies on Aging in coordinating community-based services.

1999—*Olmstead v. L.C. Supreme Court* decision required states to administer services, programs, and activities to appropriately meet the needs of people with disabilities in the most integrated setting.

2001—Department of Health and Human Services (HHS) provides grants to help states modify their long-term services and supports systems to promote home and community-based services.

2003—First federal grants made to 12 states for ADRC development.

2006—Older Americans Act required the Administration on Aging to establish ADRCs in all states (O’Shaunessy).

At the time, service development and focus were directed primarily at making services available for older adults to avoid isolation and a loss of community connection along with providing sound nutrition. Congregate meal sites and community settings such as senior centers were initially developed to address these concerns.

As these services expanded, transportation became key in providing a means for older adults to participate in social, recreational, and nutrition services, and AAAs conducted outreach to identify older adults who might be in need of services along with promoting information and referral services. The change to an equivalent focus on home-delivered meals developed as federal government and local providers continued to identify a large number of older adults who still remained at home, but for whom increases in age and disability made it difficult to leave that setting.

Thirty years later in 2003, the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) launched an Aging and Disability Resource Center (ADRC) initiative. This was part of a nationwide effort to restructure access to services and supports for older adults and individuals with physical disabilities to complement other long-term care system activities designed to provide a single point of entry for information and assistance in connecting to community-based long-term care, or LTSS.

# Review of Indiana’s Long-Term Care Services

Long-term services and supports (LTSS) available in Indiana include a variety of health and health-related assistance needed by persons who lack the capacity to care for themselves due to physical, cognitive or mental, disabilities or conditions. Persons needing LTSS include elderly and non-elderly persons with physical disabilities, behavioral health diagnoses (such as dementia), and other chronic or developmental disabling conditions.

The scope of LTSS for older adults and persons with disabilities is often referred to as the continuum of care and service sites may be the individual home, a community setting, or a long-term care facility. It is important to note, however, that this continuum does not always follow a linear progression. People may enter and exit service options many times – when and where depends on a number of variables: the availability of family and other informal support systems, disease processes and chronic conditions, rehabilitation needs, and housing options. But it is no longer necessary to view nursing home placement exclusively as the end of the care continuum. Whereas care for fragilely ill older adults may best be served in a skilled facility with twenty-four hour care provision, end-of-life care may be served in a variety of community, home, and long-term care settings.

## LTSS Funding Sources

Medicaid and Medicare, the largest payors for LTSS, are the major government health care programs that account for about two-thirds of total national spending. Out-of-pocket spending is the biggest source of private spending for LTSS and is particularly large for institutional care. Private insurance pays for only a small share of total spending on LTSS, although the number of people with private long-term care (LTC) insurance is growing slowly.

Payment sources also include various federal and state programs for older adults and private charitable donations. Private health insurance, Medicare, Medicaid, Prior Authorization (services authorized by physicians to meet acute short-term skilled needs that are provided by licensed home health agencies), and private LTC insurance all may cover stays in nursing homes as well as home health agency visits, but in different circumstances and only for certain, varying lengths of time. These multiple funding streams make it difficult to disentangle what – or who – pays for which services.

It is important to note that Medicare and private health insurance cover LTSS only as part of a post-acute care benefit that covers rehabilitative care—short stays in skilled nursing facilities and home health visits—for people needing skilled care. Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least three days. For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment rate for the first 20 days of care. Beginning with day 21, beneficiaries are responsible for copayments. For 2014, the copayment was $152 per day (MedPAC). This coverage is intended to help beneficiaries recover from acute conditions for which they are also receiving medical care, such as a fractured hip. In contrast, Medicaid and private LTC insurance cover LTSS for an extended period (typically three to five years in the case of private LTC insurance and indefinitely in the case of Medicaid), and coverage is *not* dependent upon an acute health care episode (Rising Demand…).

Longer-term rehabilitative and skilled care services are provided through a network of licensed health providers while residential options are available through Assisted Living settings, licensed residential care and nursing facilities, and combinations of continuing care communities. All of these services, whether in a residential setting or a nursing facility contribute to the definition of LTSS, and each service is critical to the continuum of care for a very diverse aging and disabled population’s changing needs. There is a further distinction between LTSS and Home and Community-Based Services (HCBS), which encompasses many of the same services but are just that – services delivered in one’s home or community.

According to the National Health Policy Forum, more than three million people in the United States relied on Medicaid for HCBS in 2010, an increase of more than 50% since 2000. Community-based services totaled $219.9 billion in 2012, and Medicaid is the primary source of payment for these services, followed by out-of-pocket payments by individuals and families. During the same time, Medicaid paid for 61% ($134.1 billion) of all national LTSS spending.

Indiana’s Medicaid expenditures for community-based services (1915(c) Waivers and Other HCBS) totaled nearly $804 million in 2011. (CMS/Truven Health Analytics). Even though the federal government shares Medicaid costs with the states, the burden on states is substantial and most likely will only increase (Woodcock, National Governors Association 2011).

Since Home and Community Based Service s(HCBS) by definition do *not* include the spectrum of “traditional” long-term care settings, these services attempt to provide formal and informal supports to allow persons to remain in their homes or in a community setting as long as possible, thus delaying an institutional placement. The wide range of HCBS and potential payment sources are included in the grid below.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Home & Community-Based Services (HCBS)** | **Medicaid Waiver** | **Medicaid** | **Medicare** | **CHOICE** | **SSBG** | **Title III - OAA** | **Private-Pay** | **Other Federal Funds** |
| Information & Assistance |   |   |   |   |   | X |   |   |
| Case Management | X |   |   | X | X | X | X |   |
| Personal /Attendant Care | X |   |   | X | X | X | X |   |
| Homemaker | X |   |   | X | X | X | X |   |
| Personal Emergency Response | X |   |   | X | X | X | X |   |
| Handyman/chore |   |   |   | X | X | X | X |   |
| Home Health Care |   | X | X |   |   |   | X |   |
| Respite-Aide | X |   |   | X | X | X | X |   |
| Respite-skilled | X | X |   |   |   |   | X |   |
| Home delivered meals | X |   |   | X | X | X | X |   |
| Congregate meals |   |   |   |   |   | X |   |   |
| Transportation | X | X |   | X | X | X | X | X |
| Senior Centers |   |   |   |   |   | X |   |   |
| Adult Day Services | X |   |   | X |   |   | X |   |
| Adult Family Care | X |   |   |   |   |   |   | X |
| Assisted Living | X |   |   |   |   |   |   | X |
| Structured Family Care | X |   |   |   |   |   |   |   |
| Home Modifications | X |  |  |  |  |  | X |   |
| Vehicle Modifications | X | X |  |  |  |  | X |   |
| Community Transitions | X |  |  |  |  |  |  | X |
| Health Care Coordination-RN | X |  |  |  |  |  |  | X |
| Nutritional Supplements | X |  |  |  |  |  |  |   |
| Legal Assistance |  |  |  |  |  | X | X |   |
| Ombudsman |  |  |  |  |  | X |  | X |
| Specialized Medical Equipment | X | X | X |  |  |  | X | X |
| Pest Control | X |   |   | X | X | X | X |   |
| ACCESS & CARE COORDINATION |  |  |  |  |  |  |  |  |
| IN-HOME SERVICE DELIVERY |  |  |  |  |  |  |  |  |
| COMMUNITY BASED SERVICES |  |  |  |  |  |  |  |  |
| ALTERNATIVE RESIDENTIAL |  |  |  |  |  |  |  |  |
| OTHER SERVICES |  |  |  |  |  |  |  |  |

# HCBS Funding Sources

## Aged & Disabled (A&D) Waiver

The broadest array of services are accessed through Medicaid waiver programs that allow Medicaid to pay for services provided in a person’s home or other community setting rather than in a Medicaid-funded facility or institution. *Waiver* refers to the waiving of certain federal requirements that otherwise apply to Medicaid program services and care delivered only in a facility setting.

Waivers generally focus on people with a greater—or more complex—need for care, since all long-term care or A&D waiver consumers must 1) meet nursing facility Level of Care, 2) have the inability to perform at least three Activities of Daily Living (ADLs) such as eating, bathing, and grooming, *and* 3) be financially eligible for Medicaid.

The Aged and Disabled (A&D) waiver provides an alternative to nursing facility admission for adults and persons of all ages with a physical disability. This waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility *if the waiver or other supports were not available*. A&D waiver services can be used to help people remain in their own homes, as well as assist people living in nursing facilities return to community settings such as their own homes and apartments.

## Traumatic Brain Injury (TBI) Waiver

The TBI Waiver provides home and community-based services to individuals who would otherwise require institutional care, but for the provision of such services.

Indiana defines a traumatic brain injury as a trauma that has occurred as a closed or open head injury by an external event that results in damage to brain tissue, with or without injury to other body organs. Examples of external agents include a mechanical force, or an event that results in interference with vital functions. Traumatic brain injury means a sudden insult or damage to brain function, not of a degenerative or congenital nature. The insult of damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability not including birth trauma related injury.

Through the use of the TBI waiver, the Indiana Office of Medicaid Policy and Planning (OMPP) and the DA seek to increase availability and access to cost-effective services to people who have suffered a traumatic brain injury.

## Money Follows the Person (MFP) Demonstration Grant

The MFP program was developed to help states move individuals from institutional settings to home and community-based settings, and is funded through a grant from the Centers for Medicare and Medicaid Services (CMS). Indiana's MFP program is designed specifically as a transition program that assists individuals living in an institution to move safely back into the community, and to ensure a safe adjustment to community living. It is not a permanent funding source and can fund a participant for only 365 days. At the end of that time, if individuals continue to meet Nursing Facility Level of Care (NFLOC), they are transitioned onto the A&D Waiver to continue services as appropriate. Indiana was approved for the MFP program in 2007, and since that time has focused on assisting eligible persons to leave institutional care by providing services for individuals to live safely in their communities. As of April 2015, the MFP program has successfully transitioned 1,553 persons from institutional settings into the community.

## Non-Waiver Services:

Indiana is divided into regions for access to support services for older adults and persons with physical disabilities. As referenced in the introductory comments the driving force for the development of the AAAs was the Older Americans Act of 1965 which authorized state designated AAAs to plan for local service delivery in their geographic areas to serve persons aged sixty (60) or older without means testing. Since the formation of the OAA refinements have been made to this definition to require preference to be given to older persons with greatest economic need, older persons living in rural areas and minority older persons with the goal of aiding persons to remain in their communities to access services and avoid isolation and premature institutionalization.

Therefore in Indiana, HCBS are accessed through the aging network via the state’s sixteen Area Agencies on Aging (AAAs), which are the critical initial access points for outreach, information, and assistance services throughout the state (see Attachment A, the Indiana AAA map).

Their assistance and brokering of services is greatly enhanced by financial support from the state-funded CHOICE program, the Social Services Block Grant (SSBG) funds, and perhaps most importantly, the Medicaid Waiver Aged and Disabled and Traumatic Brain Injury funds. The number and range of funding sources for LTSS constitutes a patchwork of services that include differing age, disability, and income requirements.

## CHOICE Services

CHOICE (Community and Home Options to Institutional Care for the Elderly and Disabled) Services are provided under similar guidelines as the Waiver services listed above, but are more flexible in income eligibility and require only two (2) deficits in ADLs. With these more accommodating eligibility standards, there is the opportunity to intervene with services before needs escalate or financial resources are diminished to the point of Medicaid’s income restrictions and while consumers can still contribute to the cost of their needed services.

The two-year Community Living Program (CLP) authorized by HEA 1391, was implemented as a pilot in January 2015 in four regions of the state—Areas 1, 2, 13, and 14 (see Attachment A - Area Agencies on Aging map)—with a goal to expand statewide in the future. This CLP demonstration is meant to evaluate the impact of changes in the CHOICE program’s eligibility to further allow individuals to receive services before their needs become extensive. The program involves a greater network of informal and formal supports based upon individual assessed needs rather than just an eligibility criteria, and focuses on supplementing resources already available to an individual. Services range from simple fall-prevention measures to getting people assistance for meal preparation or medication management if they need it to a full array of needed personal care services for those individuals without a caregiver or family available to assist.

## Social Services Block Grant (SSBG)

The Social Services Block Grant (SSBG) is permanently authorized by Title XX, Subtitle A, of the Social Security Act as a “capped” entitlement to states. This means that states are entitled to their share of funds as determined by formula, out of an amount of money that is capped in statute at a specific level (also known as a funding ceiling). Although social services for certain welfare recipients have been authorized under various titles of the Social Security Act since 1956, the SSBG in its current form was created in 1981 (P.L. 97-35).

Block grant funds are given to states to achieve a wide range of social policy goals, which include promoting self-sufficiency, preventing abuse, and supporting community-based care for the elderly and disabled (Lynch – CRS). Indiana uses SSBG funding through the AAAs for a wide range of ancillary home and community-based services for those individuals meeting both income guidelines and service need who do not necessarily have deficits in their ADLs, but do experience other risks such as abuse or neglect, including self-neglect.

Between traditional Older Americans Act services, [CHOICE](#CHOICE) and Social Services Block Grant funds, and the Medicaid waivers for persons determined eligible both financially and by level of inability to perform Activities of Daily Living ([ADLs](#ADLs)), services were provided to nearly 100,000 older adults and persons with disabilities in Indiana during 2014.

During the year 2014, these federal (Non-Medicaid Waiver) and state funding sources provided the following units of services statewide to the indicated number of unduplicated persons by service type/categories:

|  |  |  |  |
| --- | --- | --- | --- |
| **Ages 60+ *non-waiver* (OAA, SSBG & CHOICE) HCBS Service Type** | **Units of services provided** | **Persons ages 60+ served** | **Funds spent** |
| Adult Day Care | 47,110  |  109 |  $797,250 |
| Case Management | 255,725  | 68,317 | $10,083,699 |
| Chore | 34,955  |  313 |  $301,633 |
| Congregate Meals | 935,530  | 17,419 | $11,083,699 |
| Home-Delivered Meals | 1,244,931  |  8,609 | $10,464,561 |
| Homemaker | 254,002  |  2,568 |  $3,727,222 |
| Information & Assistance (I&A) | 289,253  | \* |  $3,060,504 |
| Legal Assistance | 17,147  | \* |  $445,671 |
| Nutrition Education | 99,548  | \* |  $13,599 |
| Other Services | 77,461  | \* |  $338,338 |
| Outreach | 27,690  | \* |  $365,605 |
| Personal Care | 662,121 |  2,830 |  $9,346,208 |
| Transportation | 516,813  | \* |  $6,551,315 |
| **TOTAL** | **3,462,286**  |  |  |

\*Individual counts for these services are not available, as clients are not required to register for these services. Estimate of unduplicated count of persons served for non-registered services such as health fairs, community events, health programs and testing, and calls for information is approximately 200,000 persons statewide.

Based upon ACL federal funding requirements, approximately 86,000 unduplicated persons were served during 2014 by Indiana’s AAAs and their vendors using non-waiver funds.

# Demographic Information

**Percentage of Population Served by Program Area - March 2015**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **CHOICE** | **A&D Waiver** | **TBI Waiver** | **Title III OAA** | **SSBG** |
| Female | 73 | 69 | 26 | 67 | 67 |
| Male | 27 | 31 | 74 | 33 | 33 |
| Lives alone | 49 | 37 | 10 | 53 | 44 |
| Below poverty | 35 | 53 | 70 | 56 | 46 |
| Veteran | 8 | 5 | 4 | 10 | 7 |
| Rural | 25 | 23 | 26 | 32 | 21 |
| **Ages**: |  |  |  |  |  |
| 0 – 17 | 1 | 8 | 11 | 0 | 1 |
| 18 – 59 | 17 | 30 | 86 | 1 | 21 |
| 60 – 74 | 28 | 29 | 3 | 41 | 30 |
| 75 – 84 | 27 | 18 | 0 | 31 | 24 |
| 85+ | 27 | 15 | 0 | 26 | 24 |
| **Races**: |  |  |  |  |  |
| Caucasian | 68 | 63 | 82 | 70 | 62 |
| African-American | 8 | 9 | 5 | 6 | 5 |
| Hispanic | 1 | 1 | 2 | 0 | >1 |
| Other | 1 | 2 | 1 | 1 | 0 |
| Unknown/ undetermined | 22 | 26 | 10 | 22 | 32 |
| Demographic percentages by program funding sources, March 2015, INsite.  |

# Telehealth/Telemedicine

The words telehealth and telemedicine are often used interchangeably. Each term describes an exchange of information through the use of technology to improve a patient’s health status. As reported by the American Telemedicine Association and the Institute of Medicine, telehealth is often used as a more general term as it relates to a somewhat broader scope of health-related services, such as patient education, public health, and remote patient monitoring, whereas telemedicine specifically relates to direct clinical services.

Telemedicine provides numerous ways in which to improve health outcomes through the use of two-way, real-time interactive communication between the patient and a remotely located physician or medical practitioner using audio and video equipment. The federal Centers for Medicare and Medicaid Services (CMS) sees telemedicine as an economical service delivery alternative of medical care that states can choose to cover with Medicaid funds in lieu of in-person care.

## Recent Indiana Telemedicine Policies

House Bill No. 1451, introduced during the First Regular Session of the 119th General Assembly for 2015, concerned coverage for telemedicine services. Telemedicine services means health care services delivered by use of interactive audio, video, or other electronic media, including the following: 1) medical exams and consultations, and 2) behavioral health including substance abuse evaluations and treatment. However, this did not include the delivery of health care services by use of the following: 1) A telephone transmitter for trans-telephonic monitoring, a telephone or any other means of communication for the consultation from one (1) provider to another provider. The new bill also introduced language that states a policy of accident and sickness insurance must provide coverage for telemedicine services to the same extent that, and in the same amount as, the policy provides coverage for the same health care services delivered in person. Additionally, the insurance coverage for these telemedicine services may not be subject to a dollar limit, deductible, or coinsurance requirement that is less favorable to a covered individual than the dollar limit, deductive, or coinsurance requirement that applies to the same health care services to a covered individual in person.

House Bill 1258, or the Telehealth services bill introduced in January 2014, required Indiana’s Medical Licensing Board to establish a pilot program to allow treatment (including issuing a prescription), without the creation of a typical in-person patient/physician relationship, as well as the establishment of physician standards and procedures for such a program. House Enrolled Act No. 1258 was signed by Governor Pence on March 24, 2014, and added as Chapter 14 to Indiana Code 22-22.5.

With the adoption of HEA 1258 the definition of telehealth services means the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, treatment, supervision, and information across a distance.

HEA 1258 also added pilot program requirements that telehealth services for Indiana clients must be provided only by an Indiana-licensed physician that had an established physical practice in the state, as well as ensuring standards and procedures would be followed for documentation and storage of medical records and adherence to HIPAA. The Act also prescribed conditions for the pilot as to the issuance of prescriptions, the types of services that could be provided, geographic areas served, and program duration. The language also requested a full report be submitted to the general assembly regarding outcomes including the number of patients served, prescriptions issued, in-person follow-up care required, and overall physician and patient satisfaction. This chapter of the IC expires July 1, 2016.

# Past Policies

Interim Study Committee on Public Health, Behavioral Health, and Human Services Authority: IC 2-5-1.3-4; date: September 25, 2014; Topics to be discussed include: Barriers and Benefits of Expanding to a Statewide Telemedicine Program for Addiction and Mental Health Treatment [cannot find outcome of this meeting]

SEA No. 554 became effective July 1, 2013, and was added to the current Indiana Code (IC 12-15-5-11) as it relates to implementation and rules for telehealth, and telemedicine services or certain providers, as well as reimbursement methods. At the time, the Code defined telehealth services to mean the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across a distance, whereas telemedicine services referred to a specific method of delivery of services, including medical exams and consultations, and behavioral health evaluations and treatment, including those for substance abuse, using videoconferencing equipment to allow a provider to render an examination or other service to a patient at a distant location.

With SEA No. 544, OMPP was required to reimburse the following Medicaid providers for telemedicine services regardless of the distance between the provider and patient: federally qualified health centers, certain defined rural health clinics, certified community mental health centers, and critical access hospital that met certain criteria under federal rules. Furthermore, OMPP was charged with submitting any Medicaid state plan amendment to the federal government (U.S. Department of Health and Human Services) necessary to implement and administer this new section of the Code appropriately, including the removal of the twenty (20) mile distance restriction formerly in place.

## Efficient and Cost-Effective Telehealth in HCBS/Institutional Settings

### Veterans Administration

In 2011, The Richard L. Roudebush VA Medical Center (VAMC) in Indianapolis launched an initiative to implement telehealth for use in clinical management, believing that this newer tool would enhance access to care while supporting and maintaining quality at the same time. Of the several telehealth tools available for use, clinical video telehealth (CVT), allowed veterans the opportunity to visit their providers via teleconference from a location close to the patient’s home, seemed best suited for use in many of the VA’s practices.

Over 14,000 veterans have enrolled in the telehealth program since its inception, making 23,267 visits just during 2013. The VAMC calculates that nearly 500,000 miles related to travel were avoided (by calculating the number of miles avoided in travel from home to a local satellite site as compared with traveling from home to the Indianapolis VA). By VAMC’s calculations, its telehealth program has saved $331,132 in travel costs alone since 2011. In addition, the program has been well received by veterans, with an overall satisfaction score of 96% (Wennergren).

### Nursing Facility Resident Hospitalizations

The hospitalization of nursing facility residents has emerged as an important area of concern for policy makers. These hospitalizations are already frequent, and they are becoming more so, frequently resulting in complications, morbidity, and Medicare expenditures that amount to more than a billion dollars annually.

A controlled study (Grabowski and O’Malley) undertaken during 2009 – 2011 of eleven nursing facilities in Massachusetts provided the first indications that switching from on-call to telemedicine physician coverage during “off” hours could reduce hospitalizations and therefore generate cost savings to Medicare in excess of the facility’s investment in the service. This recent study suggests that future research is necessary to test models that encourage greater engagement on the part of providers, as well as to examine the implications of increased savings for health outcomes. If the results of such studies are promising, policy makers should consider reforms that would better align the costs of telemedicine with potential savings from reduced hospitalizations.

### Chronic Disease Management - Franciscan Nurse Visiting Services

A significant need in LTSS relates to chronic disease. According to the Institute of Medicine, nearly one-hundred million Americans with chronic diseases account for about seventy-five percent of health care expenditures. Traditionally, chronic disease is managed through an episodic office-based model rather than a care management model, which uses frequent patient contact and regular physiologic measurement. Use of telehealth technologies for chronic disease care management has been associated with reductions in hospitalizations, readmissions, lengths of stay, improvement in some physiologic measures, high rates of satisfaction, increased adherence to medication, and overall cost of care. Studies of home monitoring programs have shown specific improvements in the management of hypertension, congestive heart failure, and diabetes (IOM).

Indiana’s Franciscan Visiting Nurse Services’ (FVNS) launched its telehealth program in \_\_\_\_, with an eye toward helping patients manage their chronic diseases, and reducing the number of emergency room visits and hospital admissions for those patients. The program currently focuses on five diagnoses: congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), hypertension (HTN), and diabetes (DM). The home monitoring system is used to collect data on blood pressure, heart rate, oxygen saturation, and weight. The data is then transmitted via cell phone technology into the FVNS database, where it is reviewed by a critical care RN. Based upon review, the nurse calls the patient for further information, schedules a home visit for further assessment, notifies the physician for intervention, and/or sends the results to the physician. The program cares for an average of 300 patients per month, and has seen a reduction in readmission rates from 14% in 2011 to 4% in 2014. Patient satisfaction is rated high, with nearly 90% of patients saying the program improved their health and security.

# Increase in Use of Telehealth Services

It is projected (Frisch, BMJ) that the number of primary care physicians will fall by 91,000 over the next 10 years leading to decreased access to care, and telemedicine is an evolving technology pioneered to address these projections by providing improved access to care without compromising quality medical care. A recent report shows that by the year 2018, the use of telehealth services will increase from its current level of around $230 million per year to $1.9 billion per year with an increase in the number of patients using this technology to around 3.2 million, up from 250,000 in 2013. This increase is led in part to recent changes enacted by the Affordable Care Act (ACA). With a projected 32 million additional Americans entering the health system and the baby boom generation coming of age and using Medicare services, many practitioners are realizing that telemedicine may help address the problems of providing timely access to healthcare for this the population. (p. 715, Wennergren et al)

# Other States’ Approaches to Telehealth/Telemedicine

Supporters of telemedicine say the discipline is gaining more and more attention from state legislatures around the country as policymakers look for ways to reduce health care delivery problems, contain costs, improve care coordination, and ease provider shortages. Many are either already using telemedicine, or exploring this newer service delivery as a means for achieving those goals.

According to the American Telemedicine Association, the last three years have seen the number of states with telemedicine parity laws – those laws requiring that private insurers cover telemedicine-provided services comparable to that of in-person – double. Further, many state Medicaid agencies are transforming payment and delivery methods for this developing technology, resulting in 47 state Medicaid programs that provide some type of coverage for coverage for telemedicine services. As of 2014, Connecticut, Iowa, and Rhode Island are the only states without coverage for telemedicine under their Medicaid plans. Nineteen states and the District of Columbia have enacted full parity laws (Thomas and Capistrant, State Telemedicine Gaps Analysis Coverage & Reimbursement, 2014).

Kansas, Pennsylvania, and South Carolina are the only states that have used their HCBS waivers to provide telemedicine to beneficiaries in the home, specifically for the use of home remote patient monitoring (Thomas & Capistrant). At this time, Indiana has no plans to include remote patient monitoring in its waiver services, but will be following the results reported by other states.

# Telehealth Emerging Technologies

mHealth, also known as mobile health, is a form of telemedicine using wireless devices and cell phone technologies. Mobile phones, particularly smartphones (i.e., sophisticated internet-accessible cellular phones), and other mobile computing devices, are found nearly everywhere, which enhances the potential to assess and improve health. In contrast to the Internet digital divide that limited for years, if not decades, the reach of computerized health behavior interventions for lower socioeconomic groups, mobile phone use has been rapidly and widely adopted among virtually all demographic groups.

Given the high penetration and level of computing capacity available in even basic cell phones, it is possible that these technologies can make a significant difference to public health and health care delivery. The accessibility and data availability of mHealth methodologies could be utilized to change public health and health care on a large scale, for example, by employing mobile tools to decrease the number of people who develop diabetes, prevent falls at home, and help people who need medication to take them as scheduled (NIH).

# Demographic Trends Overview

According to the American Community Survey, adults ages 65 and older made up 13 percent of the population statewide in Census 2010. To gain a full perspective of how older Hoosiers are faring, other relevant data demonstrating their demographic characteristics as compared with the state’s total population are included below.

|  |
| --- |
| **Population 65 Years of Age and Older in Indiana** |
|   |   |   | Total | 65 years and over |
|   |   |   | Estimate | Estimate |
| Total population | 6,514,861 | 866,730 |
| SEX AND AGE |   |   |
|  Male | 49.2% | 42.8% |
|  Female | 50.8% | 57.2% |
|   |   |   |
| Median age (years) | 37.1 | 73.9 |
|   |   |   |
| RACE AND HISPANIC OR LATINO ORIGIN |   |   |
|  One race | 97.9% | 99.4% |
|  White | 84.6% | 92.3% |
|  Black or African American | 9.1% | 5.8% |
|  American Indian and Alaska Native | 0.2% | 0.2% |
|  Asian | 1.7% | 0.7% |
|  Native Hawaiian and Other Pacific Islander | 0.0% | 0.0% |
|  Some other race | 2.3% | 0.4% |
|  Two or more races | 2.1% | 0.6% |
|   |   |   |
| Hispanic or Latino origin (of any race) | 6.2% | 1.6% |
| White alone, not Hispanic or Latino | 81.1% | 91.2% |
|   |   |   |
| RELATIONSHIP |   |   |
|  Population in households | 6,327,145 | 826,980 |
|  Householder or spouse | 58.8% | 92.3% |
|  Parent | 0.8% | 3.8% |
|  Other relatives | 35.0% | 2.5% |
|  Nonrelatives | 5.4% | 1.4% |
|  Unmarried partner | 2.4% | 0.6% |
|   |   |   |
| HOUSEHOLDS BY TYPE |   |   |
|  Households | 2,481,793 | 547,094 |
|  Family households | 66.7% | 53.5% |
|  Married-couple family | 50.0% | 44.2% |
|  Female householder, no husband present, family | 12.3% | 7.3% |
|  Nonfamily households | 33.3% | 46.5% |
|  Householder living alone | 27.7% | 44.6% |
|   |   |   |
| MARITAL STATUS |   |   |
|  Population 15 years and over | 5,192,108 | 866,730 |
|  Now married, except separated | 50.4% | 55.5% |
|  Widowed | 6.1% | 28.6% |
|  Divorced | 12.4% | 11.6% |
|  Separated | 1.5% | 0.6% |
|  Never married | 29.7% | 3.7% |
|   |   |   |
| EDUCATIONAL ATTAINMENT |   |   |
|  Population 25 years and over | 4,258,878 | 866,730 |
|  Less than high school graduate | 12.8% | 20.0% |
|  High school graduate, GED, or alternative | 35.2% | 43.9% |
|  Some college or associate's degree | 28.8% | 20.0% |
|  Bachelor's degree or higher | 23.2% | 16.1% |
|   |   |   |
| RESPONSIBILITY FOR GRANDCHILDREN UNDER 18 YEARS |   |   |
|  Population 30 years and over | 3,842,620 | 866,730 |
|  Living with grandchild(ren) | 3.3% | 3.3% |
|  Responsible for grandchild(ren) | 1.7% | 1.1% |
|   |   |   |
| VETERAN STATUS |   |   |
|  Civilian population 18 years and over | 4,913,683 | 866,730 |
|  Civilian veteran | 9.3% | 22.3% |
|   |   |   |
| DISABILITY STATUS |   |   |
|  Civilian non-institutionalized population | 6,414,808 | 830,879 |
|  With any disability | 13.0% | 37.4% |
|  No disability | 87.0% | 62.6% |
|   |   |   |
| RESIDENCE 1 YEAR AGO |   |   |
|  Population 1 year and over | 6,434,804 | 866,730 |
|  Same house | 84.9% | 94.2% |
|  Different house in the United States | 14.8% | 5.6% |
|  Same county | 9.2% | 3.6% |
|  Different county | 5.6% | 2.0% |
|  Same state | 3.5% | 1.3% |
|  Different state | 2.0% | 0.7% |
|  Abroad | 0.4% | 0.2% |
|   |   |   |
| PLACE OF BIRTH |   |   |
|  Total population | 6,514,861 | 866,730 |
|  Foreign born | 308,060 | 28,085 |
|  Not a U.S. citizen | 65.1% | 24.2% |
|   |   |   |
| LANGUAGE SPOKEN AT HOME AND ABILITY TO SPEAK ENGLISH |   |   |
|  Population 5 years and over | 6,087,409 | 866,730 |
|  English only | 91.8% | 95.9% |
|  Language other than English | 8.2% | 4.1% |
|  Speak English less than "very well" | 3.3% | 1.8% |
|   |   |   |
| EMPLOYMENT STATUS |   |   |
|  Civilian population 16 years and over | 5,095,287 | 866,730 |
|  In labor force | 64.4% | 16.0% |
|  Employed | 58.2% | 15.1% |
|  Unemployed | 6.2% | 0.9% |
|  Percent of civilian labor force | 9.6% | 5.5% |
|  Not in labor force | 35.6% | 84.0% |
|   |   |   |
| INCOME IN THE PAST 12 MONTHS (IN 2013 INFLATION-ADJUSTED DOLLARS) |   |   |
|  Households | 2,481,793 | 547,094 |
|  With earnings | 78.1% | 33.7% |
|  Mean earnings (dollars) | 64,262 | 37,202 |
|  With Social Security income | 29.5% | 93.9% |
|  Mean Social Security income (dollars) | 17,833 | 19,454 |
|  With Supplemental Security Income | 4.5% | 4.6% |
|  Mean Supplemental Security Income (dollars) | 9,533 | 9,790 |
|  With cash public assistance income | 2.4% | 1.3% |
|  Mean cash public assistance income (dollars) | 3,236 | 3,071 |
|  With retirement income | 18.6% | 52.8% |
|  Mean retirement income (dollars) | 17,420 | 16,742 |
|  With Food Stamp/SNAP benefits | 12.1% | 6.4% |
|   |   |   |
| POVERTY STATUS IN THE PAST 12 MONTHS |   |   |
|  Population for whom poverty status is determined | 6,317,159 | 830,879 |
|  Below 100 percent of the poverty level | 15.4% | 7.3% |
|  100 to 149 percent of the poverty level | 9.6% | 10.6% |
|  At or above 150 percent of the poverty level | 75.0% | 82.0% |
|  2009-2013 American Community Survey 5-Year Estimates; retrieved 6/12/15 at:  <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>  |

Population projections from the Indiana Business Research Center highlight the impact that aging boomers will have upon the future demographic makeup of Indiana. Trends suggest considerable growth in the number of Americans who will need LTSS in the coming decades. Life expectancy remains relatively high, baby boomers continue to age into older adulthood, and advances in medical technology allow more persons with chronic illnesses and disabling conditions to live longer and independently in the community.

The map represents the percent change in population of those ages 65 and older from 2010 to 2030. Five of Indiana's metropolitan (metro) areas will see increases of more than 80 percent in the population ages 65 and older in the next 20 years. In fact, spurred by a relatively strong net in-migration of older adults, the senior population in the Indiana portion of the Cincinnati-Middletown metro will more than double. The fast-growing Indianapolis-Carmel metro—which accounts for more than one-quarter of the state's total population—will see its senior population nearly double over the same period. The entire baby boomer cohort will be of traditional retirement age by 2030. After that point, growth in the 65+ category is expected to level off somewhat. However, between 2030 and 2050, large increases are anticipated in the 85+ age group as those boomers continue to age (IBRC).

*Frail* elderly are older adults with any combination of chronic conditions, including dementia, or who require assistance with daily activities due to mental or physical deterioration. Those persons over age 85, the “oldest-old,” are most likely to be frail and require LTSS. According to 2012 estimates, an estimated 70 percent of persons ages 65 and over will use LTSS, and persons ages 85 and over—the fastest growing segment of the U.S. population—are four times more likely to need LTSS as compared with persons ages 65 to 84. Additionally, about seven in ten persons ages 90 and over have at least one disability, and among persons between the ages of 40 and 50, nearly one in ten have a disability that may require LTSS (Kaiser). The Journal of American Medicine (JAMA) reports that seventy percent of older adults will need LTSS for an average length of three years.

Based on data gathered from Indiana’s Area Agencies on Aging, nearly 44,000 unique clients were served directly by the AAAs, excluding their vendor provided services, in SFY 2014. As demonstrated in the following graph, the majority of Indiana consumers were ages 60 and over, with over one in four (26%) age 85 or older.

## By Payor Source

According to CMS, total national spending on all LTSS was $310 billion in 2013, with Medicaid covering 51 percent of total expenditures followed by “other public funds” (21%), out-of-pocket (19%), and private insurance (8%). “Other public funds” refers to federal monies such as SSBG and OAA, state, local, and various community resources (Kaiser, Medicaid and LTSS: A Primer, May 2015).

The inclusive cost for Indiana’s Medicaid spending for *all* long-term care, from community and home settings to long-term care facilities, totaled $2,148,318,000 for the first six months of fiscal year 2015. This amount came slightly under forecasted expenditures by four and half million dollars. A review of Indiana’s home and community-based services funding streams reveals continued growth within waiver services. The graph on the following page demonstrates the sources and amounts of state dollars spent on HCBS for the past three years.

****

 A reduction in CHOICE direct expenditures was caused by use of these funds as match for Waiver services, which allowed the A&D Waiver to remain open. The impact of this match is that there has been no wait list in all of FY 15 for waiver services to serve those with the greatest need. Currently, up to 16,000 persons are receiving A&D waivers.

## By Demand and Utilization

The following represents the number of unique—or unduplicated—Hoosier consumers who received waiver and non-waiver services as of April 15, from each of Indiana’s Area Agencies on Aging (AAAs):

|  |
| --- |
| **UNIQUE CLIENTS SERVED BY MONTH BY AREA** |
| **Area/Agency Name** | Waiver | Non-Waiver | Total |
|  | **15-Apr** | **15-Apr** | **Apr-15** |
| 1 - Northwest Indiana Community Action Corp. | 957 | 2,278 | 3,235 |
| 2 - REAL Services, Inc. | 1,412 | 1,537 | 2,949 |
| 3 - Aging & In-Home Services of Northeast | 920 | 1,028 | 1,948 |
| 4 - Agency on Aging | 404 | 382 | 786 |
| 5 - Agency on Aging & Community Services | 231 | 303 | 534 |
| 6 - LifeStream Services, Inc. | 1,132 | 784 | 1,916 |
| 7 - West Central Indiana Economic Dvlp District | 336 | 458 | 794 |
| 8 - CICOA Aging & In-Home Solutions | 3,644 | 1,382 | 5,026 |
| 9 - In-Home & Community Services Agency | 568 | 512 | 1,080 |
| 10 - Agency on Aging | 287 | 236 | 523 |
| 11 - Aging & Community Services of South Central | 792 | 279 | 1,071 |
| 12 - LifeTime Resources, Inc. | 322 | 280 | 602 |
| 13 – Generations | 417 | 739 | 1,156 |
| 14 - LifeSpan Resources, Inc. | 1,148 | 600 | 1,748 |
| 15 - Hoosier Uplands | 467 | 148 | 615 |
| 16 - Southwestern Indiana Regional Council on Aging | 799 | 930 | 1,729 |
| Independent Case Managers | 390 | 0 | 390 |
| **TOTAL** | 14,226 | 11,876 | 26,102 |

# Unmet Needs

In 2013, the National Research Center conducted and evaluated a statistically valid sample of older adults’ self-assessments across Indiana and compared our state’s results with national study findings. The *Community Assessment Survey for Older Adults* (CASOA) study gauged current availability and the means for accessing information so an aging population can make plans and decisions for themselves when reviewing current options and preparing for a continuum of service needs. The CASOA findings for Indiana were consistent with other states’ concerns about transportation, housing, and a general lack of knowledge of how to get help when needed. Although needs were spread across the board, Hoosiers reporting the largest percent of unresolved needs were more likely to be ages 60 to 74, not white, not Hispanic, report a lower income, or own their homes.

Respondents were asked to rate (excellent/good/fair/poor) characteristics as they relate to adults ages 60 or over in their communities. A range of nineteen percent to 43% of respondents found availability of the following to be “poor” in their communities:

* long-term care;
* daytime care options for older adults;
* information on resources available for older adults;
* employment prospects;
* opportunities to enroll in skill-building or personal enrichment classes;
* housing option variety;
* affordable quality housing;
* financial and legal planning services;
* support services for those providing care for family/friends; and
* ease of travel by public transportation (bus, rail, on-demand/senior transportation).

Several services that are needed across a wide spectrum of older adults and the future aging population have been identified in the statewide CASOA study and in those studies focused on the AAAs’ geographic areas. The AAAs have taken this data and moved forward to update their own needs assessments by hosting multiple public hearings and surveys with their local residents in preparation for their 2016-2017 Area Plans required by the state and the federal Administration on Community Living.

These studies continue to identify basic needs that hamper aging-in-place and the ability to remain in community settings as housing and transportation along with the emerging concerns with caregiving responsibilities.

## Housing

Finding affordable senior housing may be one of the biggest challenges facing older adults and their family members. The largest provider of affordable housing in the country is the U.S. Department of Housing and Urban Development (HUD). HUD provides assistance with housing through its programs such as:

* Project-Based Section 8 Rental Assistance (PBRA), which provides subsidies to select rental complexes to help offset the cost of construction and rehabilitation.
* Public housing, or rental housing for low-income families, older adults, and persons with disabilities. Because of the great demand for these properties, there is often a long waiting list (2-5 years) for this type of housing, particularly in urban areas.
* Housing Choice Voucher program provides vouchers to eligible households to help pay rent on privately owned homes of their choosing. Housing vouchers (formerly known as Section 8) provides rental assistance in the private housing market. These vouchers are linked to specific properties run by local Public Housing Agencies (PHAs).
* Multi-family subsidized houses are private homes subsidized by HUD and offered to low income individuals and families for rent. The Section 202 program is provided specifically for the elderly and disabled to enable them to live as independently as possible. These communities typically include services such as housekeeping, transportation, and counseling.
* Senior apartments
* Residential care facilities, including county homes and group homes, which are licensed by ISDH
* Continuing care communities, which support aging in place by allowing a person to move among and between independent and assisted living to ISDH licensed residential and/or comprehensive care (a nursing facility)
* Assisted Living facilities, which are unlicensed facilities per ISDH
* Licensed Residential Care Facilities (labeled as AL in the Waivers)
* Rehabilitative facilities licensed by ISDH, which are often considered short-term and funded by Medicare based upon age and short-term rehab potential
* Skilled nursing facilities are licensed by ISDH. Short-term stays are funded by Medicare based upon age, diagnosis, and rehabilitation potential; otherwise they are paid for privately or funded by Medicaid as assets are diminished.
* Adult Family Care are family homes that provide a home setting for up to four unrelated adults.
* Structured Family Care provides a live-in caregiver for waiver participants or provides for the participant to live with the caregiver on a full-time basis.

## Transportation

Many older Hoosiers plan to age in place in their neighborhoods and communities where daily activities require some form of transportation. Inevitably, many of those persons will find their own ability to safely drive a vehicle diminish over time. Older adults need affordable alternatives to driving in order to maintain their independence as long as possible. Some will rely on relatives or friends to take them around, and a smaller number will move to places where services and activities are close by.

Pedestrian-friendly streets and recreational trails built with older adults and persons with disabilities in mind will help all Hoosiers get around safely and remain active, regardless of where they live. But only adequate public transportation services can assure that older adults are able to travel as often or as far as they would like, without worrying about inconveniencing others. Without access to affordable travel options, older adults face isolation, a reduced quality of life, and possible economic hardship. A 2004 study found that seniors age 65 and older who no longer drive make 15 percent fewer trips to the doctor, 59 percent fewer trips to shop or eat out, and 65 percent fewer trips to visit friends and family, than drivers of the same age (Aging in Place: Stuck without Options). Many Indiana communities have taken advantage of rural transportation grants and community transportation services, but a large number of older adults rely on family members and friends to transport them.

## Family Caregivers

No discussion of the provision of LTSS and unmet needs would be complete without calling attention to the immense contribution of family caregivers. Nationally, there are 12 million older adults currently receiving LTSS, and 87% of those individuals receive much of that care from unpaid family caregivers. More than two-thirds (68 percent) of Americans believe they will be able to rely on their family members, partners, and/or close friends to meet their LTSS needs when they require help, but the approaching drop in family caregiver availability will certainly have an impact.

According to AARP, the United States’ caregiver support ratio is expected to take a nose-dive as baby boomers transition from caring for others as they move into old age themselves. A period of transition will occur during the 2010s and 2020s, as younger boomers age out of their peak caregiving years and the oldest boomers age into the 80-plus high-risk years. When those boomers move on from their caregiving years, the age cohort of younger persons ages 45–64 is projected to increase by only one percent between 2010 and 2030. During the same period, the 80-plus population is expected *to increase by almost 80 percent*. The number of potential caregivers for persons 80 and over mostly likely will decline somewhat slowly during the 2010s—from 7.2 to 6.1—by 2020 as the declining numbers of boomers in prime caregiving age will be offset somewhat by the relatively small cohorts turning 80-plus who were born during the “birth dearth” of the Great Depression. But the pace of the decline is expected to accelerate during the 2020s—from 6.1 to 4.1 in 2030—especially when the oldest boomers start turning 80 years old in 2026 (Redfoot et al, AARP PPI).

Indiana’s own demographics indicate that the high number of those ages 85 and older, a lower percentage of middle-aged persons caused by out-of-state migration of younger cohorts, and age shifts with the baby boom generations’ aging into old age followed by the “baby-bust” (the sudden decline of the birth rate from the early 1960s to the early 1980s) will most likely limit Hoosier family support options within the next 15-25 years.

Significant findings in Indiana’s CASOA study mirror what is occurring on a national level, including the identification of a high level of dependency on informal caregivers and the high percentage—45%, or nearly half—of respondents who indicated they currently were caregivers. One of four respondents (25%) reported providing an average of twenty or more hours of care per week, and of all respondents, between 20% and 26% reported they felt physically, emotionally, or financially burdened by providing care for another person.

These findings underscore Hoosiers’ traditional strong sense of family support and self-reliance, but as the study further indicated, family caregivers experience high levels of stress when providing care and often experience a negative impact on their health and well-being. And if fewer family members are available to provide everyday assistance to the growing numbers of frail older people, more people are likely to need institutional care at great personal cost, as well as costs to health care and LTSS programs. Greater reliance on fewer family caregivers to provide HCBS could also add to costs borne by family members and close friends—in the form of increasing emotional and physical strain, competing demands of work and caregiving, and financial hardships.

# Program and Policy Options

As with most large systems, there are challenges. According to a 2010 report by the National Health Policy Forum, many describe the process of accessing LTSS akin to wandering through a maze. Even for persons knowledgeable about caring for older adults and younger people with disabilities, the national LTSS system has been referred to as a “labyrinth of complicated services, programs, funding streams, and eligibility requirements.” And deciphering eligibility and program coverage requirements for the multitude of institutional and home and community-based services and benefits can be overwhelming. For example, Medicaid is the major federal financing source for LTSS whether services are provided in the home, community or long-term care settings. However, its program eligibility criteria are complex, and services may be limited to only those meeting strict income and asset tests.

Since many consumers have difficulty navigating the complexity of the LTSS, more work must be done to increase the knowledge and planning capabilities for care alternatives, available programs, and benefits. Information and preparation become very important as consumers make critical decisions—often when they are at a crisis point such as being discharged from a hospital and must transition to home or a care facility. Another important area of focus are the persons currently living in nursing or rehabilitation facilities who want to go back home with supportive care; they face significant challenges navigating access to community services.

In evaluating the nation’s LTSS, a recent report by AARP, the Commonwealth Fund, and the Scan Foundation, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers, 2014* (Scorecard), was reviewed in which the following framework for assessing system performance was established. The study identified the following five key characteristics of a high-performing LTSS system:

1. consumers can easily find and afford services they need, and there is a safety net for those who cannot afford services;
2. a person-centered approach to LTSS places high value on allowing consumers to exercise choice and control over where they receive services and who provides them;
3. services maximize positive outcomes and consumers are treated with respect;
4. family caregivers’ needs are assessed and addressed so they can continue in their caregiving role without being overburdened; and
5. LTSS are arranged in such a way as to integrate effectively with health care and social services, minimizing disruptions such as hospitalizations, institutionalizations, and transitions between settings.

The map below depicts state rankings on overall LTSS performance. It is important to note this map represents only a snapshot in time. States may have made improvements in their LTSS systems that are not reflected in the most current (2009 to 2013) data available.



Further analysis of the 2013 data used in the Scorecard indicates that Indiana lags behind other states in the development of a wide range of LTSS.

The table below demonstrates the finding that Indiana consistently scored in the lowest quartile with an *overall* ranking of 47th among all states and District of Columbia. It is notable that overall rankings for our state ranged from a “high” of 33rd for Effective Transitions [among Settings], to a “low” of 51st for Support for Family Caregivers.



One area referenced on the Scorecard in which Indiana does have limited success is within the Accessibility and Affordability dimension, which provided an evaluation of how affordable services are for people of moderate and higher incomes, how effective the safety net is for those who cannot afford services, and how easily consumers of all incomes can find the LTSS they need. Indiana ranked among the five highest in the nation for its early development of its Aged and Disability Resource Centers (ADRCs).

However, ADRC development is but one of several indicators reflecting LTSS accessibility and affordability. Those indicators included private pay affordability, the cost of nursing home and home health care, and the number of older adults with long-term care insurance coverage, along with measures of the percentage of persons with a disability and low income and who receive basic Medicaid services, and in particular, Medicaid LTSS. Indiana scored low on each of these other indicators as compared with other states.

**Lack of Knowledge and Access**

As the CASOA study identified, a high percentage of Hoosier older adults acknowledged a lack of awareness of services and access to those services as a greater concern for them when compared with other states. Overwhelmingly, nearly nine out of ten people (88%) also indicated they plan to stay in the community where they currently reside, and wish to age in place. To enable that choice of access to home and community-based services is critical, but potentially not well understood by those respondents. Information is key for an aging and disabled population needing a continuum of LTSS, and that lack of knowledge impacts access to services.

A vital information system to aid an individual’s decision-making are the ADRCs. As envisioned by the Older Americans Act (OAA) amendments, the Administration on Aging (AoA), and the Centers for Medicare and Medicaid Services (CMS), Hoosier ADRCs exist to help persons of all ages, disabilities, and income levels access LTSS more easily through single points of entry, make more efficient use of care options, and maximize the services available.

Each of Indiana’s sixteen AAAs has been awarded the designation as an ADRC in the past with the goal of operating as a visible and trusted resource within its own multi-county geographic area (see Attachment A – the AAA state map). The Administration for Community Living (ACL), the newly formed umbrella agency which now includes AOA, and Centers for Independent Living (CILs) along with CMS, has defined five key functions ADRCS must perform: information and referral/awareness (I&R/A), options counseling, streamlined eligibility determination for public programs and streamlined access to services, person-centered transition support, and quality assurance and continuous improvement. Not all Hoosier ADRCs perform all aspects of these functions, and the statewide goal is to move them all forward to greater visibility and effectiveness for all residents of all ages in Indiana.

The expected role of an ADRC is to inform individuals concerning home and community-based service options, and provide other information to enable individuals to self-select the services and care they need. To be most effective, ADRCs must function as part of a statewide network of organizations and systems that provide access to LTSS across all populations and payers. Members of this statewide network have to connect with each other, and the way to do that is through building community partnerships and moving from a focus on eligibility and offering an individual a set menu of services, toward a more proactive, consumer-focused approach of identifying individual needs through in-depth assessment. This model is currently being tested in HEA 1391’s CLP pilot projects located in four areas of the state.

ADRCs must be prepared to assess the needs of individuals of all ages and income levels, along with providing comprehensive options counseling to offer service alternatives across the continuum of care and across a funding continuum of donated services, federal, and state services, together with private pay options. There is evidence to support the fact that many state HCBS programs fail to address fully the assessed needs of people who require a large amount of assistance (Konetzka). Again, Indiana’s pilot program attempts to fully assess needs and abilities rather than disabilities, and further evaluate family and informal supports to meet wide-ranging identified needs.

Eventually, Indiana’s ADRC aging network must: 1) expand its visibility and accessibility to allow for the broadest network of available information on the range of services regardless of payer sources, 2) allow an individual or family member to interact directly with the network for self-referral to do their own planning and determination of care needs and options, and 3) alert consumers to wider ranges of services beyond the current traditional model of services.

The Division of Aging views the ADRCs as a primary door for individuals to access information and services, and recently released a Request for Proposals to its ADRCs to apply for a one-time grant opportunity to address two targeted areas: building community partnerships and building a local resource database for the state’s future network development. The DA views these grants as an opportunity for improving the overall functioning and effectiveness of our ADRC network in preparation for integration into the No Wrong Door initiative.

## No Wrong Door Initiative

Since early 2013, the Family and Social Services Administration agency has taken steps to examine its service delivery systems and the infrastructure in support of those systems. In September 2014, Indiana’s Division of Aging was awarded a planning grant from the U.S. Administration for Community Living (ACL), the Centers for Medicare & Medicaid Services (CMS) and the Veterans Health Administration (VHA) to develop a plan to implement a **No Wrong Door System of Access to Long Term Care Services and Supports for All Populations and All Payers** (NWD). To take the ADRC model to its highest level of effectiveness, it must be included within the broader NWD system.

We know there is a growing need for LTSS as our population ages, and there are not sufficient resources to fund existing “doors” to handle the demand. Consumers must be *met where they are*—understanding their values and needs and connecting with them in a way that is effective for them—with information and support so they can make informed choices in order to purchase or obtain the right care at the right time in the least restrictive setting. This NWD planning grant provides us with the means to capitalize on recent positive momentum toward better service integration in a more strategic and organized manner.

Leaders of each division within the Family and Social Services Administration agency are collaborating in the development of NWD to ensure all populations and all payers can enter to access the long-term services and supports they need. NWD touches all demographics from children to older adults and those with physical disabilities as well as mental and developmental issues, regardless of financial status. A NWD system is one that:

* Recognizes that resources are limited and insufficient to address the growing need for counseling and assessment for long-term services and supports;
* Identifies the many doors consumers already use in their attempts to access long-term services and support;
* Addresses all populations and all payers; and,
* Creates tools and training to prepare the individuals and organizations that staff those doors in order to provide appropriate assessment and supported decision-making to consumers and their families.

Indiana is using its one-year grant period to prepare a three-year plan for implementing a No Wrong Door system by involving key stakeholders in an analysis of the strengths and weakness of the current system, and what a No Wrong Door system should look like, in addition to other significant considerations. Key stakeholders include ADRCs, community healthcare systems, discharge planners, nursing and assisted living facilities, Community Mental Health Centers, Centers for Independent Living, and Veterans Administration Healthcare Systems.

Indiana’s path to a NWD system will be incremental, over a series of phases. The initial stage will involve transforming the state’s Pre-Admission Screening process, which is the gateway to nursing facility admission and related to the screening process for the state’s Medicaid waiver programs. The key objective in this phase will be to leverage appropriate technology to create an efficient business process to allow streamlined access to whatever LTSS are appropriate for a consumer transitioning out of hospital care. Subsequent phases of Indiana’s plan will focus on adapting this transformed process to the needs of other populations, which will include, but are not limited to:

* re-energizing Pre-Admission Screening and Resident Review, a federal requirement that helps ensure appropriate specialized service needs are identified and plans for those services are developed regardless of care setting;
* reviewing how individuals who come through Adult Protective Services are referred for services, and streamlining that process;
* creating connections with Indiana organizations that support veterans, the mentally ill, those with intellectual and developmental disabilities, and homeless populations, including faith-based community organizations.

The rationale behind NWD is to make it easier for people of all ages, disabilities, and income levels to learn about and access the services and supports they need. The NWD system also provides states with a vehicle for improving the coordination and integration of the multiple access functions associated with their various state-administered programs that pay for LTSS. FSSA believes NWD is a chance for Indiana to look across the entire system and determine how we can adjust to meet our consumers’ needs, placing them at the center of the very systems that serve them. We are also aware that the necessary tools and trainings to prepare the individuals and organizations that manage those doors in order to provide assessment and supported decision-making to consumers and their families are not currently in place.

A number of states have taken advantage of the ACL’s funding mechanism for developing NWD, and while each has its own unique perspective, a recurring theme runs throughout: states must be fully committed, fully engaged, and have a deep understanding of what a successful No Wrong Door system looks like. Vermont’s Department of Disabilities, Aging and Independent Living, for example, has been working on its NWD initiative for over nine years, using a grassroots approach in bringing stakeholders together. It has worked diligently to build trust, and clarify responsibilities and expectations of each partner to commit to building its NWD system. Pennsylvania’s Link to Aging and Disability Resources leveraged its partners and stakeholders into submitting 77 Letters of Support along with its initial NWD grant application. North Carolina’s Division of Medical Assistance is another new grantee in the design phase of its three-year NWD implementation, and its leadership also underscores the value of using existing relationships and making new connections in its state.

Indiana is using its one-year planning period to prepare a three-year plan for implementing a No Wrong Door system by involving key stakeholders in an analysis of the strengths and weakness of the current system, and what a No Wrong Door system should look like, in addition to other significant considerations. Key stakeholders in our LTSS NWD system include Aging and Disability Resource Centers, community healthcare systems, discharge planners, nursing and assisted living facilities, Community Mental Health Centers, Centers for Independent Living, and Veterans Administration Healthcare Systems.

Key players in the planning process include not only the Division of Aging (DA), but other divisions within Indiana’s Family and Social Services Administration (FSSA): the Office of Medicaid Policy and Planning (OMPP), Division of Mental Health and Addiction (DMHA), and Division of Disability and Rehabilitative Services (DDRS), as well as the Indiana’s Commission on Aging, and CHOICE (Community and Home Options to Institutional Care for the Elderly and Disabled) Boards, the Pre-Admission Screening (PAS) Work Group, the Indiana Hospital Association, Home Care Task Force, Alzheimer’s Task Force, and representatives from all sixteen of Indiana’s Aging and Disability Resource Centers (ADRCs).

Numerous formal meetings have been held over the past nine months with a variety of stakeholder groups affiliated with state government, healthcare, aging, and persons with a disability, as well as other advocacy groups, in efforts to obtain acceptance and a willingness to support the NWD concept. Information will continue to be posted on FSSA’s website: <http://www.in.gov/fssa/4936.htm>.

## AAAs’ Needs Assessments

Similar to the statewide CASOA study, the majority of the AAAs’ Area Plans for 2016-2017 indicated that through their local community needs assessments and surveys, access to service continues to be an unmet need throughout the state. This may include “not knowing who to call” for information and assistance as well as the lack of awareness of an aging network of service. The Area Plans also continue to indicate a great need for transportation to assist individuals in meeting their own community access needs.

An emerging and escalating unmet need also identified in the AAAs’ community assessments is support and assistance for caregivers of frail elderly. Another unmet need is a waiting period between a service application and the eventual receipt of services. Nationally, more than 400,000 people were on a waiting list for HCBS waiver programs during 2014 (Kaye).

At this time, Indiana has not developed a wait list policy different from the traditional “first-come-first” placements. Further, the DA has managed to keep the A&D Waiver “open” throughout this fiscal year, which in turn, has driven down wait lists for the CHOICE program. Please note this is the result of focusing on those persons with the greatest needs (deficits in three or more ADLs), but it has come at the cost of the use of CHOICE funds as the match for the waiver program. The result may have driven down waiting lists, but it also decreased the amount of flexibility used to meet the needs CHOICE funding offers. However, what we do not know or have even been able to fully measure, is the “hidden” waitlist of persons who are currently in the process of having income or LOC eligibility determined. The time involved in these processes can be extensive based upon a variety of factors.

# The Future of LTSS in Indiana

Ten years ago, a study commissioned by the Family and Social Services Administration (FSSA) identified recommendations to strengthen community-based LTSS by:

* Reviewing CHOICE program for opportunities to serve those most in need;
* Monitoring the Quality Assessment Fee (see page 52);
* Fostering an environment for the development of more HCBS;
* Developing outreach and education on HCBS;
* Prioritizing those on waiting lists who are most at risk of nursing home placement;
* Streamlining the waitlist process to better identify and serve those most at risk;
* Developing service delivery models that enhance consumer choice; and
* Enhancing consumer long-term care options counseling

Long-term goals for serving more aging Hoosiers include:

* Development of non-medical housing;
* Development of adult day care housing models;
* Exploring a pilot of long-term care coordinated and capitated program; and
* Development of affordable housing options.

For Indiana to manage increasing numbers of older adults and disabled persons, the system must further expand to identify and quantify unmet LTSS needs to aid efforts in long-term planning. Philosophically and operationally, the focus of service delivery to an increasing population of aging and disabled individuals should not be driven solely by service availability and eligibility criteria, but by assessed needs so we can focus on enhancing abilities rather than developing dependencies on programs and services prematurely.

Across the United States and certainly in Indiana, older adults, people with disabilities, and family caregivers are struggling to find and afford the services and supports they need to maintain their independence and quality of life. The system of LTSS must transform, and soon. The population is growing older, more people are developing disabilities at younger ages, and family caregivers are walking a high-wire tightrope in trying to balance family and work responsibilities. LTSS issues touch all segments of society: individuals of all ages and incomes, state and federal policymakers, as well as providers of services (2014 Scorecard).

# Review of Medicaid reimbursement for skilled nursing facility care

As of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the Office of Medicaid Policy and Planning (OMPP) published a notice of proposed changes to the reimbursement methodology for nursing facilities (NFs). At that time, the OMPP proposed to continue the three percent (3%) reduction currently set to expire on June 30, 2015, for rates paid to nursing facilities, under the Medicaid state plan and state regulations, at 405 IAC 1-14.6, as amended by LSA Document #13-422, posted at 20131204-IR-405130422FRA. This three percent (3%) reduction will remain in effect through June 30, 2017. Beginning July 1, 2017, the OMPP proposes to remove the three percent (3%) rate reduction.

The change in reimbursement is necessary in order to remain within the available Medicaid appropriation. It is estimated that the fiscal impact of continuing the three percent (3%) reduction will be an annual savings of state and federal expenditures of approximately $13.9 million for FFY 2015 (federal share of $9.2 million and state share of $4.7 million), and $55.6 million for FFY 2016 (federal share of $37.0 million and state share of $18.6 million), as compared with state and federal expenditures without the three percent (3%) reduction (see chart below).

Prior to this extension of the reduction, the OMPP had announced a reduction in the reimbursement for NFs by five (5) percent as of May 24, 2011. That reduction was extended through June 30, 2015.

|  |  |  |  |
| --- | --- | --- | --- |
| **State of Indiana, Family and Social Services Administration** |  |  |  |
| **Fiscal Impact Calculation (Values in $ Millions)** |  |  |  |  |
| **Proposed Effective Date: July 1, 2015** |  |  |  |  |  |
| ***Total Increase / (Decrease) in Estimated Medicaid Payments*** |  |  |  |
|  |  |  |  |  |  |  |
| **Nursing Facility: 3% Rate Reduction/**Fee-for-Service Program |  |  |  |
|  |  |  |  |  |  |  |
| **State Fiscal Year** |  |  |  |  |  |  |
|  | **From:** | **7/1/2015** |  |  | **7/1/2016** |  |
|  | **To:** | **6/30/2016** |  |  | **6/30/2017** |  |
|  |  | SFY 2016 | SFY 2016 |  | SFY 2017 | SFY 2017 |
|  |  | 12 Months | Total |  | 12 Months | Total |
| Total Decrease |  |  $ (54.7) |  $ (54.7) |  |  $ (57.6) |  $ (57.6) |
|  |  |  |   |  |  |   |
| Federal Share |  |  $ (36.4) |  $ (36.4) |  |  $ (38.3) |  $ (38.3) |
| State Share |  |  $ (18.3) |  $ (18.3) |  |  $ (19.3) |  $ (19.3) |
|  |  |  |  |  |  |  |
| **Federal Fiscal Year** |  |  |  |  |  |  |
|  | **From:** | **7/1/2015** | **HCFA 179** |  | **10/1/2015** | **HCFA 179** |
|  | **To:** | **9/30/2015** | **Reporting** |  | **9/30/2016** | **Reporting** |
|  |  | FFY 2015 | (Thousands) |  | FFY 2016 | (Thousands) |
|  |  | 3 Months |  |  | 12 Months |  |
| Total Decrease |  |  $ (13.9) |  |  |  $ (55.6) |  |
|  |  |  |  |  |  |  |
| Federal Share |  |  $ (9.2) |  $ (9,239) |  |  $ (37.0) |  $ (36,956) |
| State Share |  |  $ (4.7) |  |  |  $ (18.6) |  |
|  |  |  |  |  |  |  |
| Applicable FMAP |  | 66.52% |  |  | 66.52% |  |
| State Share |  | 33.48% |  |  | 33.48% |  |
| **Notes** |  |  |  |  |  |  |
| 1. The FFY 2015 base FMAP for Indiana is 66.52% (79 FR 3385) and is used to estimate the FMAP for both FFY  |
|  FMAP for both FFY 2016 and FFY 2017. |  |  |  |  |
| 2. Fiscal estimates provided by Milliman |  |  |  |  |  |
|  |  |  |  |  |  |  |

# RUG-IV Comparison

RUG (Resource Utilization Groups) is a patient classification system for nursing home patients used by the federal government to determine reimbursement levels for skilled nursing facilities. This system categorizes residents into a payment group based upon their care and resource needs. Skilled nursing home facilities determine a RUG based on a resident’s classification items documented during the Minimum Data Set (MDS). The MDS is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents in Medicare and/or Medicaid-certified long-term care facilities. The MDS contains items that measure physical, psychological, and psychosocial functioning, and give a multidimensional view of the patient's functional capacities and assists staff in identifying health problems.

The RUG-IV methodology includes several enhancements to the classification system including more delineation of resource use among Rehabilitation, Extensive Services, Special Care, and Clinically Complex, an update to reflect resident resource use (nursing services) that aligns with current standards of care, and the inclusion and further evaluation of special resident conditions such as Alzheimer’s Disease/dementia, ventilator dependent, and traumatic brain injury. The RUG-IV classification system was implemented by CMS for Medicare's nursing facility prospective payment system (PPS) in October 2010.

RUG IV essentially recalibrates the RUG III in order to put more money into complex patient cases that require intensive nursing services. This monetary shift is accomplished by adjusting therapy group payments. In other words, payments for intensive nursing care will rise while total payment for therapy groups will remain fairly constant. This redistribution of money addresses an ongoing problem of over-reimbursing therapy services and under-reimbursing medically complex residents.

To compute the estimated fiscal impact, we compared each nursing facility's actual July 1, 2013 direct care rate calculated using the current RUG-III 34-group method, to their estimated July 1, 2013 direct care rate calculated using both the RUG-IV 48 and 66-group methodologies. The difference between the 48 and 66-group methodologies is a greater delineation of resource use among residents receiving rehabilitation (therapy) services. The 48-group model includes 5 different rehabilitation classifications while the 66-group model includes 23 different rehabilitation classifications.

Indiana has decided to adopt the RUG IV 48 Grouper for one year, starting July 1, 2016. The OMPP will offset the additional cost to the state of using the 48-group methodology by transferring the state share of the additional cost from the Closure and Conversion Fund, making it cost-neutral to the Medicaid program. What occurs beyond year one will be determined by ongoing conversations regarding rebalancing Medicaid long-term care expenditures and Indiana’s five to eight-year plan for doing so.

The following table summarizes the estimated fiscal impact:

|  |  |
| --- | --- |
| **Model Description** | **Estimated Fiscal Impact** |
| RUG-III 34-group model compared to RUG-IV 48-group model | $10.6 Million increase in annual Medicaid Expenditures |
|  |
| RUG-III 34-group model compared to RUG-IV 66-group model  | $8.9 Million decrease in annual Medicaid Expenditures |

The difference in fiscal impact between the 48-group and 66-group models is explained by the greater delineation of nursing resource use in the rehabilitation classifications with the 66-group model. When nursing resource use for Medicaid rehabilitation residents is further refined under the 66-group model, their nursing resource use was, on average, less than that for all other rehabilitation residents. This finding is not surprising since most Medicaid residents receive fewer therapy services for shorter periods of time than Medicare residents. As seen in the following table, a comparison of the case mix indices and percent of resident days in each RUG group under the 48 and 66-group model is helpful in illustrating this point.

|  |  |  |
| --- | --- | --- |
| RUG-IV 48-Group Model |  | RUG-IV 66-Group Model |
| RUG Group | Case Mix Index | % of Medicaid Resident Days | RUG Group | Case Mix Index | % of Medicaid Resident Days |
|  |  |  | RUX | 2.98 | 0.05% |
|  |  |  | RUL | 2.87 | 0.01% |
|  |  |  | RVX | 2.92 | 0.05% |
|  |  |  | RVL | 2.45 | 0.04% |
|  |  |  | RHX | 2.85 | 0.09% |
|  |  |  | RHL | 2.40 | 0.00% |
|  |  |  | RMX | 2.75 | 0.42% |
|  |  |  | RML | 2.45 | 0.27% |
|  |  |  | RLX | 2.52 | 0.18% |
|  |  |  | RUC | 1.74 | 0.68% |
|  |  |  | RUB | 1,74 | 0.65% |
|  |  |  | RUA | 1.11 | 0.15% |
|  |  |  | RVC | 1.68 | 2.27% |
|  |  |  | RVB | 1.24 | 0.00% |
|  |  |  | RVA | 1.23 | 2.15% |
|  |  |  | RHC | 1.61 | 4.14% |
|  |  |  | RHB | 1.33 | 0.00% |
|  |  |  | RHA | 1.02 | 2.95% |
|  |  |  | RMC | 1.52 | 23.78% |
|  |  |  | RMB | 1.36 | 28.21% |
|  |  |  | RMA | 0.94 | 14.46% |
|  |  |  | RLB | 1.67 | 18.19% |
|  |  |  | RLA | 0.79 | 1.26% |
| RAE | 1.65 | 22.45% |  |  |  |
| RAD | 1.58 | 24.53% |  |  |  |
| RAC | 1.36 | 31.85% |  |  |  |
| RAB | 1.10 | 13.09% |  |  |  |
| RAA | 0.82 | 8.08% |  |  |  |
| Total |  | 100.00% |  | Total |  | 100.00% |

# Five to Eight-Year Plan

Indiana’s Long-Term Care system has experienced significant changes over the last ten to fifteen years, which has resulted in a complicated structure. In order to create a more predictable system with outcomes that provide service and supports in the least restrictive setting compatible with appropriate care and resources, FSSA, with input from Indiana’s nursing facility trade associations and other various stakeholders, have begun designing a five to eight-year plan that will provide recommendations toward the goal of establishing a more balanced system by Fall of 2015. Following are the workgroups that have been determined, along with the tasks with which they have been charged.

* **Assisted Living/Supportive Housing Workgroup**
* Developing a plan for the growth of assisted living within Indiana that would allow for the continued expansion of Home and Community Based Services;
* Determining the fiscal impact of Assisted Living if it were included as a State Plan service under Medicaid; and
* Reviewing current policies and make recommendations to promote growth and expansion.
* **Reimbursement Workgroup**
* Reviewing the effect of Managed Care if Nursing Facilities were part of the plan;
* Determining the impact of NF institutional spending compared with HCBS and determining what targets should be for Indiana; and
* Reviewing other states’ policies and making recommendations for Indiana’s existing policies.
* **Entry Point Workgroup**
* The Division of Aging will engage the nursing facility industry (and other stakeholders) in the areas of ADRC/entry point concerns.
* Transforming and streamlining the State’s current Pre-Admission Screening (PAS) process: leverage technology, engage stakeholders, comply with CMS PASRR regulations;
* Leading a collaborative planning effort with DDRS, DMHA, and OMPP to develop a three-year plan to create a *No Wrong Door* system for access to long term services and supports for all populations and all payers in order to leverage technology, engage stakeholders, and identify and utilize current doors effectively and efficiently; and
* Reinvigorating the ADRC network; driving the network to more consistent consumer experiences, improving the community partnerships across the network, and creating a statewide information and referral database.

# Medicaid Reimbursement for Skilled Nursing Facility Care

Medicaid expenditures for nursing facility care in the first six months of fiscal year 2015 totaled $1,351,264,000 for an estimated 29,600 individuals’ care.

The Medicaid nursing facility rates are determined pursuant to the rate setting methodology as defined in 405 IAC 1-14.6, which are comprised of several different rate components and rate add-ons. These components are:

**Direct Care Component** which includes all residents’ direct cost, historical patient-related costs adjusted for inflation and case-mix of residents based upon acuity level. A portion of this direct care component is subject to a minimum occupancy level. A profit add-on is also included if the provider’s costs are less than established efficiency parameters and are further adjusted based upon quality scores.

**Indirect Care Component** which includes indirect services related to patient care such as dietary services, social services, physical plant operations and utilities. Indirect cost, historical patient-related costs are adjusted for inflation. A profit add-on is also possible if the provider’s costs are less than established efficiency parameters and are further adjusted based upon quality scores. A portion of the indirect cost add-on is subject to a minimum occupancy level.

**Administrative Component** is based on an established Medicaid reimbursement rate at 100% of annual median administrative costs adjusted for inflation. A portion of the administrative costs are subject to a minimum occupancy level.

**Capital Component** reimburses for capital costs associated with the facility, equipment, and improvements, property taxes and insurance. Facility costs are reimbursement of a “fair rental value” calculated based on a statewide facility valuation times a rental rate tied to published Treasury bond rate. A profit add-on is also included if the provider’s costs are less than established efficiency parameters and are further adjusted based upon quality scores. The Capital Component is subject to a minimum occupancy level to encourage efficient provider utilization of resources.

**Therapy Component** reimburses for direct therapy services that are provided to Medicaid residents. Reimbursement is based upon each provider’s historical Medicaid-only patient related therapy costs adjusted for inflation.

# Medicaid Long-Term Care Costs Will Challenge States as Population Ages

States will face pressure to increase spending on Medicaid long-term care as the population rapidly ages. All states will be challenged to control costs, but those with the unfavorable combination of high long-term care expenditures and high growth in their over-65 population are at particular risk. The extent to which states succeed in managing these expenses will depend on the flexibility provided by the federal government and local political factors (Moody).

* Seven states will be more challenged by Medicaid long-term care costs than others. Compared to other states, Alaska, Delaware, Maine, Minnesota, New Hampshire, North Carolina and Oregon spend more per capita on Medicaid long-term care than the median. All these states are expected to see growth in their over-65 populations that outpaces the nation, according to the Census Bureau.
* Some states have curtailed growth in long-term care spending through effective policies. Even as the state median for long-term care spending growth was 6.5% from 1999-2009, six states held their average annual increase below 4%: Arizona, Michigan, New Mexico, Pennsylvania, Vermont and Wisconsin. States contained costs through policies such as offering lower-cost alternatives to traditional nursing home care.
* Effective policy changes to offset escalating costs will not come easy. Cost control will depend on national and local factors. Most changes by states in Medicaid services require federal government approval through a program waiver. At the local level, the electoral power of a growing elderly population and the political influence of long-term care providers are hurdles to reform (Moody).

Seven states will be more challenged by Medicaid long-term care costs than others. As the population ages more rapidly, all states will be pressured to spend more on Medicaid long-term care. But seven states are most at risk from costs spiking because they have both the highest spending for long-term care and highest projected growth in their elderly population. The list includes: Alaska (Aaa negative), Delaware (Aaa stable), Maine (Aa2 stable), Minnesota (Aa1 stable), New Hampshire (Aa1 stable), North Carolina (Aaa stable) and Oregon (Aa1 stable). For long-term care, these seven states spent on average $157 more per capita than the 50-state median ($335) in 2009, using data from the Centers for Medicare & Medicaid Services. Additionally, all are expected to see growth in their over-65 populations above the 33.6% median from 2014-24, based on Census Bureau data.

The least-pressured states are Tennessee (Aaa stable), Oklahoma (Aa2 stable), Indiana (Aaa stable), South Dakota (Aa2 stable), Illinois (A3 negative), Missouri (Aaa stable), Alabama (Aa1 stable) and Michigan (Aa2 positive). These eight states on average spent $39 less per capita for Medicaid long-term care than the 2009 median, while all expected to see growth in their over-65 populations below the median (Moody).

Long-term care for the elderly and disabled represents one of the largest components of total Medicaid spending, 28.3% in 2012. Costs have increased more quickly than inflation, even when adjusted for the growth in the general population and the population over 65 (see Exhibit 2). The costs, however, have grown more slowly than total Medicaid spending and total US spending (public and private) for long-term care (Moody).

**Some states have curtailed growth in long-term care spending through effective policies**

Despite the pressure of an aging population, many states have effectively curtailed Medicaid long-term care costs through policies that focus on lower-cost service models and eligibility requirements. Spending on long-term care varies significantly from state to state, due primarily to variation in eligibility requirements and services covered. Compared to the 50-state per capita median of $335 in 2009, the amount ranged from $18 in Arizona to $895 in the more populous New York (Aa1 stable) (Moody).

While long-term care costs increased from 1999 through 2009, Exhibit 5 emphasizes how little the growth in states’ spending is related to the growth in their over-65 populations, suggesting policies are effective at keeping costs down. Medicaid long-term care costs increased at an median rate of 6.5% per year from 1999-2009, but six states— Arizona (Aa2 stable), Michigan, New Mexico (Aaa stable), Pennsylvania (Aa3 stable), Vermont (Aaa stable), and Wisconsin (Aa2 positive)—experienced an average annual increase of less than 4%. Vermont actually saw an average annual decrease of 3.7%. Along with Arizona, Washington (Aa1 stable) and South Carolina (Aaa stable), experienced below-average growth, even though the percent increase in their over-65 populations was in the highest quintile for the 50 states.

States have primarily contained costs by emphasizing lower-cost alternatives to traditional nursing homes, including home- and community-based care. New Mexico, for example, introduced a personal care option in 1999, which emphasized in-home care and using nonprofessionals to provide personal care services such as bathing and running errands. Tennessee's use of managed care has kept the growth in its long-term care costs below national levels, relative to the growth of its over-65 population. This has also contributed to the growth in Tennessee’s total Medicaid costs at a significantly lower level than the national increase (Moody).

# Future Care Models for Reimbursement Methodology

The nursing facility quality assessment fee generates approximately $166 million annually for the state of Indiana. These funds are used to leverage approximately $335.8 million in federal Medicaid funds, for total Medicaid expenditures of $501.8 million. The current legislation requires 70.6% of the assessment be used to pay the state’s share of costs for Medicaid nursing facility services (or approximately $354.3 million State and Federal dollars per year), and 29.4% of the assessment revenue to pay the state’s share of other Medicaid services (or approximately $147.5 million State and Federal dollars per year).

# Capacity & Occupancy

As of October 2014, Indiana has 498 Medicaid certified nursing facilities—down from 511 facilities in 2011—with 49,565 beds (Nursing Facility Medicaid Cost Reports and ISDH website). Of these, 483 facilities are dually certified.

As of October 2014, Indiana has 527 comprehensive nursing facilities, with a total of 50,045 licensed beds. Within those 527 facilities, occupancy rates range from a low of 26% to a high of 91%, with the majority of facilities falling in the 60-70-80% occupancy range. Historical data from the Indiana State Department of Health (ISDH) is shown in the table below. Please note that data prior to 2011 is not available.

## LTC Capacity Right-Sizing Initiative

Indiana has 503 nursing facilities that participate in the Medicaid program, with just over 50,300 beds in service. The average occupancy currently is about 79%, meaning that about 10,000 beds (or 20%) are unoccupied at any given time. Excess capacity creates systemic inefficiencies and is costly to providers and the Medicaid program. Medicaid pays for 6 out of 10 residents in a nursing facility. A moratorium on nursing facility construction will go into effect July 1, 2015 and expire June 30, 2018. This legislation should help to stem further growth in the Industry but does little to address the current excess capacity.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date | # of NFs | Certified Medicare Beds | Certified Medicaid Beds | Dually-Certified Beds (MA/MK) | Total # of Licensed Comprehensive Care Beds | Occupied Beds |
| 1/28/2011 | 508 | 5,808 | 2,351 | 40,721 | 50,107 | 80% |
| 5/20/2011 | 514 | 6,016 | 2,154 | 41,024 | 50,649 | 79% |
| 9/21/2011 | 512 | 6,215 | 2,154 | 41,430 | 51,287 | 79% |
| 1/13/2012 | 511 | 6,379 | 2,154 | 41,367 | 51,230 | 78% |
| 5/11/2012 | 511 | 6,379 | 2,154 | 41,356 | 51,038 | 79% |
| 12/21/2012 | 499 | 7,136 | 1,936 | 41,391 | 51,363 | 78% |
| 4/11/2013 | 488 | 7,034 | 1,647 | 41,665 | 51,235 | 78% |
| 6/11/2013 | 488 | 7,084 | 1,647 | 41,685 | 51,235 | 78% |
| 9/9/2012 | 515 | 7,200 | 1,493 | 41,704 | 51,458 | 78% |
| 12/11/2013 | 519 | 7,549 | 1,493 | 41,704 | 51,670 | 74% |
| 2/3/2014 | 518 | 7,387 | 1,493 | 41,710 | 51,508 | 74% |
| 2/28/2014 | 519 | 7,382 | 1,374 | 41,908 | 51,509 | 77% |
| 4/1/2014 | 520 | 7,430 | 1,374 | 41,852 | 51,648 | 76% |
| 5/5/2014 | 521 | 7,296 | 1,370 | 41,787 | 49,545 | 76% |
| 6/3/2014 | 523 | 7,429 | 1,370 | 41,787 | 51,526 | 76% |
| 7/2/2014 | 524 | 7,308 | 1,339 | 42,066 | 49,863 | 77% |
| 8/1/2014 | 525 | 7,164 | 1,315 | 42,312 | 49,941 | 76% |
| 9/4/2014 | 525 | 7,164 | 1,315 | 42,312 | 49,965 | 76% |
| 10/10/2014 | 527 | 6,958 | 1,307 | 42,603 | 50,045 | 76% |

The occupancy data appear to demonstrate a downward trend and this is supported by the fact that the number of people who reside in Indiana nursing facilities has declined during this time period, despite the increase in the number of people who might be eligible for nursing facility care. This occurred alongside an increase in the number of nursing facility beds. Possible reasons for this decline are the growth in Indiana of the number of people who receive long-term services and supports in their home, the explosive growth of assisted living facilities within Indiana, and the possibly improved health of Indiana older adults allowing them to prevent or delay nursing facility admission if or until they become seriously frail.

# Indiana’s Nursing Facility Moratoria

In 2005, Indiana’s FSSA stated that a “brief moratorium on the building of nursing homes in the state is necessary because of the Medicaid nursing home quality assessment fee that was recently approved for the state by the federal government.” According to the Health Finance Commission/Legislative Services Agency, at that time, some felt such a move would create a flood of additional nursing facilities, including those from other states, moving into Indiana. When asked by the Health Finance Commission whether the moratorium would include any exceptions, the FSSA’s response was that it hoped the moratorium would be needed for less than two years. While acknowledging that a moratorium is a complicated issue, there was some disagreement among Indiana nursing facility trade associations. The group generally supported a short moratorium if necessary, but with caveats ranging from “as long as there were no exceptions,” to only “with an exemption for continuing care retirement communities or facilities with high occupancy.”

In Indiana’s State Government’s July – December 2005 Performance Report, it was reported that FSSA “failed to assist seniors in maintaining their health and finding services that best fit their needs, often resulting in more seniors in nursing homes than is appropriate given their needs or eligibility status. Indiana has almost 50% more nursing facility beds than the national average; supply exceeds demand, resulting in a higher bed day cost since fixed costs, such as heating bills, are not allocated across a larger group of people.” FSSA’s response was to seek ways to assess more appropriately the needs of older adults by looking at alternative care options instead of defaulting to nursing facilities. Beginning December 5, 2005, a temporary (90-day) moratorium was instituted for new Medicaid certifications on nursing home beds. The Medicaid Oversight Committee also approved a nursing facility reimbursement rate containment proposal to reduce the rate of payment to nursing facilities. The estimated savings to the state in SFY06 was nearly $13 million ($12,900,000) (Indiana State Government’s Performance Report, July – December, 2005, Volume I, No. 2 March 31. 2006 Office of the Governor).

In 2011, additional legislative action established a moratorium on the certification of new Medicaid beds through the passage of Public Law 229-2011, Sections 163-164. One of the resulting statutes, IC 16-28-16, which applied to comprehensive care facilities for which construction begin prior to June 30, 2011, expired on June 30, 2014. The current moratorium is codified in IC 16-29-6 and applies only to facilities for which construction began after July 1, 2011. There are exceptions for replacement beds, small house facilities and continuing care retirement communities.

During the 2014 legislature, the state senate passed a bill that would put a five-year moratorium on new nursing home construction. Supporters of Senate Bill 173 held that the state has enough nursing homes already, with thousands of empty beds. Opponents of the nursing facility moratorium claimed the legislation would have the potential of removing approximately 3,000 potential jobs from Hoosiers, and a last-minute push by lobbyists stopped the proposed five-year moratorium on nursing home construction.

# Today’s climate

House Bill 460 in this year’s legislative session proposes a three year moratorium on the construction of new facilities to allow demand to catch up with supply. Indiana’s long-term care facility occupancy has dropped to 76%, which adds an estimated cost increase of approximately $25 million dollars shared by the federal and state Medicaid program. Many feel these funds could be better spent on expanding Indiana’s home and community-based services and offering options to older adults to choose where they live, and where they receive services as they age.

# Cost Impact of Excess Capacity

We know that the impact of excess nursing facility bed capacity results in an increase in direct costs. For example, even when there are empty beds in a facility, the electricity bill must still be paid so the lights stay on. A theoretical 3% decrease in occupancy has the potential to cost Medicaid approximately $22 million because the fixed costs per each resident increase over the same time.

# Impact of Excess Capacity on Quality of Care

There is some evidence that higher occupancy leads to higher quality of care. This seems counterintuitive, but is a result of the economies of scale in nursing facilities. When occupancy is higher, staffing generally increases and both the cost of care and fixed costs are spread among higher numbers of residents. When occupancy falls and fixed costs increase, facilities cut staffing because that is the largest expense in any nursing facility building. Lower levels of direct care staff are strongly correlated with quality of care.

# The Future

With the increase in home care, nursing facilities are seeing a more frail resident population; many facilities currently have fewer residents, but these residents have higher acuity. Lower occupancy rates have been fueled by a number of factors, including initiatives to keep older adults and disabled residents out of facilities and in home and community settings, as well as the ballooning assisted living industry. Indiana is aggressively promoting Home and Community-Based Services (HCBS) care options through programs such as “Money Follows the Person,” which seeks to transition thousands of Medicaid-eligible residents out of nursing facilities and into community settings.

Financial concerns, hospital discharge patterns, and the location of homes throughout the state also are factors. Low occupancy rates produce a challenge for the entire facility and its operations. Of course, facilities wish to maintain staff and ensure the provision of high quality care to a more frail population, but at the same time, the facility operation also must remain financially viable. A number of nursing facilities are upgrading buildings, diversifying services, and marketing to residents for short-term rehabilitation or transition-from-hospital-to-home stays. Others are expanding their rehabilitation offerings, or even creating more “home-like” long-term care residences.

Many nursing facilities have watched their census fall simultaneously with an increase in the level of care needs of their residents during a time of shrinking Medicaid and Medicare funding. But there will very likely continue to be a strong need for high-quality skilled nursing homes. The number of people needing LTSS will increase more than 20% by the year 2025. Once that “silver tsunami” hits, Indiana will need high-quality facilities for the portion of that population that needs skilled, long-term nursing care. Indiana currently is facing challenges in rebalancing its long-term care system while trying to ensure that nursing facility beds are available when and where they are needed.

# Value-Based Purchasing

Indiana embarked on a multi-phase nursing facility quality improvement initiative designed to tie Medicaid reimbursement policy to a comprehensive Total Quality Score, derived from routinely collected clinical and administrative data (e.g. Medicaid cost reports or Minimum Data Set (MDS) assessments. This work is known as *Value-Based Purchasing* or VBP.

The implementation of the Quality Assessment Fee was retrospectively identified as the first phase of Indiana’s VBP initiative. This work continued as Phase 3 in 2010 with the formation of a Clinical Experts Panel (CEP) to assist the Division of Aging with the study and evaluation of the quality measures that were most closely identified with nursing facility care quality. This work group ultimately arrived at a set of recommended measures that they determined to be:

* Representative of multiple dimensions of quality;
* Valued by consumers and other stakeholders;
* Valid and reliable;
* Administratively feasible; and
* Could be improved with a reasonable effort by nursing facility operators.

As a result of the work of the CEP, the following quality measures are monitored and utilized to determine a quality rate add-on, using funds collected through the QAF:

* ISDH Report Card Score
* Nursing Hours
* RN/LPN Retention Rate
* CNA Retention Rate
* RN/LPN Turnover Rate
* CNA Turnover Rate
* Administrator Turnover Rate
* Director of Nursing Turnover Rate

Another product of the Phase 3 CEP was the implementation of independently conducted satisfaction surveys of nursing facility residents, residents’ family members and friends, and employees. These data have been collected for two years now. Phase 4 of VBP will begin in 2015 to review the data and determine the process by which the satisfaction data, or other quality measures, such as the CMS Clinical Quality Indictors, may be utilized in the continued evolution and refinement of these quality improvement initiatives.

# Upper Payment Limit (UPL) & Intergovernmental Transfer (IGT) Programs

The Upper Payment Limit (UPL) program is connected with the federally sponsored, state-administered Medicaid program. The UPL program is authorized in Indiana state statute and operated according to the state Medicaid Plan, which is approved by the federal CMS and administered by the Office of Medicaid Policy and Planning (OMPP) within the Office of the Secretary of Family and Social Services Administration (FSSA). (LSA) The UPL program in Indiana provides supplemental payments to non-state government owned or operated (NSGO) nursing facilities that enter into a payment agreement with the FSSA/OMPP. Total payments to the 324 Indiana NSGO nursing facilities under the UPL program YTD were approximately $706 million (state and federal dollars).

The same federal regulations that require the calculation of an UPL also allow Indiana to make supplemental payments to nursing facilities which are owned or operated by a non-state unit of government (NSGO). The regulations allow the payments to be made only to those facilities and in Indiana that equates to County Owned Hospitals. The State makes these supplemental payments on a quarterly basis (estimated payments), followed by a year-end settlement (true-up to actual calculation). In essence, the payments consist of the difference between the Medicaid rate and the Medicare rate for each facility that is a NSGO facility. The quarterly estimated payments use the prior year’s cost report information, which is then balanced against the final payment of the state fiscal year (SFY) using the current year’s cost report. Each NSGO entity funds the state’s portion of the payment through an Intergovernmental Transfer (IGT) so that the program continues to operate at no cost to the state outside of administrative costs. This methodology was implemented on October 1, 2012.

# Incentives for quality care and quality outcome:

**Value Based Purchasing** offered a reimbursement methodology for add-on based upon quality scores. QIO Agency is currently working with ISDH to develop some quality measures and outcome scores based upon critical issues i.e. bed sores development and healing times.

**Phase III of QAF** provides scoring up to 100 points with 70% based upon Report Card scores formula that consists of retrospective of the previous three years’ scores to set the annual score. The remaining scoring is based on a mixture of personnel issues, set by formula of hours spent on the floor, staff turn-over levels, RN turn-over levels and DON turn-over levels.

**Satisfaction Surveys** conducted in 2013 and 2014 used to measure residents’ satisfaction; family satisfaction and employees’ satisfaction.

Since February 2015, a new Clinical Experts Panel has reviewed satisfaction data and reviewed process for a continuation of surveying residents and their families. The panel will be involved in updating the report card scoring formula, establishing new personnel metrics reviewing CMS clinical standards and examining the new satisfaction data collected during the spring and summer of 2015.



# Cost of Construction and Impact on other Buildings

# Glossary (link back to the glossary entry here from text)

**Activities of Daily Living (****ADLs)**are self-care activities a person performs daily, such as eating, dressing, bathing, transferring between the bed and a chair, using the toilet, and controlling bladder and bowel functions. The ability or inability to perform ADLs can be used as a very practical measure of ability/disability in many disorders.

**Administration on Aging (AOA)** is the federal agency designated through the Older Americans Act (OAA) of 1965, and is the conduit for OAA federal funding to be dispersed to designated state units on aging based upon population of persons ages sixty (60) and older. The goals for this funding are to reduce isolation of older persons, provide nutritional needs, offer information and referral to persons seeking services, and to provide outreach to identify isolated or vulnerable older persons.

**Administration for Community Living (ACL)** brings together the efforts and achievements of the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the HHS Office on Disability to serve as the Federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan.

**Adult Day Services (ADS)** are community-based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational, and therapeutic activities, as well as supervision, support services, and personal care. These services must be provided in a congregate, protective setting and meals and/or nutritious snacks are required.

**Adult Family Care (AFC)** is a comprehensive service in which the participant of services resides with an unrelated caregiver in order for the participant to receive personal assistance designed to provide options for alternative long term care to individuals who meet nursing facility level of care and whose needs can be met in a home-like environment. The participant and up to three (3) other participants who are elderly or have physical and/or cognitive disabilities who are *not* members of the provider's or primary caregiver's family, reside in a home that is owned, rented, or managed by the Adult Family Care provider.

**Aged and Disabled Waiver Services** are provided in home and community-based settings for those individuals who meet Nursing Facility Level of Care (NFLOC). The waiver allows payments to be made for their services in the community in lieu of payments for services within a nursing facility.

**Aged and Disability Resource Centers (ADRCs)**

**Assisted Living (AL) Medicaid Waiver**is a residential option that provides personal care assistance, housekeeping, attendant care and companion services, medication management (to the extent permitted under State law), and therapeutic social and recreational programming. Services are provided in a private apartment, which provides a homelike environment in an ISDH-licensed residential care facility Services include 24-hour on-site response staff. This program offers a way to promotes maximum independence, while providing supervision, safety, and security.

**Attendant Care (ATTC)**services primarily involve hands-on assistance for aging adults and persons with disabilities. These services are provided in order to allow older adults or persons with disabilities to remain in their own homes and to carry out functions of daily living, self-care, and mobility.

**\*\*\*Auditory Therapy** is provided by a licensed speech pathologist and includes screening, assessment, direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids.

**\*Behavior Management/ Behavior Program and Counseling** includes training, supervision, or assistance in appropriate expression of emotions and desires, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

**Case Management** is a comprehensive service comprised of a variety of specific tasks and activities designed to coordinate and integrate all other services required in the individual’s care plan. Case Management is required in conjunction with the provision of any home and community-based service.

**CHOICE (Community and Home Options to Institutional Care for the Elderly and Disabled)** program funds began in 1984, and the program continues to focus on the role of community-based services as a means to avoid premature institutionalization. This Indiana state legislation recognized over thirty years ago that significant numbers of older adults were being cared for in nursing homes when their care could be provided in most cases more cost-effectively at home and in the community. Older adults and persons with disabilities who entered a nursing facility after an illness or injury often became long-term care residents because of the requirement to eliminate personal resources, such as their own residences, to become eligible for Medicaid funds to cover their care in the nursing facility. By that point, many had nowhere to go. The CHOICE funding still emphasizes focusing on earlier identification of available “options” for care in the community for those persons who might be able to stay in their homes longer with supportive community-based care.

**Community Transition Services** include reasonable set-up expenses for individuals making a transition from an institution to their own home in which the person is directly responsible for his or her own living expenses in the community and will not be reimbursed for any subsequent move(s). Reimbursement is limited to a lifetime cap for set-up expenses up to $1,500.

**Environmental Modifications** are *minor* physical adaptations to the home. The modifications must be necessary to ensure the health, welfare, and safety of the individual and enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Maintenance is limited to $500 annually for the repair and service of environmental modifications that have been provided through the waiver. There is also a lifetime cap of $15,000.

**\*\*Environmental Modification Assessments** determine the scope and specifications for environmental modifications necessary to enable an individual to function with greater independence within their home, and without which they would require institutionalization. An assessor reviews the feasibility and writes the specifications that serve as the criteria for obtaining and evaluating bids. Upon completion of the work, the assessor conducts a post-project inspection to assure project completion.

**\*\*\*Family Care Assistance** helps caregivers in obtaining access to the services and resources that are available within their communities.

\*\*\***Family Care Information** is a service for caregivers that provides the public and individuals with information on resources and services available to the individuals within their communities.

**\*\*\*Gerontology Counseling** assists older individuals in overcoming losses, establishing new goals while in the process of discovering the lifestyle changes that are often associated with aging, and to reach decisions based on the importance of being in the present as well as looking for future opportunities.

\*\*\***Habilitation Day Group/Individual** assists with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; this service takes place in a non-residential setting separate from the home or facility in which the individual resides.

**Handy Chore** services consist of minor home maintenance activities essential to an individual’s health and safety, and include plumbing, heating, storm door, window, and screen repairs; gutter and roof patching; heavy cleaning; broken step repair; installation of health and safety equipment such as handrails, ramps, deadbolts, fire extinguishers, smoke detectors, locks, and ground maintenance.

**Health Care Coordination** services are provided to prevent or stabilize deteriorating health, manage chronic conditions, and to improve health status, and include the services of a Registered Nurse to manage the health care of the individual including physician consults, medication ordering, and development and nursing oversight of a healthcare support plan.

**Home and Community-Based Services (HCBS)** include a wide range of services and options as defined in 455 IAC 2 that allow care to be offered to persons in either their own home or various community settings. Eligibility for HCBS varies by payment source. Medicaid waivers have the strictest guidelines as they require the participant to meet Nursing Facility Level of Care (NFLOC) and Medicaid guidelines. Other funding sources may use the number of deficits in Activities of Daily Living (ADLs) to determine eligibility.

**\*\*\*Home Health Aide** duties include the performance of simple clinical procedures only as an *extension* of nursing or therapy services, i.e., assistance in ambulation, transferring, exercises, and assistance in administering medications that are ordinarily self-administered. Any home health aide services offered by an HHA must be provided by a qualified home health aide.

**Homemaker** services offer direct and practical assistance consisting of household tasks and related activities. The services assist the individual to remain in a clean, safe, healthy home environment and are provided when the individual is unable to meet these needs or when an informal caregiver is unable to meet these needs for the individual.

**Home Delivered Meals** are nutritionally balanced meals that help prevent institutionalization because the absence of nutrition in individuals with frail and disabling conditions presents a severe risk to health. No more than two meals per day will be reimbursed under the waiver.

**\*\*\*Individual Counseling** services are provided by a licensed psychologist with an endorsement as a health service provider in psychology, a licensed marriage and family therapist, a licensed clinical social worker, or a licensed mental health counselor.

**\*\*\*Information Assistance (I&A)** ensures that adults and disabled individual to access all available benefits and services. This includes providing answers to questions, assisting clients to receive needed service, follow up with clients to make sure service referred are appropriate.

**\*\*\*Legal Assistance** assists older adults understand and maintain their rights, exercise their choices, help them benefit from available services and resolve disputes. The program also promotes the need for lifetime planning through the understanding and the use of advance directives.

**Long-Term Services and Supports (LTSS)** include human assistance, supervision, cueing and standby assistance, assistive technologies, devices and environmental modifications, health maintenance tasks (e.g., medication management), information, and care and service coordination for people who live in their own home, a residential setting, or a nursing facility. LTSS also include supports provided to family members and other unpaid caregivers.

**Nursing Facility Level of Care (NFLOC)** is a means of determining a person’s level of physical and other needs that demonstrate care could be provided within a skilled nursing facility.

**\*\*\*Nutrition Counseling** is performed by a health professional in accordance with state law and policy, and helps individuals who are at nutritional risk, because of their health or nutritional history, dietary intake, medication use or chronic illnesses, with options and methods for improving their nutritional status.

**\*\*\*Nutrition Education**, overseen by a dietitian or individual of comparable expertise, is a program that promotes better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants and caregivers in a group or individual setting.

**Nutritional Supplements** include liquid supplements, such as Boost® or Ensure® to maintain an individual’s health in order to remain in the community. Supplements should be ordered by a physician based on specific life stage, gender, and/or lifestyle. There is an annual cap of $1,200.

**Older Americans Act (OAA)** is the federal legislation enacted on July 14, 1965 to direct a focus on the needs of persons over age sixty (60) with an emphasis on improving nutrition, providing outreach to isolated older adults, and providing information and referral for needed services based solely on age and without means testing.

**\*\*\*Outreach** is a service that assists with identifying potential clients or their caregivers and encouraging their use of existing services and benefits.

**Options Counseling** is a person-centered process whereby individuals, family members and/or significant others are supported to develop a plan for addressing long term services and supports needs that aligns with their preferences, strengths, values, and needs.

**Personal Emergency Response Systems (PERS)** are electronic devices enabling certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed 24/7 by trained professionals.

**Pest Control** services prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease and/or annoys humans and is causing or is expected to cause more harm than is reasonable to accept. Pests include insects such as roaches, mosquitoes, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice. There is an annual cap of $600.

**\*\*\*Physical Fitness** education or programs are designed to keep elderly clients active by promoting stretching and other activities that keep muscles, bones, and joints engaged and not sedentary.

**\*Residential Based Habilitation** services provide training to regain skills that were lost secondary to the traumatic brain injury.

**Respite**services are those services that are provided temporarily or periodically in the absence of the usual caregiver. Service may be provided in an individual’s home; the private home of the caregiver, or in a Medicaid-certified nursing facility. The level of professional care provided under respite services depends on the needs of the individual.

**Specialized Medical Equipment & Supplies** are medically prescribed items necessary to assure the health, welfare and safety of the individual that enable a person to function with greater independence in the home, and without which he or she would require institutionalization.

**\*Structured Day Program** provides assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, and takes place in a non-residential setting, separate from the home in which the individual resides.

**\*\*Structured Family Caregiving** offers persons the opportunity to receive care in their own home or the home of his or her primary caregiver. The principal caregiver cannot be the participant’s spouse, the parent of a participant who is a minor, or the legal guardian of the participant.

**\*Supported Employment** services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported Employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

**Transportation** services enable individuals served under the waiver to gain access to waiver and other community services, activities and resources. Transportation services under the waiver are offered in accordance with an individual’s plan of care and whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

**Traumatic Brain Injury (TBI) Waiver** provides home and community-based services to individuals who, but for the provision of such services, would require institutional care. A TBI is trauma that has occurred as a closed or open head injury by an external event that results in damage to brain tissue, with or without injury to other body organs. Examples of external agents are: mechanical; or events that result in interference with vital functions. Traumatic brain injury means a sudden insult or damage to brain function, not of a degenerative or congenital nature. The insult of damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability not including birth trauma related injury. Any closed head injury occurring before age twenty-two (22) or any open or closed-head injury occurring after age 22.

The service includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

**Transportation** services enable individuals served under the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. Transportation services under the waiver shall be offered in accordance with an individual’s plan of care and whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, if applicable, and shall not replace them.

**Traumatic Brain Injury Waiver -**

**Vehicle Modifications** are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to be safely transported in a motor vehicle. Vehicle modifications, as specified in the Plan of Care/Cost Comparison Budget, may be authorized when necessary to increase an individual’s ability to function in a home and community based setting to ensure accessibility of the individual with mobility impairments. These services must be necessary to prevent or delay institutionalization. The necessity of such items must be documented in the plan of care by a physician’s order. Vehicles necessary for an individual to attend post-secondary education or job-related services should be referred to Vocational Rehabilitation Services. Maintenance is limited to $500 annually for repair and services of items that have been funded though the waiver, and there is a $15,000 lifetime cap.

*\* TBI waiver service only*

*\*\* A&D waiver service only*

*\*\*\* SSBG services only*

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