AoA State Plan Public Hearing

July 8, 2010 10am IGCS Conference Rm. 4

All attendees, please sign in.

Name	Email Address or Preferred Contact Information
Ann Allen	aallen@ifgi.org
Lorna Moore	LMoore@aecaxi.org
Paul Chase	pchase@aarp.org
Bob Decker	rdecker@Lucashealthgroup.com
Becky Carter	exdir@INassistedliving.org
Gloria Wetnight	gwetnight@westcentralin.com
Elaine Provost	elaineb@midlandmeals.com
Laura Boyle	lboyle@cicoa.org
Kelly Williams	kmillwill@aol.com
Dena Long	Ind Health Care Association
Rebecca Kasper	Ind-Assoc. for Home + Hospice Care
Scott Titus	stitus@ihca.org
Jim Leich	jimleich@iahsa.com
Gwen Benta Wolf	gbwolf@agingihs.org
Ruth Ratzlaff	rratzlaff@agingihs.org
Karen Filler	Karen.Filler@fssa.in.gov
JACKIE Cissell	JACKIE.Cissell@FSSA.IN.GOV
FAITH LAIRD	
Kristen S. LaFace	Kristen.laface@iaaaa.org

Testimony of Paul Chase, Associate State Director for Public Policy, AARP Indiana
FSSA/Division of Aging State Plan on Aging, 2011-2014
July 8, 2010

Thank you for the opportunity to submit testimony regarding the Indiana Division of Aging's draft State Plan on Aging. In that it serves as a guidepost for the development and implementation of strategies to improve Indiana's long-term care delivery system over the next four years, it is very important that consumers, consumer advocacy organizations, health and human service providers and other interested groups and individuals have this opportunity to offer comments to ensure that Indiana residents have access to a full range of long-term services and supports that promote consumer independence, choice, dignity, autonomy and privacy.

We provide this testimony with the understanding that the Federal Administration on Aging dictates the goals the state is to achieve over the next four years, with the state developing the objectives, strategies, outcomes and performance measures designed to meet these goals.

Challenges to our Current Long-Term Care System

Surveys consistently show that the overwhelming majority of people age 50 and older want to "age in place". This fact is confirmed by the Indiana AdvantAGE Survey conducted in 2008, included as "Attachment C" to the draft plan, revealing that 94% of respondents would like to stay in their current residence for as long as possible. Of concern is that 39% of respondents are "not very confident" that they will be able to do so.

Meanwhile, the demand for home and community-based alternatives to nursing home care continues to grow as baby boomers age. They start turning 65 next year. The U.S. Census Bureau projects that the number of Americans age 65 and older will rise 36% from 2010 to 2020, compared with a 9% increase for the population as a whole.

Indiana has a long way to go to ensure that its residents have access to a full range of home and community-based alternatives to nursing home care to address their long-term care needs and preferences. Medicaid is the primary funding source for the majority of long-term services and supports in Indiana. A September, 2007 article in Stateline.org ranked Indiana 45th in the percentage of Medicaid dollars spent on homecare services. Focusing on older people and adults with physical disabilities separate from other long-term care populations, AARP's 2009 publication entitled "Across the States" ranked Indiana 48th in the percentage of Medicaid expenditures for home and community-based services in 2007.

Unfortunately, the economic downturn has only increased our challenges. A waiting list for Medicaid Aged and Disabled Waiver services was instituted in December of 2009, and the state has been unwilling to ante up additional state dollars to expand the number of waiver slots and draw down additional federal dollars. At the June, 2010 CHOICE Board meeting Director Laird reported that there were 2,569 people on the A & D Waiver waiting list. Director Laird also stated that there were 3,693 people on the CHOICE waiting list. And in May of this year, the AAAs received formal notice that, due to declining revenues, they should expect a 15% reduction in CHOICE funding

from the amounts in their current contracts, a 10% reduction in PAS/PASRR reimbursement rates, and that other program funding streams may also be impacted.

While up to 1,393 additional waiver slots were slated to come online for the period July 1, 2010 to June 30 2011, the Division of Aging has signaled its intention to slow down the process for making these slots available. At the June CHOICE Board meeting Director Laird said that her agency expects to first determine the number of waiver slots that are "truly vacated" in July and August, and anticipates that they will gradually make additional waiver slot allocations beginning in September. She also indicated that, due to budget issues, the Division is not requesting any amendments to the number of waiver slots requested.

What we have then is a perfect storm, with growing numbers of individuals seeking long-term care services, waiting lists for two public assistance programs that fund the majority of home and community-based services in the state, a bad economy, and policies that have resulted in Indiana's continued ranking at the bottom of states in a balanced long-term care system. The inability to access vital home and community-based services is placing enormous strains on family members and friends. In Indiana alone over one million Hoosiers already contribute nearly $8 billion each year in unpaid care – more than five times the amount Indiana spends each year for all long-term care services, nursing home and HCBS care combined. Informal caregivers are overwhelmed with the growing demands being placed on them.

A November, 2008 report published by the AARP Public Policy Institute, entitled "Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update", quantifies the costs of caregiving beyond merely the simple accounting of hours. According to the report, caregivers to persons age 50 or older reported spending an average of $5,531 out-of-pocket in 2007. Long-distance caregivers had the highest annual expenses (($8,728).

The loss of wages, health insurance and other job benefits, retirement savings, and Social Security benefits holds serious consequences for caregivers. Nevertheless, more than one-third of caregivers to persons age 50 or older reported quitting their job or reducing their work hours in 2007. Another recent study cited by the report found that midlife women in the labor force who begin caregiving are more likely to leave the labor force entirely than to reduce their hours. According to the report, a recent summary of decades of evidence on the physical and mental health effects of caregiving noted that caregivers are at risk of becoming "patients" themselves. The greater the intensity in the type and quantity of assistance provided, the greater the magnitude of the health effects, which are largely due to chronic stress. Meanwhile, both the aging of the population and shortages of health and long-term care workers, including nurses and paraprofessionals, are placing additional pressures on health and long-term care systems.

For those with no caregiver support, or whose caregivers are unable to take on any additional responsibilities without compensation, and who can no longer wait for CHOICE or Medicaid Waiver services for assistance, nursing home placement is the only option for their long-term care needs. Unfortunately, Indiana's track record for nursing home quality is poor. According to a

March 7, 2010 article in the Indianapolis Star, Indiana has more of the "most poorly performing" nursing homes than any other state in the U.S., ranking Indiana 51st in the country. Yet as an entitlement, an increasing number of older and disabled Hoosiers who have exhausted their private resources, or who had no personal resources to begin with, will end up in a nursing home – an antithetical result to the goal of a more balanced long-term care system, and one that is very costly to our state.

AARP studies confirm that we can serve roughly three people in the home and community for every person in a nursing facility. The Division of Aging's own data reflect the cost-effectiveness of home and community-based care. It's July 1, 2008 to June 30, 2009 Financial Review report documents a monthly per-person saving of $730 for Medicaid A & D Waiver as opposed to nursing home expenditures. That amounts to a per-person annual savings of $8,760. The cost-effectiveness of the CHOICE program is even more dramatic. According to the CHOICE Annual Report for SFY 2009, the average cost per month for a CHOICE client was $423.81, compared to the average cost per month of a client in a nursing facility of $4,575.89, for an overall per-person yearly savings of $49,825, of which $18,470 is the state's share.

Granted, the CHOICE program is designed to serve a healthier population. According to the report, however, the average program participant was a white female, age eighty-five or older, and the only member of her household. Moreover, she would have circulatory, nervous, and/or muscular impairments and be unable to perform three or more assessed activities of daily living. In other words, the average CHOICE client is already medically eligible under Medicaid for nursing facility level of care. And though this individual may not meet financial eligibility requirements, on average it is much less expensive to the state to maintain as many individuals as possible on CHOICE than to make expenditures for them under the Medicaid Waiver or in a nursing home.

Strategies to Expand Home and Community-Based Services

Accordingly, any strategic plan for improving Indiana's long-term care delivery system must focus on cost-effective initiatives designed to expand home and community-based alternatives to nursing home care. This is in line with the Division of Aging's vision statement, which is to provide long-term care options to traditional facility placement while striving to improve quality of life by providing community-based care.

Phase 2

Under Objective 3.1 of Goal #3 in the draft plan, one of the strategies put forth by the Division of Aging for expanding the availability of HCBS is to continue rebalancing the nursing home entitlement program to benefit HCBS. The Phase 2 initiative, which restructures the nursing home reimbursement system to dis-incentivize facilities from admitting patients with the lowest level of need and which rewards only those facilities that have good report card scores, is a nice example of how the Division is freeing up money previously going to nursing homes for HCBS. Now that the program is finally approved and the implementation phase has begun, it is expected to free up roughly $20 million dollars for that purpose. We are told that $5 million should be available by the end of calendar year 2010, with additional funds becoming available over the next several years

(which raises the question of why the Division has set a target date of 2014 for this performance measure).

However, we are unaware of any other initiatives along that line. With its focus on improving nursing home quality, Phase III has more to do with redirecting existing dollars than with freeing up dollars that would support more individuals in the home or community. If the Division of Aging has other ideas for rebalancing the nursing home entitlement program to benefit HCBS, it would be helpful to see these strategies listed in the draft plan.

New Opportunities Under the Patient Protection and Affordable Care Act

One strategy we can suggest would be to implement the Community First Choice Option under the new Patient Protection and Affordable Care Act. The CFC Option would cover HCBS attendant services and supports as a new Medicaid state plan service. This would put attendant care services on par with nursing home care, avoiding any waiting list or other enrollment restrictions for eligible individuals. The CFC Option has the added benefit of an increased federal Medical Assistance Percentage (FMAP) of six (6) percentage points for expenditures related to that service.

Another strategy would be to implement the State Balancing Incentive Payments Program under the new federal health care law. This program provides a five-year grant to states that spend less than fifty (50) percent of their Medicaid LTC dollars on non-institutional services and supports. Under this program, Indiana could receive an enhanced FMAP of five (5) percentage points. This influx of federal funds could be used for new or expanded Medicaid non-institutional services and supports. For example, Indiana could choose to expand coverage through our Medicaid A & D Waiver. It could also choose to expand coverage through a Medicaid HCBS state plan amendment option. In such case, the Division could establish a higher income eligibility level than currently offered under the state plan amendment. It could also enroll individuals using less stringent needs-based eligibility criteria than those used for institutional services.

Ohio's Home First Program

Yet another strategy would be to adopt a program similar to one recently enacted in Ohio. Ohio's Home First program allows for the transfers of funds that would otherwise be used to pay for nursing home care to be used instead to pay for Medicaid Waiver services. The program serves individuals who were on a waiting list for waiver services and have since been admitted to a nursing facility, as well as individuals who are currently on a waiting list and at imminent risk of nursing facility placement, or who are the subject of abuse, neglect or exploitation and who, without access to waiver services, will be placed in a nursing facility.

Recommendations from AARP's "Striking A Balance" Report

Other strategies to expand HCBS include those set forth in an AARP Indiana-commissioned report entitled "Striking a Balance: Recommendations to Improve Indiana's Long-Term Care System", published in December, 2009. The report is the culmination of a six-month study which examined the status of Indiana's long-term care system, analyzed "best practices" from other states' LTC systems, solicited input from state legislators, state executive branch officials, area agencies on

aging, service providers, consumer advocates, and the long-term care insurance industry, and concluded with a series of recommendations to improve Indiana's system in key areas of access, financing, services and quality.

Presumptive Eligibility

One such recommendation, which continues to be vetted, but which is not mentioned in the draft State Plan, would be to implement presumptive eligibility procedures for the Medicaid Waiver. This would be feasible to the extent the Division is able to eliminate the waiting list for waiver services, which additional state dollars, and/or additional federal dollars available under the Patient Protection and Affordable Care Act, could make possible. Planning that begins in the near term would allow the AAAs to make presumptive eligibility determinations, with appropriate safeguards, to immediately authorize the start of waiver services to people who are at risk of institutionalization once the waiting list is eliminated. The Division could choose to narrowly define the circumstances under which presumptive eligibility could be allowed, or could pilot such a program in one or more AAAs before statewide implementation. As documented in the report, states using presumptive eligibility have found their error rates to be extremely small while cost-savings are significant by avoiding unnecessary nursing facility care. And as mentioned above, on average the state saves over $8,700 for each person on the Medicaid waiver as opposed to in a nursing facility, demonstrating that by investing additional state matching dollars in the Medicaid Waiver program, the state can save money in the long run by reducing more costly nursing home expenditures.

REAL Services' Nursing Home Options Counseling Progam

Other recommendations from the "Striking a Balance" report involve the development and implementation of targeted options counseling programs for people recently admitted to nursing facilities, as well as for people being discharged from a hospital to a nursing facility. We note that since 2006 REAL Services, the Area 2 Agency on Aging, has assigned case managers to specific nursing facilities, where they provide options counseling to newly admitted individuals on a weekly basis to determine whether they may be better served at home with appropriate supports. The Division of Aging should evaluate this program with the goal of expanding it statewide.

CICOA's Hospital Discharge Options Counseling Program

The draft State Plan on Aging does mention the Division's involvement in a grant between CICOA Aging and In-Home Solutions, the Area 8 Agency on Aging, and Wishard Memorial Hospital, which integrates two of CICOA's care managers into Wishard's discharge planning process to provide timely, on-site access to comprehensive options counseling, care management and, when appropriate, pre-admission screening. In the body of the draft State Plan the Division suggests that it has a plan to evaluate this pilot program with the goal of expanding it statewide. We believe this program has great potential and should be included as one of the strategies under Objective 3.1 of Goal #3.

Enhancing Indiana's Self-Directed Attendant Care Program

Still another recommendation from the "Striking a Balance" report would enhance the self-directed attendant care program to allow spouses and parents to serve as caregivers. While it is very positive

that Indiana has established a self-directed attendant care program, it should promote its usage by allowing a broader definition of who can be a caregiver. Most states that have established self-directed care programs in recent years have delegated authority and responsibility to enrollees to choose their own caregivers, including spouses and parents. Indiana could allow for these additional categories of caregivers under limited circumstances and where there is a shortage of qualified in-home workers. Allowing those with whom the consumer is most closely connected serve as attendant care providers in clearly defined circumstances would avoid unnecessary institutionalizations and could save the state money. The results for these programs have demonstrated at least cost neutrality, satisfactory quality and high consumer satisfaction.

The foregoing list is not exhaustive, but is provided to demonstrate a number of strategies that are currently being discussed or have at least been offered as reasonable strategies to balance our LTC system, require little if any additional funding to implement, and could result in significant cost-savings for the state while expanding home and community-based options for consumers.

Additional Grant Opportunities

We are pleased to know that the Division also intends to pursue grant opportunities under Objective 3.1 of Goal #3. We have recently provided information about the availability of several grant opportunities related to strengthening ADRCs, including 100% federall-funded grants to expand options counseling through the ADRCs and to coordinate medical and social service systems to enable individuals to remain at home or in the community after a hospital, rehabilitation or skilled nursing facility visit (ARDC Evidence-Based Care Transition Programs). We hope the Division will pursue one or more of these grants, and we will continue to inform the Division of new public and private grant opportunities as we become aware of them.

"Global Budgets" for Area Agencies on Aging

However, we are unsure what the Division means when it suggests one of the purposes of those grant opportunities is to redesign or remodel the Non-Waiver HCBS programming. We don't find a specific reference for this recommendation in the body of the draft State Plan. What may be a greater need for individuals seeking services that can be provided with CHOICE, SSBG or Title III funds is for the AAAs to have more flexibility in managing these LTC programs at the local level, as recommended in AARP's "Striking a Balance" report. The reality is that a person may qualify for a number of program and services. Although it is important that services be allocated to specific budgets, systems should be developed to give more flexibility to meet people's needs across all programs for which they are eligible. For better customer service and improved outcomes, the report recommends that the Division should work with the AAAs to design a more flexible local system, which could include a single allocation for all LTC enrollees that meets defined standards and outcomes.

Allowance for Use of CHOICE Funding Pending Medicaid Eligibility

The report also recommends that the Division should make it clear that CHOICE funds are permitted to be used pending Medicaid eligibility. While it is understandable why the state would want to maximize a federally-financed program, it needs to use its state funds to ensure that people

can receive appropriate HCBS to avoid unnecessary institutionalization or a decline in their health condition. Since it can take months for Medicaid Waiver approval, people needing services and public support should be able to access needed CHOICE services in the interim. State policy must be clear that this is an appropriate use of state funds.

Recruitment, Training and Support for Caregivers

Particularly now, with shrinking revenues and growing demand for long-term services and supports, any strategic plan for improving Indiana's long-term care delivery system must also focus on programs that leverage the tremendous contributions already being provided by informal caregivers. We are pleased to see that, under Objective 3.2 of Goal #3, the Division places caregiver support high on its priority list, with plans to pursue programs and outreach for caregivers and to explore a statewide caregiver program. We agree that Indiana should develop and implement a variety of methods to encourage and sustain family caregivers on a uniform, statewide basis, such as providing more opportunities for respite care, education, training and other forms of health and emotional support as recommended in AARP's "Striking a Balance" report.

Our report also recommends that the Division designate a lead entity to take responsibility for recruiting and training needed long-term care workers. The AAAs are in the best position to know about gaps and shortages, and, with appropriate resources, should be given responsibility for provider sufficiency. However, the state must have a coordinated LTC workforce strategy, especially in the recruitment and training of in-home workers, given projected demographic changes. Workforce and education entities must work with human services entities to develop and implement that strategy.

Similarly, our report recommends that the Division should focus its workforce strategy on recruiting and retaining in-home care providers to meet the need for services where people want them. This must include a focus on increased pay and benefits as well as education and training. Consumers want quality services and are willing to pay a reasonable amount for those services. A trained and well-compensated in-home workforce not only supports the individual needing care at home, but also supports family caregiving. Developing and implementing a thoughtful strategy is vital for the sustainability of a LTC system into the future.

A strong workforce recruitment and training component is also critical to ensuring that home and community-based options are both available and accessible to a growing population in need of long-term services and supports, including racial and ethnic minority populations and older adults who live in rural communities. While outreach is an important component for increasing access for populations that have traditionally been underserved, as set forth in Objective 2.1 under Goal #2, the ability to meet their long-term care needs cannot be met unless coupled with a strong workforce and training component that is responsive to their educational and caregiving needs.

Consumer Outreach, Information, Education and Referral and the Role of ADRCs

We are pleased to see that one of the Division's strategies to promote the need for long-term care planning (Objective 1.1 under Goal #1) is to continue utilizing the ADRCs to provide education and

referral information for individuals seeking long-term planning advice. Since the ADRCs can assist individuals regardless of income or asset limitations, they are also in a great position to promote private pay options, another strategy under Objective 1.1, to the extent the public is made aware of their services. Any effort to balance our long-term care delivery system must include a strong consumer education component, which goes hand in hand with strategies to promote the availability of long-term care options as an alternative to nursing facility placement outlined in Objective 1.2 of Goal #1. As discussed in AARP's "Striking a Balance" report, ADRCs need adequate and dedicated funding to properly serve an ever-increasing workload of people needing assistance with their long-term care needs. Additional funding is especially necessary with continuing outreach efforts to give people vital information and counseling at crucial times, including in-home counseling for at-risk individuals who are unable to travel to the ADRC. We support such programs, and will support efforts to seek additional funding to sustain them.

Long-Term Care Educational Campaign

We also support initiatives designed to educate consumers of all ages about their potential need for long-term care and to encourage them to make a plan for how to pay for that care (another of the strategies listed under Objective 1.1, Goal #1). This is one of the recommendations set forth in AARP's "Striking a Balance" report, which suggests implementing a long-term care educational campaign targeted to all Indiana residents, beginning at the secondary school level and focused on younger working-age adults, that encourages planning for and financing their long-term care needs. We recommend that one state entity be designated to coordinate this effort, which would involve the education system and the insurance department, as facilitating the purchase of long-term care insurance should be included in any such campaign.

Long-Term Care Insurance Partnership Progarm

Therefore, we also support the strategy under Objective 1.1, Goal #1, to seek out partnerships with long-term care insurance providers. We believe this can be best accomplished by coordinating with the Department of Insurance and expanding efforts to promote the Long-Term Care Insurance Partnership Program with Medicaid. These partnership policies include a key feature known as Medicaid asset protection. These policies protect all or part of an individual's life savings they would otherwise have to spend down should they use up their policy benefits and need to apply for Medicaid to pay for their continuing long-term care needs. Additionally, state requirements for issuance of these policies include a provision that benefits increase by five (5) percent annually or at the Consumer Price Index inflation rate to keep up with rising costs.

CLASS Program

The Division should also collaborate with the ADRCs to make sure consumers are aware of these policies. However, the cost of long-term care insurance is prohibitive for many, while others are currently excluded due to a pre-existing medical condition. Accordingly, the Division should also make sure procedures are in place to inform working consumers about the Community Living Assistance Services and Supports (CLASS) Program, a new program under the Patient Protection and Affordable Care Act that will be available as early as January, 2011. This voluntary national

insurance program will help individuals pay for the long-term services and supports they need to live in their homes and communities. The automatic payroll deduction feature for the monthly premium offers greater opportunities to afford coverage, and benefits are guaranteed once an individual has paid premiums for five years. The CLASS Program offers a solution for some – one has to be in the workforce to qualify - to the challenge of financing long-term care, particularly for those for whom private long-term care insurance is unaffordable, and should be included in any strategy to expand consumer knowledge about private financing for their future .long-term care needs.

Health and Wellness Initiatives

With passage of the Patient Protection and Affordable Care Act, promoting statewide health and wellness initiatives, as set forth in Objective 4.1 of Goal #4, should include as a strategy the promotion of free annual wellness visits and a personalized prevention plan under Medicare. It should also provide greater specificity as to how the Division intends to inform older adults about the availability of health and wellness programs, such as through ADRCs, senior centers, county welfare agencies, as well as any efforts to reach underserved communities. The statewide infrastructure contemplated in the Chronic Disease Self Management Program may provide that level of specificity; however, there is no performance measure listed for Objective 4.2, unless it is to develop a statewide database of CDSMP programming, which might only be available to those computer-savvy individuals with Internet access. Without more information about how Indiana residents will gain access to the evidence-based programming referenced in the body of the draft State Plan, it is unclear how this will be accomplished.

Preventing Abuse, Neglect and Exploitation

We support the objectives and strategies designed to protect the rights of older individuals and to prevent abuse, neglect and exploitation as set forth under Goal #5. Stepped up efforts to inform the public of a hotline and consumer complaint process, coupled with the development of stronger relationships between the AAAs, local prosecutors and adult protective service investigators, and simplified procedures for filing complaints should reduce instances of abuse, neglect and exploitation. One component that is not mentioned is how the Division will ensure that corrective action is being taken on a timely basis. We recommend the inclusion of strategies that document any actions taken by the Division, as well as a grievance and appeal process for consumers and their advocates who are dissatisfied with the complaint resolution.

Conclusion

It is our understanding that the Division was limited to twenty (20) pages for its State Plan narrative, inclusive of goals, objectives, strategies and performance measures that will inform its work over the next four years. As such, we recognize the challenges it must have encountered in setting forth a comprehensive and inclusive set of objectives and strategies to accomplish the goals established by the Administration on Aging. Nevertheless, as a blueprint for our long-term care system over the next four (4) years, we believe the draft State Plan on Aging should provide greater specificity on how the Division plans to balance Indiana's long-term care delivery system.

We have provided a number of recommendations for possible inclusion in the draft plan. And while we commend the Division for many of the strategies contained in the draft, some of which support recommendations contained in AARP's "Striking a Balance" report, we believe others need to be more fully developed to provide a clear path to the goal of a more balanced long-term care delivery system.

Thank you for the opportunity to submit testimony on this important issue. We stand ready to work with the Division of Aging and other stakeholders to implement recommendations from the State Plan on Aging once formally approved and adopted, as well as any other strategies that help us balance Indiana's long-term care delivery system.

Respectfully submitted,

Paul Chae

Comments from the Indiana Association for Home & Hospice Care, Inc.

on the Family & Social Services Administration – Division of Aging State Plan, 2011 – 2014

July 8, 2010

Good Morning. I am Rebecca Kasper and I am here on behalf of the Indiana Association for Home and Hospice Care (IAHHC). IAHHC represents over 300 personal service, home health and hospice providers who serve more than 60,000 Hoosiers each year. IAHHC appreciates the hard work the Division of Aging has put into developing this plan and appreciates the additional opportunity for public comment.

IAHHC is pleased to see recognition in the plan of the dramatic increase in the use of Home and Community Based Services (HCBS) and the need to expand HCBS availability with "new ideas or approaches," as outlined in Objective 3.1. We particularly recognize the need for creative ideas given the State's current economic difficulties.

While we support the objective and the goals, we feel that the strategies and performance measures could benefit greatly from increased detail and additional specifics. This would allow both the Division and the provider community to better understand the plan of action and work together on specific projects or tasks.

IAHHC would also like to note that we support the initiation of Phase III outlined in the plan, as we strongly supported the development of Phase II. We are concerned about the Target Dates listed in the plan for Objectives 3.1 and 3.2. Specifically, we are hopeful that June 2014 represents an end date, not a start date, to "utilize the funds provided from the Phase II, Quality Assessment Fee (QAF) to expand HCBS." Those funds are needed by HCBS well before 2014, and we would encourage the Division to begin distribution of those funds as quickly as possible.

Again, IAHHC applauds the ambition of the Division's plan, and hopes that additional information can be added. We look forward to working with the Division and the rest of the provider community, to achieve these goals to improve the care of our state's elderly population. Thank you.

Indiana Association of Area Agencies on Aging

For Hoosiers of All Ages and Abilities... There's No Place Like Home

July 8, 2010

Ms. Faith Laird
Director, Division of Aging
Indiana Family and Social Services Administration
402 West Washington Street
Room W454
Indianapolis, IN 46204

Dear Director Laird:

On behalf of the network of Indiana's sixteen Area Agencies on Aging, and of other industry partners with an interest in the State Plan, the Indiana Association of Area Agencies on Aging (I4A) respectfully submits this further set of comments on the State Plan that is required of state units on aging that receive Older Americans Act funds from the federal Administration on Aging, in follow-up to comments provided June 29, 2010.

First, I4A thanks the administration for its flexibility and responsiveness in creating additional opportunities to review and comment on the plan. Indiana's AAAs desire to be an integral partner with Division of Aging (DA) in developing and implementing a vision for Indiana that helps all older adults and people with disabilities remain healthy and vital members of their families and communities.

To this end, we strongly support and encourage a review and revision of the strategic planning process that led to the current proposed plan over the next several months. We believe that by intentionally and meaningfully engaging AAAs, older adults, people with disabilities and other industry partners, we can together submit to the Administration on Aging a State Plan that will truly have a positive and future-reaching impact for Indiana residents that benefit from local, state and federally funded aging and disability services.

I4A offers this further set of comments to the State Plan in two parts: a general set of comments and specific recommendations related to plan objectives and strategies.

Ms. Faith Laird
July 8, 2010

General comments:

- I4A supports DA's vision of redefining the long-term care marketplace in Indiana and is a dedicated partner in achieving that vision. There is much in the plan that suggests the maintenance of and completion of current strategies, objectives, and level of service. I4A encourages DA to reach beyond this maintenance level of effort to ensure full realization of its goal to rebalance the long-term care marketplace in Indiana prior to the end of the current gubernatorial administration. To this end, we propose additional, aggressive, urgent and targeted efforts toward rebalancing long-term care than already exist. We also suggest that several of the plans target dates be expedited. Now more than ever, we call upon DA through this State Plan, to be an innovative and energetic driver of change, including advocacy for additional investment now that will shift Indiana's long-term care cost curve anticipated for the future.

- I4A encourages additional and ongoing efforts related to both needs assessment and evaluation. While we note the inclusion of the statewide AdvantAGE survey as supporting documentation, AAAs also recognizes its limitations. First, the assessment primarily supported the previous State Plan. I4A's supports the implementation of new and ongoing efforts toward assessment and evaluation for this current State Plan. Second, the survey's telephone methodology resulted in the exclusion of the most needy clients who lacked telephones or were unable to use a telephone as the result of mobility or cognitive impairments. New assessment efforts should be inclusive of consumers not normally able to participate by phone, internet or attendance at a public hearing.

- I4A encourages more meaningful engagement of the CHOICE Board in the State Plan. The CHOICE Board is mentioned in the plan as having a key role in reviewing and recommending all state policies on aging. However, it has only been in recent meetings that the Board has realized that its charge, by statute, reaches beyond the confines of CHOICE policy.

Specific comments:

Goal #1: Empower older Hoosiers, their families, and consumers to make informed decisions about their existing health and long–term care options			
No.	**Objective**	**Strategy**	**Comments**
1.1	**Promote the need for long-term care planning to the public at large.**	Utilize the ADRCs to provide education and referral information for those seeking long term planning advice.	I4A notes that several of the performance measures related to this objective involve the development of tools and guidance to be implemented through ADRCs/AAAs. We also note that Indiana has mandated that all AAAs be certified as ADRC's that provide individual Options counseling, education, outreach, and other services. For 2011, DA will provide just over $41,000 to each AAA, regardless of the AAAs client volume, to provide ADRC services. This is a clearly inadequate funding level to provide the current required level of service. To the extent that DA desires to educate Hoosiers of all ages about long-term care planning and HCBS, I4A notes the need for a comprehensive marketing plan to achieve this goal. Regarding private pay options, each Indiana AAA now offers some form of private pay service. Private pay in AAAs is already regulated to the extent that if a AAA chooses to use public funding to operate its private pay program, any income generated must return to the program. **I4A recommends that:** DA prioritize the aggressive pursuit of additional state and federal resources to fund ADRCs adequately if it proposes to rely on ADRCs to implement strategies related to this objective. DA establish numeric goals regarding the actual numbers of persons that will create long-term care plans as a result of these
		Promote Private Pay options to consumers.	
		Provide outreach to consumers of all ages and encourage them to think about long-term care before they are in need of HCBS.	
		Seek out partnerships with long-term care insurance providers.	

			strategies so that performance may be more easily measured. DA include in this plan a comprehensive marketing strategy that integrates statewide and local ADRC efforts regarding long-term care options and HCBS relevant to the target populations they are trying to reach. DA establish numeric goals regarding the numbers of persons that will be educated regarding long-term care options and HCBS as a result of these strategies so that performance may be more easily measured. DA provide funding necessary to fulfill additional requirements and service levels required of AAAs related to private pay options.
1.2	**Promote the availability of long-term care options as an alternative to nursing facility placement.**	Educate consumers regarding HCBS, Assisted Living, Adult Day Service and Adult Foster Care services. Rebrand Adult Foster Care to Adult Family Care to avoid confusion regarding its Purpose.	AAAs are concerned regarding promoting the availability of HCBS as an alternative to nursing home care when Medicaid waiver services are closed to new consumers and CHOICE has been cut from its original appropriation level. While ongoing education efforts with the public are critical, there must be supply to meet the demand such promotion will create. AAAs also suggest that the performance measure, "Educate Case Managers regarding the benefits of Assisted Living, Adult Day Services and Adult Foster Care" be revised to reflect the need to increase capacity for the services themselves. AAA case managers are already the most knowledgeable persons in the state regarding national, statewide, local and private resources related to HCBS in Indiana. From the AAAs perspective, the problem is <u>not only</u> one of education, but <u>primarily one</u> of adequate resources in the public and private sectors to meet the growing demand for HCBS.
1.3			I4A notes that while DA proposes performance measures for

			Objective 1.3, no such objective appears in the plan. To the extent DA intends an Objective 1.3 involving partnership building and assessment related to elderly minority, ethnic and cultural sub-populations, we would reiterate recommendations provided for Objective 2.1. Finally, I4A notes a discrepancy in the timelines proposed for objectives 1.3 and 2.1, even though they would appear to have identical strategies and performance measures.

Goal #2: Establish easy accessibility to existing health and long-term care options			
No.	**Objective**	**Strategy**	**Comments**
2.1	**Provide outreach to minority populations and cultural epicenters within the community.**	Pursue new opportunities and partnership for elderly, minority, and cultural organizations.	**I4A recommends that:** Beyond assessment and general outreach plans, DA and its partners, in direct conjunction with AAAs, identify best practices and develop specific strategies to link underserved persons, including cultural, ethnic and racial minorities, with their local ADRCs. DA establish numeric goals regarding the actual numbers of underserved persons that will initiate service as a result of these strategies so that performance may be more easily measured.
		Identify distinctive education and care giving needs that are not being met in elderly, cultural and minority sub-communities.	

Goal #3: Enable seniors to remain in their own homes with a high quality of life for as long as possible through the provision of home and community based services, including supports for family caregivers.			
No.	**Objective**	**Strategy**	**Comments**
3.1	**Pursue opportunities to expand HCBS availability with new ideas or approaches.**	Continue rebalancing the nursing home entitlement program to benefit HCBS. Pursue grant opportunities to redesign or remodel the Non-Waiver HCBS programming and strengthen ADRCs.	**I4A recommends that:** DA and OMPP establish a specific mechanism that calculates the anticipated dollar amount of long-term care related cost savings related to QAF and nursing home diversion. DA and OMPP increase funds available to HCBS through Medicaid Waiver and/or CHOICE by this same anticipated dollar amount over and above already appropriated amounts. DA expedite the completion of QAF Phases II and III to a date within the term of expiration for the current administration. DA establish numeric goals regarding the actual numbers of older adults that will remain in their own homes as a result of these strategies so that performance may be more easily measured.
3.2	**Provide learning opportunities for caregivers and informal supports to empower them to care for their loved ones.**	Pursue programs and outreach for caregivers. Explore a statewide caregiver program.	**I4A recommends that:** DA assess the level and types of care-giver supports already being provided through AAAs to determine where specific programmatic and geographic gaps exist prior to establishing new statewide programming. AAAs be integrally involved in the development of new care giver supports if program delivery is anticipated through the

Goal #3: Enable seniors to remain in their own homes with a high quality of life for as long as possible through the provision of home and community based services, including supports for family caregivers.			
No.	**Objective**	**Strategy**	**Comments**
			AAA network. DA establish numeric goals regarding the actual numbers of care givers to be served through increased programming so that performance may be more easily measured.

Goal #4: Empower older people to stay active and healthy through the Older Americans Act services and the new prevention benefits under Medicare.			
No.	**Objective**	**Strategy**	**Comments**
4.1	**Promote statewide health and wellness initiatives.**	Promote statewide nutrition initiatives and activities. Engage other state agencies in health and wellness initiatives. Make statewide programming resources available via the internet.	I4A notes that DA currently plans activities for National Nutrition Month as suggested in performance measures for this objective. Further, it is unclear how DA will be able to document that engaging other state agencies in health and wellness initiatives, e.g. INShape Indiana, actually results in specific, measurable improvements in the health status of older adults and people with disabilities. While I4A supports overall health promotion, I4A is unaware of evaluations of specific initiatives such as INShape Indiana that demonstrate such improvement. I4A recommends that: DA create strategies and performance measures related to promoting and educating Medicare recipients about new prevention benefits under Medicare. DA consider additional strategies and performance measures for this objective that concretely demonstrate a direct link between health promotion and increased health status. DA include an evaluation component regarding improvement in the health status of older adults and people with disabilities should it pursue existing health promotion strategies with other state agencies. DA establish numeric goals regarding the measurable

Goal #4: Empower older people to stay active and healthy through the Older Americans Act services and the new prevention benefits under Medicare.			
No.	**Objective**	**Strategy**	**Comments**
			improvement in the health status of older adults and people with disabilities as a result of these strategies so that performance may be more easily measured. DA expedite the development of a statewide database of CDSMP programming to June 2011, as data regarding these programs can be easily accessed through the Indiana State Department of Health and I4A.
4.2	**Pursue opportunities to strengthen evidence based programming options at the local agency level.**	Expand health and wellness initiatives to include evidence based programming such as Enhanced Fitness, in addition to Chronic Disease Self Management Program (CDSMP).	

Goal# 5: Ensure the rights of older individuals and prevent abuse, neglect, and exploitation.			
No.	**Objective**	**Strategy**	**Comments**
5.1	**Pursue greater collaboration among Adult Protective Service investigators and case management entities.**	Strengthen the communication between AAAs, local Prosecutor offices, and APS investigators.	AAAs note that "APS 101" is already part of new case manager orientation and recommend that alternative performance measures be considered for this objective and strategy.
5.2	**Promote the use of the statewide APS Hotline and Consumer Complaint Process.**	Identify dissemination methods for informing the public of APS Hotline and Consumer Complaint Process.	I4A recommends that DA establish numeric goals regarding the increase in reports to APS to be realized as a result of these strategies so that performance may be more easily measured.
		Simplify the process of registering a complaint with the State.	I4A requests clarification of the term "Consumer Complaint Process" and whether it relates to APS reports only, or to more general consumer complaints. While I4A supports actions to simplify and automate reports to APS, I4A also notes that APS has a very narrow definition of complaint they will investigate. Further, each AAA already has established processes for documenting and resolving general "consumer complaints" at the local level. Typically, a AAAs lead qualify assurance professional and case managers all play a role in documenting and resolving consumer complaints. Each local AAA complaint process already includes mechanisms for taking unresolved complaints to the state level. AAAs are not aware of concerns regarding the need to simplify registering these complaints with the state. I4A would be concerned if it is the intent of DA to consolidate local complaints directly to the state level before a AAA has an opportunity to resolve a consumer complaint locally. Such consolidation would impose an additional layer of

Goal# 5: Ensure the rights of older individuals and prevent abuse, neglect, and exploitation.			
No.	**Objective**	**Strategy**	**Comments**
			bureaucracy that ultimately does not solve a consumer's problem.
5.3	**Improve the incident and consumer complaint reporting processes to provide a timely evaluation and reporting of potential fraud, abuse, neglect, or exploitation situations.**	Simplify the process of submitting and reviewing incidents.	**I4A recommends that:** The timeline for simplifying incident submission and review, and automating incident reporting through the internet be expedited for completion by June 2011 as opposed to June 2012.
		Streamline the incident review process.	

Ms. Faith Laird
July 8, 2010

In conclusion, Indiana's AAAs stress their ongoing desire and appreciation for inclusion and partnership with DA in achieving their shared vision and responsibility regarding long-term care policy and services in Indiana. I4A hopes to be a resource to DA in the continuing development of the OAA State Plan.

Respectfully submitted,

Kristen LaEace
CEO, Indiana Association of Area Agencies on Aging

4755 Kingsway Dr. • Suite 402
Indianapolis, IN 46205
317.205.9201
Fax 317.205.9203
www.iaaaa.org