Home and Community Based Services Report

Family and Social Services Administration – Division of Aging

P.L. 224-2017:
Chapter 19. Home and Community Based Services
Sec. 1. (a) Before October 1, 2017, the division shall report to the general assembly in an electronic format under IC 5-14-6 a plan to expand the scope and availability of home and community based services for individuals who are aged and disabled. The report must include the following:

(1) Evaluation of the current system of services to determine which services provide the most appropriate use of resources.

(2) Study of the eligibility assessment process, including the function and financial assessment process, for home and community based services to determine how to streamline the process to allow access to services in a time frame similar to that of institutional care.

(3) Options for individuals to receive services and supports appropriate to meet the individual's needs in a cost effective and high quality manner that focuses on social and health outcomes.

(4) Evaluation of the adequacy of reimbursement rates to attract and retain a sufficient number of providers, including a plan to regularly and periodically increase reimbursement rates to address increased costs of providing services.

(5) Migration of individuals from the A&D waiver to amended Medicaid waivers, new Medicaid waivers, the state Medicaid plan, or other programs that offer home and community based services.

List of Acronyms

AAA: Area Agency on Aging

AARP PPI: AARP Public Policy Institute

ACL: Administration for Community Living

A&D Medicaid waiver: Aged & Disabled Medicaid waiver

ADL: Activity of daily living

ADRC: Aging and Disability Resource Center

ASAP: Aging Services Access Points

CaMSS: Case Management for Social Services

CAP: Client Assessment Protocol

CDAC: Consumer-Directed Attendant Care

CHOICE: Community Home Options to Institutional Care for the Elderly and Disabled

CMS: Centers for Medicare and Medicaid Services

COPD: Chronic Obstructive Pulmonary Disease

DA: Division of Aging

DCS: Department of Child Services

DDRS: Division of Disability and Rehabilitation Services

DFR: Division of Family Resources

DMHA: Division of Mental Health and Addiction

DOL: Department of Labor

DSW: Direct Service Workers

FI: Fiscal intermediary

FFY: Federal Fiscal Year

FMAP: Federal Medicaid Assistance Percentage

FSSA: Indiana Family and Social Services Administration

GRACE: Geriatric Resources for Assessment and Care of Elders

HCBS: Home- and community-based services

HEA: House Enrolled Act

I&R/A: Information, referral & assistance

IADL: Instrumental activity of daily living

IHCDA: Indiana Housing and Community Development Authority

ISDH: Indiana State Department of Health

LIHTC: Low-income housing tax credit

LLC: Limited Liability Corporation

LOC: Level of care

LTSS: Long-term services and supports

MAC: Medicaid Administrative Claiming

MFP: Money Follows the Person

MCO: Managed care organization

MLTSS: Medicaid managed long-term services and supports

MMIS: Medicaid Management Information System

NCI-AD: National Core Indicators for Aged and Disabled

NPA: Nurse Practice Act

NWD: No Wrong Door

OAA: Older American's Act

OMPP: Office of Medicaid Policy & Planning

OOR: Owner-occupied rehabilitation

PACE: Program of All-Inclusive Care for the Elderly

PASRR: Pre-Admission Screening and Resident Review

PCT: Person-centered thinking

PE: Presumptive Eligibility

RUGs: Resource Utilization Groups

SFY: State Fiscal Year

SOP: Standard operating protocols

SSBG: Social Services Block Grant

SSI: Supplemental Security Income

TBI: Traumatic brain injury

TSAO: Tailored Supports for Older Adults

Executive Summary

House Enrolled Act (HEA) 1493 requires the Division of Aging (DA), of the Indiana Family & Social Services Administration (FSSA), to prepare a report that details a plan to expand the scope and availability of home and community-based services for individuals who are aged and disabled. The requirements of the report are as follows:

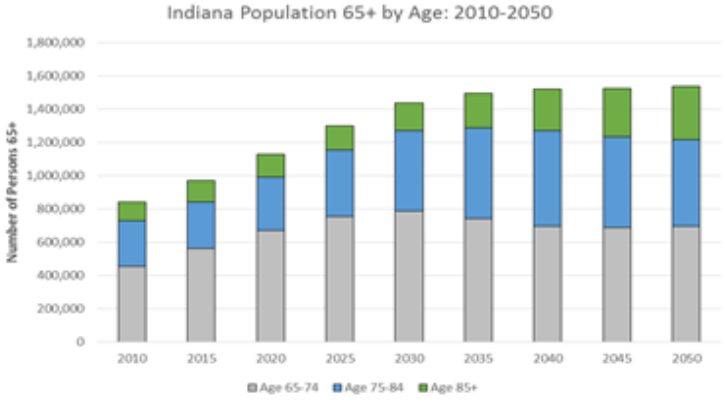
1. Evaluation of the current system of services;
2. Study of functional and financial eligibility process;
3. Identification of options for services and supports that are cost effective, high quality, and focus on social and health outcomes;
4. Evaluation of reimbursement rates including rate methodology; and
5. Review of potential migration of individuals from one waiver to another or one service from another should that be necessary.

FSSA DA has built this report upon a robust stakeholder engagement process and is committed to ongoing dialogue and engagement of stakeholders throughout this system as we develop and implement future changes leading to the expansion of publicly-funded home- and community-based services (HCBS) in Indiana.

Indiana has observed major systemic changes over the last nearly four decades. These include (but are not limited to) massive changes in health care that intersect with long term services and supports (LTSS), and the growth in Medicaid as the largest payer of all LTSS, both in Indiana and the United States at large. The largest change is still unfolding: the aging of the Baby Boomer generation.

This generation is an ongoing force of change in American society since their youth, both through sheer numbers and culturally. By the year 2020, 17% of all Hoosiers will be age 65 or older. In 62 of Indiana's 92 counties, that figure will exceed 20%.

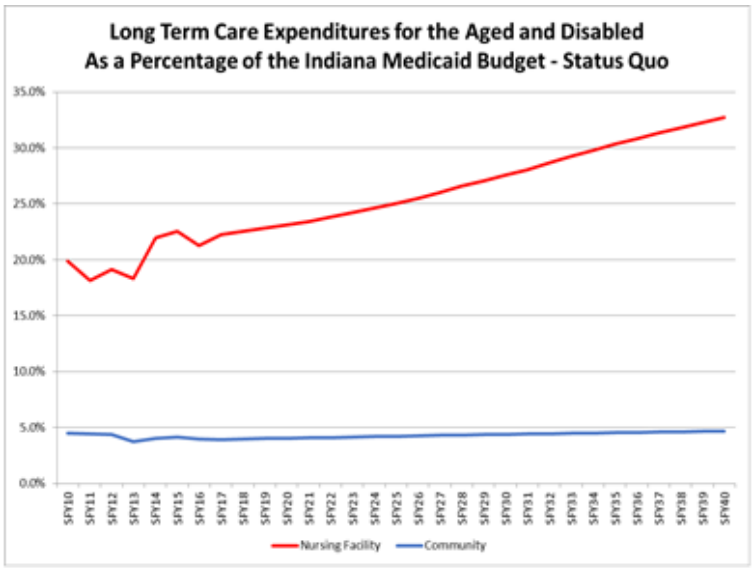
Indiana Age 65+ Population Growth, 2010-2050



Data Source: Milliman Forecast

Based on the demographics alone and assuming no changes to state or federal policy, total LTSS expenditures for the nursing facility eligible Medicaid population will account for 37% of the total Medicaid budget by 2040.

Stakeholder Comment: "We've always been able to map things for boomers. We needed more grade schools, we needed more high schools. Now we need more dementia care." – Geriatrician



Data Source: Milliman Forecast

Across the United States, we have observed a significant shift in Medicaid spending frequently referred to as "rebalancing" of Medicaid-funded LTSS. The objective in many states has been to shift the balance of Medicaid LTSS expenditures from institutional settings to services provided in one's home or a community-based setting. This shift in the balance of spending is not only driven by the demographic changes in the population but also by legislative and regulatory changes to provide services in settings that are more inclusive and integrated into the community as well as people's preference to "age in place" and stay out of institutional settings. 94.9% of online survey respondents to DA's stakeholder survey indicated that remaining in their own home as they age was very important to them.

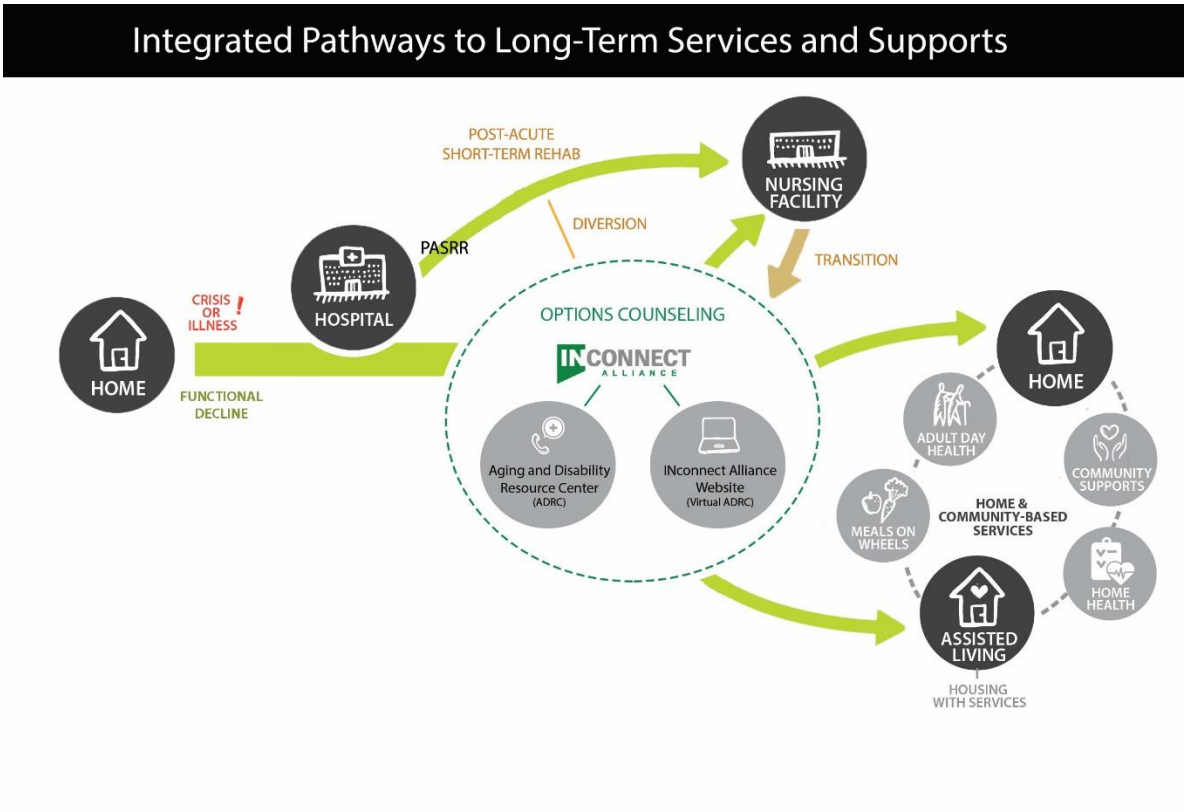
Indiana ranks 45th among all states in the proportion of Medicaid-funded LTSS dollars on HCBS settings versus institutional LTSS, well behind the national average. In an effort to create a more person-centered system that meets the needs and expectations of consumers and their families, this report outlines a vision for a future state that provides efficient and effective access to services and supports when individuals need them, provided in homes or in community based settings, prevents or delays nursing facility placement, and maximizes an individual's ability to remain as independent as possible within their community.

Steps Indiana chooses to take to move toward this vision are predicated on:

a) Provide for high quality and cost effective HCBS options as alternatives to nursing facility placement;
b) Support caregivers' ability to provide ongoing informal supports;
c) Mitigate direct care workforce challenges;
d) Reduce fragmentation in systems of access and oversight.

e) Promote informed decision making and improved social and health outcomes through needs-based, person-centered practices.

Increasing access to HCBS as an alternative to nursing facilities means that the pathways by which people access information and services need to be more visible, integrated, and consistent. This is characterized by the diagram below, which depicts the role of access to high quality information and options counseling through INconnect Alliance in facilitating people's access to the full range of LTSS available in Indiana.



As a result of extensive stakeholder engagement and qualitative and quantitative research conducted through this process, FSSA DA presents a set of potential next steps within this report. It is our hope that effort and engagement resulting from this report brings this alignment and supports action toward a system that ensures the full participation of all people in community life, the same as people without disabilities.

	High Level Goals					Implementation Considerations				
Suggested Action Steps (in order of appearance, with page number)	**Provides for availability of HCBS options**	**Supports caregivers**	**Mitigates workforce challenges**	**Reduces fragmentation**	**Informed decision making/person-centered**	**Legislation Change Required**	**Indiana Administrative Code Change Required**	**Waiver or State Plan Change Required**	**Estimated timeline to implement**	**Already in progress**
1. New Medicaid service option for support services in congregate settings, i.e. housing with services as described in IC 12-10-15. (p. 26)	•		•	•		•	•	•	9 months	•
2. Enhance the current dementia care or specialty care competencies. (p. 26)	•				•		•	•	9 to 18 months	
3. Create a State Plan on special needs housing. (pp. 28-29)	•			•					12 months	
4. Combine the waiver service and State Plan home health prior authorization processes. (p. 34)	•		•	•			•	•	12 months	
5. Review the use of Medicare home health hours as part of the State Plan home health prior authorization process. (p. 34)			•	•					6 months	
6. Align understanding of scope of practice regulations (p. 35)			•	•	•		•	•	6 to 9 months	
7. Increase the use of the healthcare coordination service on the A&D waiver. (p. 35)	•			•	•		•	•	9 months	•
8. Raise the standards for case managers and the expectations for levels of coordination between care providers. (p. 38)	•			•	•		•	•	9 months	•
9. Expand the use of consumer-directed care and structured family care. (p. 40)	•		•		•		•	•	9 to 18 months	
10. Convene a workgroup to review overlap in process, clarify roles, identify changes to the oversight process, or organizational structures. (p. 41)				•					6 months	
11. Explore ways to create more universal waiver programs – children's services waiver; roll TBI into existing waivers. (p. 42)	•			•	•		•	•	18 to 24 months	•

12. Develop a Medicaid HCBS program focused on at risk individuals not yet at nursing facility level of care. (p. 44)	•	•	•	•	•		•	•	18 to 24 months	•
13. Select and implement an evidence based caregiver assessment tool and new caregiver support services. (p. 45)	•	•			•		•	•	18 to 24 months	
14. Maintain more than adequate approval levels to assure that all those who qualify can access A&D Medicaid waiver services. (p. 45)	•								ongoing	•
15. Establish a more streamlined process that allows persons to access HCBS while the financial eligibility determination process is occurring. (p. 53)	•			•	•	•	•	•	18 to 24 months	
16. Implement an options counseling trigger for individuals staying longer in nursing facilities. (p. 58)	•				•		•		6 months	•
17. Train medical staff and discharge planners to educate individuals about all LTSS options. (p. 58)	•				•		•		6 months - ongoing	•
18. Amend Indiana's State Plan to add services such as targeted case management and other transition supports. (p.61)	•				•		•	•	12 months	
19. Continue marketing and branding of INconnect Alliance brand (p. 61)	•	•		•					ongoing	•
20. Build partnership with Indiana 211 for community resources and I&A support. (p.61)	•			•				•	6 months	•
21. Expand functionality of the INconnect Alliance website. (p. 61)	•			•	•				6 to 24 months	•
22. Strengthen designation requirements for INconnect Alliance members/ADRCs. (p. 62)	•			•	•		•		12 months	•
23. Create a comprehensive resource site for family caregivers, including links to training resources. (p. 62)		•			•				6 months	•
24. Pursue FMAP and MAC reimbursement for ADRC functions. (p. 62)	•				•		•	•	9 to 18 months	•

Introduction

House Enrolled Act (HEA) 1493 requires the Division of Aging (DA), of the Indiana Family & Social Services Administration (FSSA), to prepare a report on home- and community-based services (HCBS). The requirements of the report are as follows:

- Evaluation of the current system of services;
- Study of functional and financial eligibility process;
- Identification of options for services and supports that are cost effective, high quality, and focus on social and health outcomes;
- Evaluation of reimbursement rates including rate methodology; and
- Review of potential migration of individuals from one waiver to another or one service from another should that be necessary.

The report is organized into six sections:

1. Background: a general review of the delivery of long-term services and supports (LTSS) including HCBS, demographics, budget, and other challenges in the provision of LTSS to Hoosiers.
2. Services: a review of expenditure data, policy information, and oversight considerations for the most utilized services by Medicaid HCBS waiver participants.
3. Reimbursement: an evaluation of rates and rate methodology.
4. Eligibility Policies and Processes: an evaluation of the processes by which individuals are determined to be eligible for HCBS participation prior to services starting.
5. Pathways to Services: a report on the paths that people take into LTSS and an introduction to a "No Wrong Door" system of access that integrates and streamline these paths.
6. Conclusion: a summary including all suggested actions noted throughout the report. Information on the potential migration of individuals from one waiver to another is contained in Appendix A. Additional appendices as noted throughout this document provide additional detail and context to support the statements and data presented in this report.

The statute also outlines requirements for the DA to consult with stakeholders, including:

- Consumers;
- Organizations representing consumers; and
- Experts in the field of HCBS to provide insight concerning the needs of Indiana residents seeking services and supports to allow the individuals to remain at home and in the individuals' communities.

The DA developed a robust process to engage and consult with stakeholders in the development of this report. Details about the stakeholder engagement process are found in Appendix B. Stakeholder engagement activities included:

- Meetings with 270 total participants in sixteen areas of the state, primarily home health and personal services agencies and Area Agencies on Aging (AAA) staff;

- Two days of public comment, with input from 34 organizations and individuals;
- An online survey of potential consumers and caregivers, case managers, and HCBS providers that 1,234 persons responded to; and
- Phone surveys of 998 current Aged & Disabled (A&D) Medicaid waiver participants, age 85+, and/or their caregivers;

Additionally, DA relied on stakeholder engagement efforts from other activities, including our No Wrong Door (NWD) planning effort from 2015-2016 and the results of participation in the National Core Indicators for Aged and Disabled in 2016 (NCI-AD).

HCBS in Action

Mr. Brown is 76 years old and lives with his wife, who is his primary caregiver. Mr. Brown has been deaf since he was 5 years old. He is diagnosed with dementia, high blood pressure, chronic obstructive pulmonary disease (COPD), and iron deficiency. He requires prompting and cueing for bathing and dressing. He also needs prompts to take his medicine. Mr. Brown receives 6 hours per week (3 hours on Tuesdays and Thursdays) of attendant care under the waiver to assist with personal care needs. The attendant assists with bathing, dressing, medication reminders, meal prep, and kitchen clean up and changing linens. These services provide a much needed respite for Mrs. Brown.

This stakeholder input contributed extensively to the evaluation of the current state of HCBS in Indiana, and in the development of potential actions to address the challenges and opportunities that exist in the provision of LTSS to Hoosiers. DA is grateful to all who have participated in this process.

DA is the operating agency for HCBS for older adults and individuals of all ages with physical impairments. Funding for these services include: Older Americans Act (OAA), the Community Home Options to Institutional Care for the Elderly and Disabled program (CHOICE), Social Services Block Grant (SSBG), Traumatic Brain Injury (TBI) Medicaid waiver, and the A&D Medicaid waiver. In this report we focus primarily on the A&D waiver program because it serves older adults and persons with physical disabilities who would otherwise qualify for nursing facility level of care, and has been the primary source of growth in HCBS in Indiana over the past ten years.

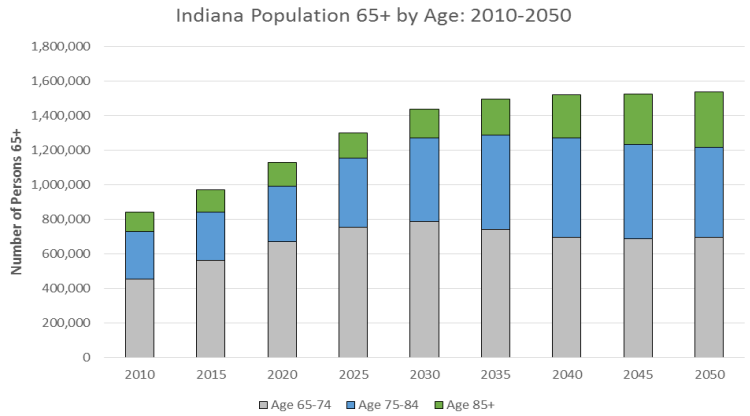
Background

In the late 1980s, Indiana legislators, advocates, and human service administrators collaborated in the design and implementation of programs and policies that emphasized HCBS. The state-funded CHOICE program, and the state's nursing facility pre-admission screening requirement are both examples of Indiana's desire to prevent unnecessary or premature nursing facility admissions.

Indiana has observed major systemic changes over the last nearly four decades. These include (but are not limited to) massive changes in health care that intersect with LTSS, and the growth

in Medicaid as the largest payer of all LTSS, both in Indiana and the United States at large. The largest change is still unfolding: the aging of the Baby Boomer generation.

Indiana Age 65+ Population Growth, 2010-2050

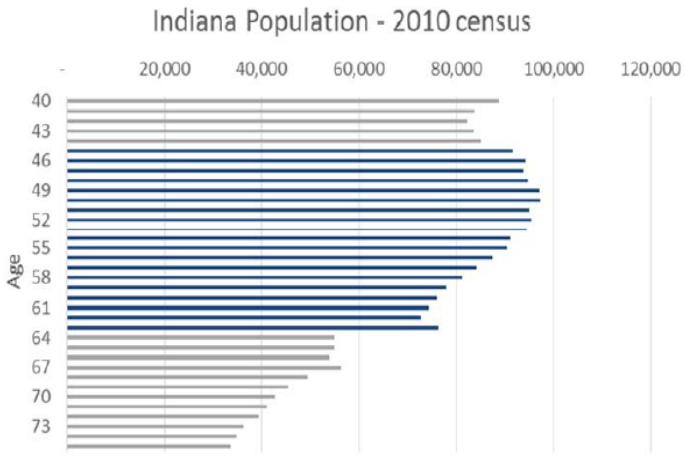


Data Source: Milliman Forecast

This generation is an ongoing force of change in American society since their youth, both through sheer numbers and culturally. By the year 2030, the entire generation will be 65 and over, with the largest population growth occurring in those 85 and older.

By 2020, 17% of all Hoosiers will be age 65 or older. In 62 of Indiana's 92 counties, that figure will exceed 20%. Data from the Kaiser Commission on Medicaid and the Uninsured suggests that 70% of persons age 65 or older will need some type of LTSS. People aged 85 and over are four times more likely to need LTSS than persons aged 65-84.

Baby Boomers have also shaped many cultural expectations since the mid-20th century, frequently referred to as the "Me" generation. For this reason, in this report, services are evaluated as "appropriate" both for cost-effectiveness, and by the manner in which they meet individualized needs and preferences of recipients.



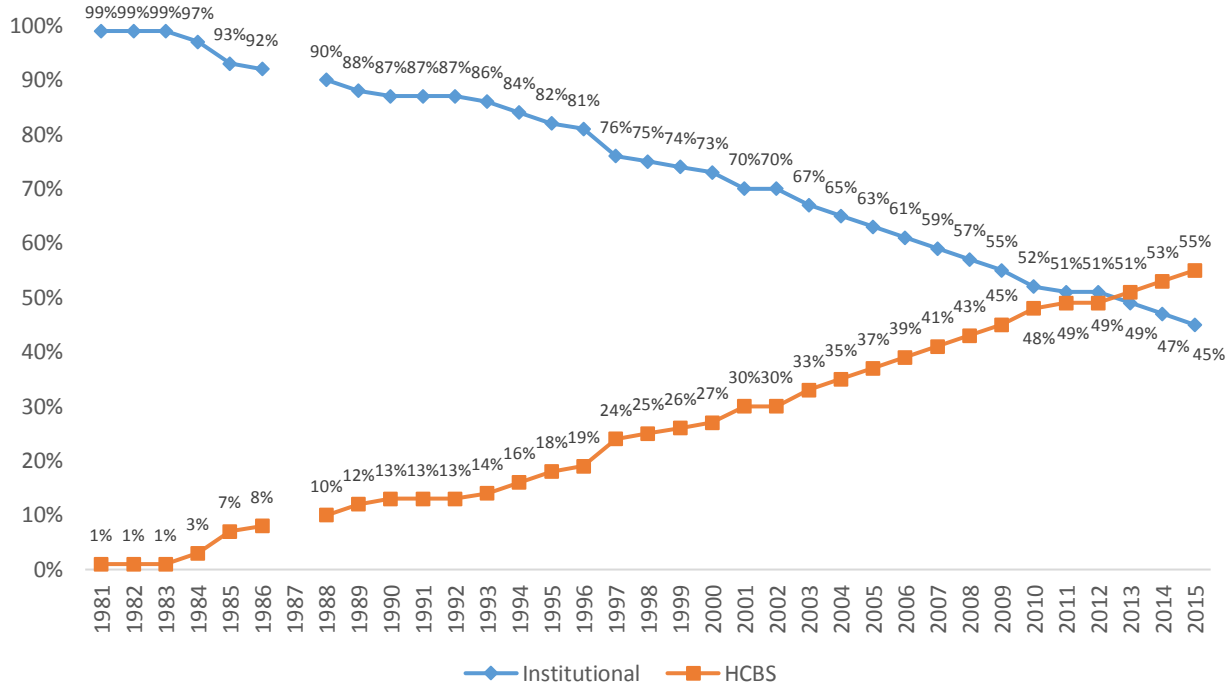
Data Source: Milliman Forecast

Across the United States, we have observed a significant shift in Medicaid spending frequently referred to as "rebalancing" of Medicaid-funded LTSS. The objective in many states is to shift the balance of Medicaid LTSS expenditures from institutional settings to services provided in one's home or a community-based setting.

According to a 2016 report from the Centers for Medicare and Medicaid Services (CMS), LTSS accounted for almost 25% of Medicaid spending with slightly over half (53%) spent on HCBS in Federal Fiscal Year (FFY) 2014. According to CMS data FFY 2013 was the crossover point – the point at which HCBS exceeded institutional care expenditures for the first time since Medicaid was enacted in 1965. As a point of reference:

- In 1980, HCBS represented less than 10% of the $13 billion in Medicaid LTSS expenditures nationally.
- By 1990, HCBS was 25% of the $70 billion in Medicaid LTSS.
- By 2014, HCBS was 53% of the $152 billion spent nationally on Medicaid LTSS.

National Medicaid HCBS and Institutional LTSS Expenditures as Percentage of Total Medicaid LTSS Spending, FY 1981-2015



Data Source: Truven Health Analytics Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015 Report.

This shift in the balance of spending is perceived as desirable for a number of reasons:

1. People's preference to "age in place" and to stay out of institutional settings; 94.9% of online survey respondents to DA's stakeholder survey indicated that remaining in their own home as they age was very important to them.
2. Legal and regulatory requirements to provide services in settings that are more inclusive and integrated into their larger communities.
3. The potential to prevent or delay premature Medicaid eligibility and/or institutionalization through early HCBS intervention.
4. More cost efficient HCBS compared to institutional care.

Indiana is well behind the national average in this area. Across all populations, Indiana spends 34% of its state and federal Medicaid dollars on HCBS versus institutional LTSS as of federal fiscal year 2015.

The legal requirement to provide services in HCBS settings is based on the 1999 United States Supreme Court decision in *Olmstead v L.C.* In *Olmstead*, the Supreme Court held that states are

required to provide community-based services for people with disabilities who otherwise would be entitled to institutional services when such placement is appropriate; the individual does not oppose such placement; and the placement can be reasonably accommodated, taking into account state resources and the needs of other individuals with disabilities. Subsequent actions have confirmed that *Olmstead* applies to nursing facility residents or persons at risk of nursing facility placement.

Other federal requirements shape the provision of HCBS, particularly Medicaid waiver programs. CFR 42 441.725 describes the requirements of a person-centered process for developing a waiver service plan. These requirements include offering HCBS setting choices and service alternatives, while capturing the participant's preferences and needs. Person-centered practices not only assure compliance with these federal requirements but also improve service alignment and delivery, positively impacts the participant's experience, and can lead to more efficient use of resources as well. A system focused on eligibility and "cookie cutter" service plans driven by a menu of services does not result in efficient or effective service plans. A person-centered process with a focus on needs assessment and with emphasis on the individual's own strengths and resources as well as their preferences can have positive outcomes for the individual and the state. The resulting service plans are driven not by eligibility and a service menu but rather by the individual identifying their unmet needs and only providing services that align to those needs.

Stakeholder Comment: Don't do for someone what they are able to do adequately for themselves. – AAA Director

CFR 42 441.710 outlines the required characteristics of an HCBS setting. This rule, often referred to as the Settings Rule, was established in 2014 and states were given until 2022 to assure that waiver services are provided in non-institutional settings per these new guidelines. Indiana has submitted a transition plan to comply with this rule. The impact of the Settings Rule falls largely on provider owned and controlled settings, both residential, such as assisted living, and non-residential, such as adult day services.

Waiver and State Plan Expenditures Among A&D Waiver Enrollees Age 22+, SFY 2016

	All A&D Waiver Enrollees, Age 22+	Per Enrollee Per Month
Waiver	$185,929,499	$1,176
State Plan	$254,303,836	$1,609
Total	$440,233,335	$2,786

Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS, SFY 2016

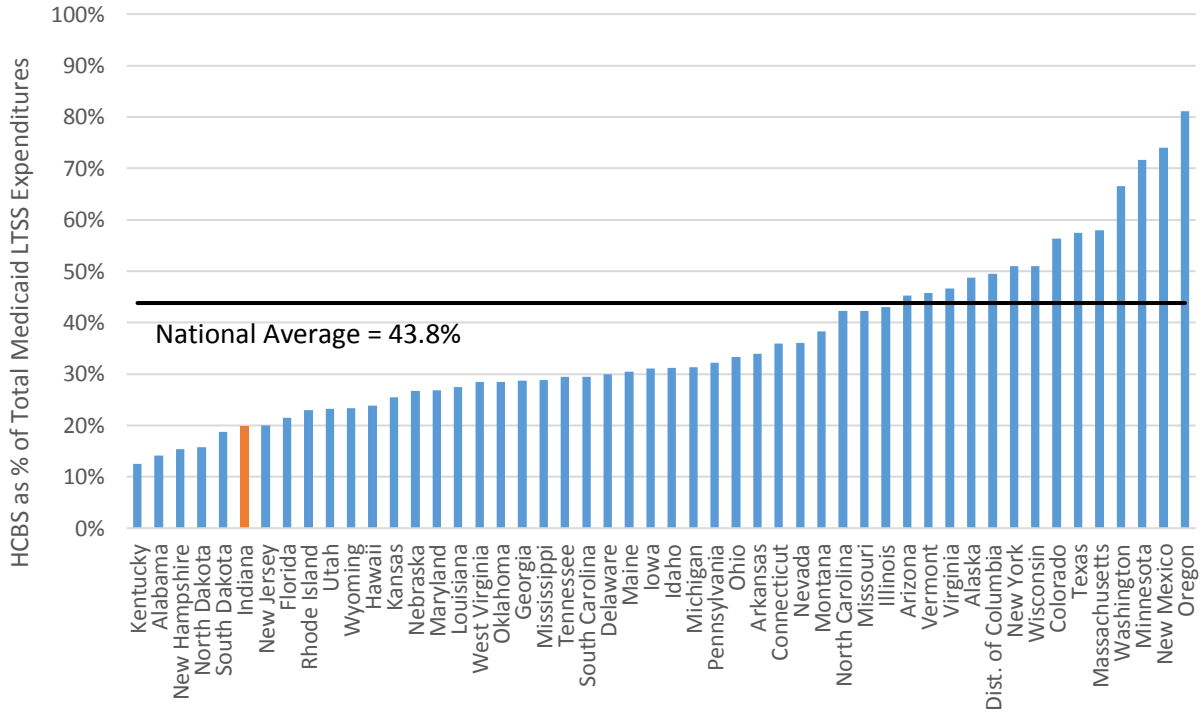
Indiana Medicaid expenditure data confirm that, generally, HCBS are less expensive than nursing facility care. According to monthly financial review data from Milliman, Indiana expenditures averaged $4,263 per enrollee per month for each Medicaid nursing facility resident. As noted in the

table, monthly expenditures for each adult participant (age 22+) on the A&D waiver were $2,786. Eligibility criteria for Medicaid funded nursing facility stays and participation on the A&D waiver are identical. Managing the costs and expenditures associated with LTSS is of critical importance to the state of Indiana when those costs are considered against the changing demographics.

Since Medicaid's inception in 1965, states have been required to provide nursing facility services as part of their State Plan, which means that all persons who meet minimum need criteria and who are eligible for Medicaid are eligible to receive those services. In 1983, Congress authorized states to offer HCBS, but these services are optional and not required State Plan benefits. As a result, in many states, including Indiana, nursing facilities are the dominant setting for LTSS delivery.

With concerted effort by families and advocates and important policy changes, the delivery system has shifted toward one that is more person-centered and focused on providing services in the home and community. Despite progress, Indiana ranks in the bottom (45th in the US) for the proportion of LTSS spent on HCBS for older adults and persons with physical disabilities (less than half of the national average).

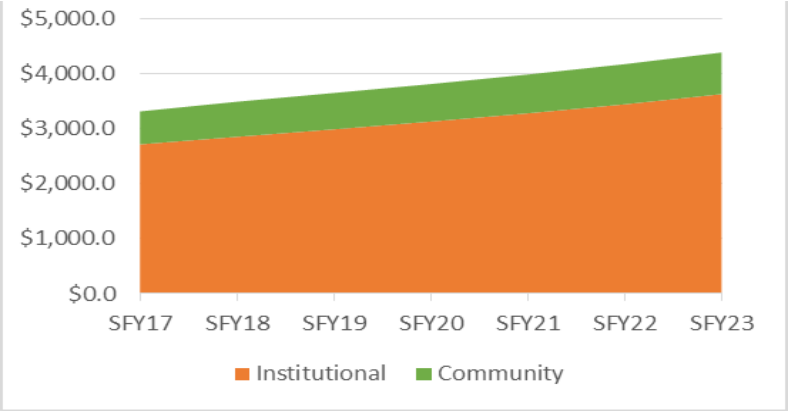
Medicaid HCBS Expenditures among Older Adults and People with Physical Disabilities



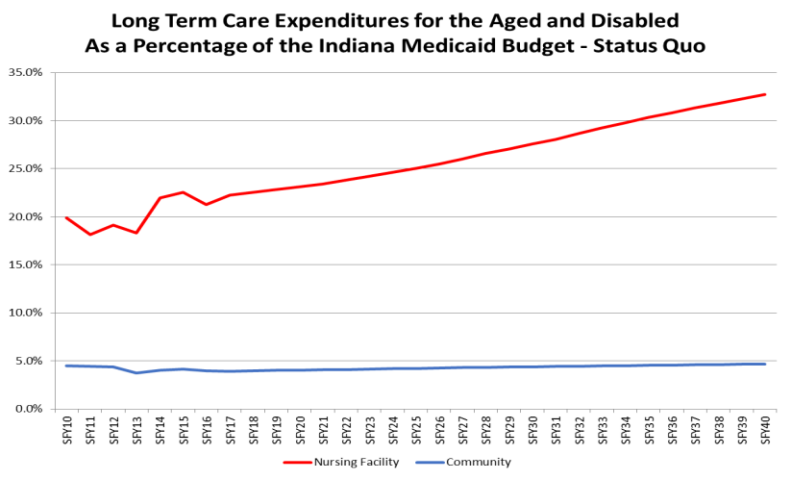
Data Source: Truven Health Analytics Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015 Report.

This graph to the right presents data on projected state and federal LTSS spending in institutional and community settings through SFY 2023. Total spending is projected to grow $1.07 billion (32% growth) based on expected changes in population demographics during this period, assuming 3% annual cost growth for institutional services, 2% cost growth for HCBS and no significant changes to policy.

Projected LTSS Spending, SFY 2017-SFY 2023 State and Federal (in millions of dollars)



Data Source: Milliman Forecast



Data Source: Milliman Forecast

Based on the demographics alone and assuming no changes to state or federal policy, nursing facility expenditures are expected to grow over time while the trend for LTSS expenditures in the community will remain relatively flat see graph to the left). Further, total LTSS expenditures for the nursing facility eligible Medicaid population will account for nearly 35% of the total Medicaid budget by 2040.

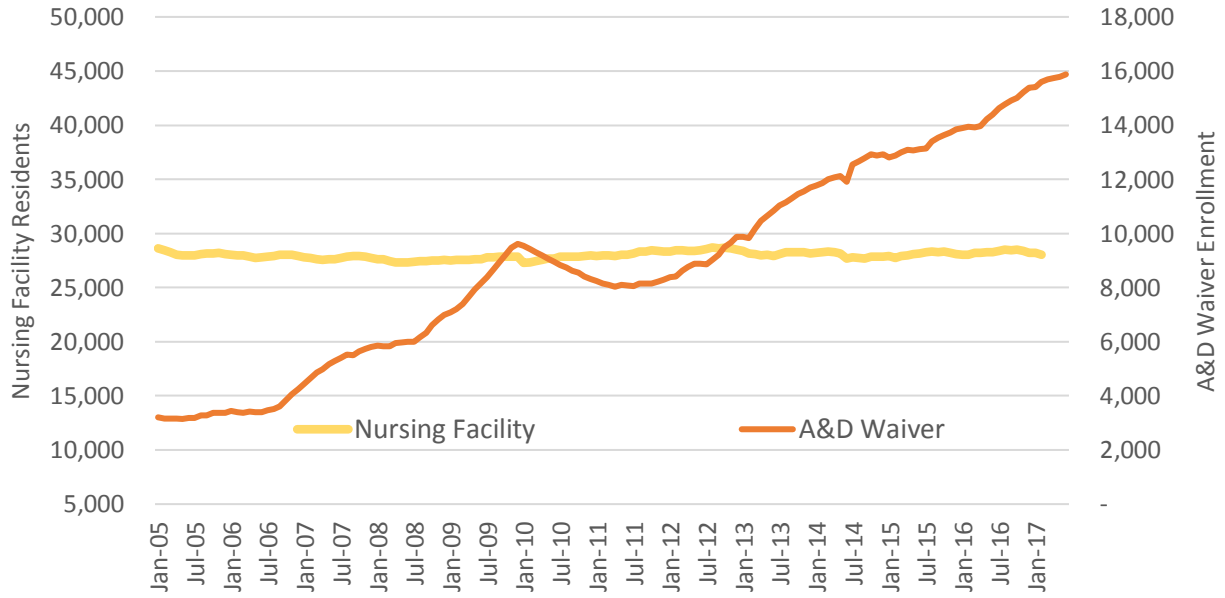
Publicly-funded services augment those supports provided informally (non-paid). For example, an older person may reside with a family member who provides day-to-day supports, but attend an adult day service while their family members are at work or school. According to our online survey, 78.8% of people currently receiving services noted that their family members or friends felt prepared in helping them with their daily activities. Most caregivers provide a wide range of supports to their loved ones. According to the online survey we conducted, the most common supports informal caregivers provide to their loved ones include: taking them shopping or shopping for them, providing transportation to medical appointments, providing social activities or companionship, and helping with household chores.

Human capital is the most critical resource in LTSS. The demographics of caregiving, both paid and unpaid, are challenging. The rate at which Baby Boomers are aging exceeds the growth of the population of younger persons available to provide care. Available information, gleaned through stakeholder input and utilization review, suggests that Indiana may already be experiencing a shortage of available workers.

Aged and Disabled Medicaid Waiver

We focus primarily on the A&D Medicaid waiver program in this report. This program has experienced the largest growth of any of DA's HCBS programs over the past ten years. The A&D waiver requires participants to have a nursing facility level of care and be eligible for full coverage Medicaid discussed in more detail later in this section. The A&D waiver has been in operation in Indiana since 1990. For many years growth was limited by wait lists and periodic "slot releases" to add participants. However, since July of 2013, there has been no wait list for the A&D waiver. Growth on the waiver has been substantial during this time. The nursing facility Medicaid resident census has remained relatively constant during this time.

Medicaid Nursing Facility Resident Count vs. A&D Waiver Participant Count



Data Source: Milliman Monthly Financials

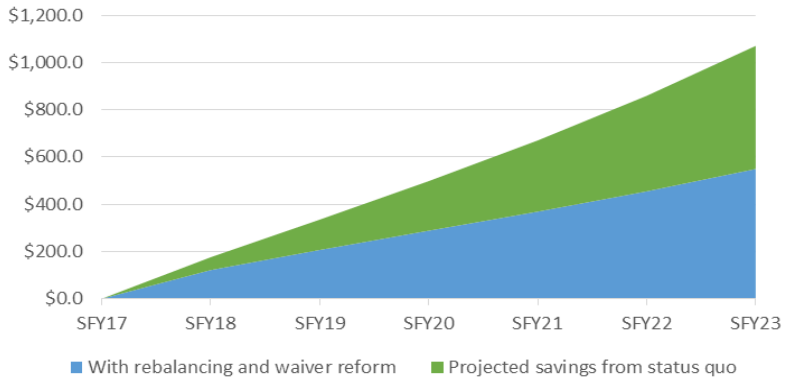
Financial Impact Considerations

There is no question about the fact that between now and 2030, Indiana will face increased expenditures for LTSS, simply because the number of people likely to use LTSS is going to increase dramatically. Projected growth of $1.07 billion in LTSS Medicaid expenditures in Indiana over the next six years represents 32% growth based on demographic enrollment growth alone. Policy and program changes now could mitigate that growth rate.

Today there are over 28,300 Medicaid recipients in nursing facilities. To achieve the shift proposed here, that number would have to be reduced to 24,300 by 2023. That is a decrease of 14%. According to analyses produced by Milliman, at the same time the current HCBS enrollment of 15,250 has to grow to 24,300, an increase of nearly 60%. HCBS enrollment has grown by similar numbers over the past 4 years already. The current system is strained already by this growth. Investments will have to be made to ensure this shift can occur, including but not limited to:

- Information technology and data to support care coordination across the system;
- Commitment to maintaining open access to the current A&D waiver to avoid wait list conditions that may push people to nursing facility care and pressure on non-Medicaid funding sources to cover gaps;
- Steps taken to insure adequate supply of providers;
- Increased levels of care coordination and utilization management through case management services;
- Funding of new HCBS programs to support people and their families prior to nursing facility level of care; and
- Funding of options counseling as a State Plan service.

Expenditure Growth from State Fiscal Year 2017 – State and Federal (in millions)



Data Source: Milliman Projections

Approximately 3% of the 1.5 million Indiana residents enrolled in Medicaid meet the nursing facility level of care requirements. These roughly 44,000 participants account for about 30% of the Medicaid budget (state and federal). They represent 33% of the state share Medicaid appropriation. Currently approximately 26% of Indiana's Medicaid expenditures are directed toward LTSS for the population meeting nursing facility level of care requirements. If no policy changes made, LTSS spending (both nursing facility and HCBS) will make up approximately 37% of Indiana's Medicaid budget by 2040. This is not a sustainable forecast for Indiana's Medicaid budget. The challenge of LTSS transformation is how to serve more people at a reduced total per capita cost so that the overall slope of these lines is reduced.

The graph above demonstrates the projected growth in expenditures if the current spilt between institutional and HCBS settings continues as is and the potential savings if we can shift more people into HCBS settings. To realize the savings reflected here, we would have to move from

almost 65% of the nursing facility level of care Medicaid populations being in nursing facilities to 50%. This graphic represents a savings of $520.8 million dollars in 2023.

There are additional ways to impact the slope of this cost curve. The largest drivers of overall expenditures are the medical State Plan services. This includes long term home health benefits, but also expenditures associated with emergency room utilization, hospitalizations, and intermittent stays in nursing facilities for many participants.

There are ways to mitigate the impact of these changes so that the increase in expenditures is less steep:

- Increase use of HCBS alternatives to nursing facilities;
- Focus on those family caregivers and support needs like housing and transportation.
- Provide support earlier before caregivers and other support systems completely breakdown;
- Manage care and service utilization, and provider certification and oversight in a more coordinated, less fragmented fashion.

There has been a dramatic increase in the number of states developing managed long term services and supports programs (MLTSS) in pursuit of similar objectives. Managed care also creates predictability in the expenditure of public dollars, and managed care entities take on the role of accountable organization. According to reports from the Kaiser Family Foundation and NASUAD, states have evidenced mixed results with MLTSS and more data is needed around the impact of MLTSS programs on satisfaction, quality of life and physical health outcomes, and cost effectiveness. Per Senate Enrolled Act 1493, Indiana is prohibited from implementing MLTSS until after December 31, 2019; however the principles of managed care can be applied in our fee-for-service environment. Whether in an MLTSS environment or a fee-for-service environment, it is important to offer a spectrum of services and supports and assure that an adequate provider network exists.

HEA 1493 asks for an evaluation to determine which services are “most appropriate” in the use of resources and in achieving quality outcomes in integrating LTSS and health care. Identifying “appropriate” services is not as simple as just comparing expenditures. The federal and legislative drivers towards home and community based settings influence what is considered most appropriate. States are expected to offer LTSS in the least restrictive settings possible.

Determination of appropriate services has to be the result of a person-centered planning process that focuses on the needs and preferences of the person. HCBS programs must offer a spectrum of services and settings to support this person-centered process. So, the appropriateness of services hinges on a number of factors:

- All costs associated with the service;
- The preference of consumers;
- The impact of workforce challenges;

- Legal obligations of the state;
- Reliance on informal supports/family caregivers;
- Impact of the service in achieve desired outcomes related to healthcare and integration of LTSS; and
- Medicaid regulations.

As FSSA evaluates services to determine which provide the most appropriate use of resources, consideration must be given to the workforce implications of various services. Congregate settings such as assisted living and adult day services provide for efficiencies of scale in meeting the needs of multiple people in one location. Structured family care relies on paid family members to meet LTSS needs. Medicaid participants who "self-direct" their own services have the ability to identify and hire their own caregiver, liberating non-traditional workforce who might not otherwise become direct service workers. This protects and extends limited workforce resources.

The themes of the suggested actions include in this report are simple:

- Provide for high quality and cost effective HCBS options as alternatives to nursing facility placement;
- Support caregivers' ability to provide ongoing informal supports;
- Mitigate direct care workforce challenges;
- Reduce fragmentation in systems of access and oversight.
- Promote informed decision making and improved social and health outcomes through needs-based, person-centered practices.

Workforce Challenges

Discussion during the 2017 legislative session centered on the role of Medicaid reimbursement in the recruitment and maintenance of an adequate, high quality direct service workforce. The landscape of factors that may impact workforce availability includes, but is not limited to: general economic conditions, demographics, regulations, and the capacity of the training pipeline to meet demand for services and support. All must be considered in the continued development and evolution of Indiana's LTSS delivery system.

A strong theme throughout the stakeholder input process was the challenge of hiring and retaining an adequate number of qualified workers to meet service needs. According to the data provided by Milliman, we expect the population age 65 and older in Indiana to increase between 2015 and 2030 by almost 43%. According to workforce data gathered by PHI, by 2024, the direct service workforce is anticipated to increase by only 23%. This suggests that the workforce will not be adequate to meet the needs of the growing population.

Direct service workers have one of the highest turnover rates among all jobs in the LTSS sector. According to the Bureau of Labor Statistics, turnover rates are 70% annually in nursing facilities

and estimated to be 50% in home care. Additionally, there are continuous concerns about continuity of services and the need for ongoing training.

Across the board, workforce challenges create gaps in service coverage and underutilization of service authorizations that have been deemed necessary for the person to remain in the community. Challenges with staffing emerged as one of the most commonly-cited concerns during provider listening sessions. Several sites noted high staff turnover. Providers from one region noted that it may be due to the inability to offer benefits such as health insurance. High turnover rates create difficulty when assessing the capacity to provide additional services to persons. NCI-AD survey results from 2016 indicate that 37% of A&D waiver participants surveyed report that their paid support staff change too much. Many providers noted during meetings with DA leadership difficulty in finding quality employees and a general need to elevate the profession and create career ladders.

In public comment for this report, a family member in Indiana described working with three home care agencies over the course of a year and more than 20 direct service workers in a six-month period to obtain support for her mom. The family member was interrupted at work two to three times a week because a direct care worker could not staff the shift. These challenges can lead to people losing or quitting jobs or turning to nursing facility placement to care for their loved one.

According to PHI, median wages for personal care aides, home health aides, and nursing assistants in Indiana are lower than for all occupations by $4.51-$6.43 per hour. Additionally, Indiana direct-care workers are only about half as likely as the general U.S. population to have health insurance. Because of these two factors, it is often difficult to employ a workforce willing to fill the gap. These conditions are exacerbated when the unemployment rates are low. In June 2017, Indiana's unemployment rate was 3.1%. According to STATS Indiana, 47 counties have unemployment rates that are lower than the state as a whole. Several of the suggested actions in this report seek to mitigate workforce challenges.

Family Caregivers

HCBS can augment the care and support provided by informal caregivers. HCBS are cost-effective relative to nursing facility care in part due to the presence of informal caregivers. In the 2016 NCI-AD survey, 62% of A&D waiver participants surveyed reported that a family member was providing additional assistance to them. 43% of those surveyed indicated that a family member providers most of their care. Simply attributing savings to Medicaid due to unpaid caregivers under values the total contribution that family caregivers or other informal supports make to meet the needs of persons with physical or cognitive challenges. According to the AARP Public Policy Institute and the National Alliance for Caregiving, nearly one million family caregivers in Indiana in 2013 provided care to an adult with limitations in daily activities

at any given point in time, and over 1.3 million provided care at some time during the year. The estimated economic value of their unpaid contributions was approximately $9.4 billion in 2013.

Information collected through the stakeholder engagement process confirms the reliance on unpaid caregivers here in Indiana. When these caregivers die, become ill, or give up due to stress or economic challenges, risk of nursing facility placement escalates sharply. Caregivers and other advocates spoke strongly about the need for education and other services that support and prolong unpaid caregivers' ability to continue in their caring role, thereby preventing or delaying nursing facility placement.

During the public comment period and in the online survey, stakeholders communicated that caregivers feel ill-equipped to safely provide some of the hands-on care that is required. They shared that the burden of caregiving can feel quite overwhelming. Caregivers shared stories of their work being impacted by the responsibilities associated with being a caregiver, including job loss. They underscored the value of services such as respite, which can provide caregivers the opportunity to have a break. The needs of caregivers are not routinely assessed by Aging and Disability Resource Centers (ADRCs), Indiana's intake point for all HCBS programs overseen by DA.

HCBS in Action

Pauline is a 75 year old woman with diagnosis of chronic renal failure, hypertension, neuropathy, arthritis, and history of stroke with right side weakness, as well as impaired vision in her right eye. Pauline receives dialysis three days a week. Pauline is confused with respect to date and time. She also reports experiencing frequent confusion or forgetfulness. Pauline has nursing facility level of care. Her specific needs include limited assistance with bathing, dressing, transfers, and ambulation. Pauline's daughter is her primary caregiver. She works full time and has teenage children. She provides care after work and on weekends. Medicaid State Plan home health hours are provided during the week while her daughter works. Waiver supports Pauline with two home delivered meals per day, homemaker services (2 hours, 3 days a week), and a personal emergency response system.

Other states have begun to develop programs to assess caregiver needs and provide targeted supports and services to caregivers. See Appendix C for information on other states' caregiver support programs. Several of the suggested actions in this report offer additional supports to caregivers.

Stakeholder comment: "It is hard to know where to start when considering the need for care giving. We get invitations all the time to attend presentations about financial planning for aging. Are there public presentations about planning for care-giving and other needs of aging in place?"
– Community Member

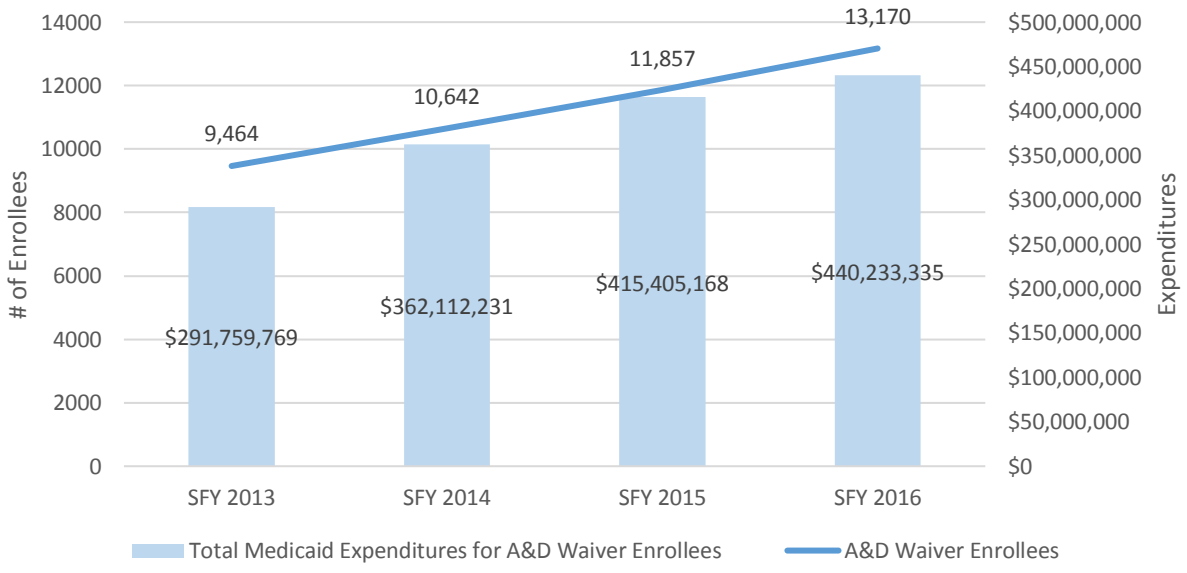
Services

Appendix D contains a listing of services available to older adults and persons of all ages with physical disabilities through Division of Aging programs, including all of the previously mentioned funding sources. The AAAs who manage OAA and CHOICE grant funds have discretion to use the funds to best meet the needs of their communities and the people they serve. Medicaid waiver services are more strictly defined. Approval is required from the Centers for Medicare and Medicaid Services (CMS) at the federal level for each service that is covered by the waiver. Changes can be made over time but the amendment process is lengthy and complex. In the survey conducted for this report, the majority (86.9%) of respondents currently receiving services noted that their services meet all or some of their needs. As part of the NCI-AD survey of 2016, 61% of A&D waiver participants surveyed indicated that their services met all their needs.

Expenditures, utilization of State Plan and waiver services

Indiana spent $440 million in total Medicaid expenditures for adults on the A&D waiver in SFY 2016 or an average cost of $2,786 per enrollee per month. A&D waiver enrollment grew approximately 40% between SFY 2013 to SFY 2016 due to increased demand and the elimination of the waiver waitlist in July 2013.

A&D Waiver Enrollment and Total Medicaid Expenditures for Adults 22+, SFY 2013-2016



Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS, SFY 2013-2016. Enrollment based on last month of each state fiscal year.

The next two tables describe the top State Plan services by total expenditures and then by total utilization. Among A&D waiver enrollees, home health topped State Plan services in SFY 2016 at $157 million or nearly 36% of total Medicaid expenditures for A&D waiver enrollees.

Physician services or the cost share for Medicare-funded physician services was the top State Plan benefit based on utilization.

Top State Plan Services by Total and Per Member Per Month (PMPM) Expenditures for A&D Waiver Enrollees Age 22+, SFY 2016

Service Type	Total Expenditures	Per Member Per Month (PMPM) Expenditures
Home Health Services	$157,446,713	$1,043
Inpatient Services	$22,085,832	$146
Prescribed Drug Services	$19,349,584	$128
Home and Durable Medical Equipment	$12,127,248	$80
Outpatient Services	$11,976,721	$79

Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS, SFY 2016.

Top State Plan Services by Utilization for A&D Waiver Enrollees, Age 22+, SFY 2016

Service Type	# of Participants Using Service in SFY 2016	% of Total Waiver Enrollees (n=16,514)
Physician Services	13,550	82.1%
Outpatient Services	11,544	69.9%
Medical Supplies	10,138	61.4%
Clinic Services	9,608	58.2%
X-Ray Services	9,513	57.6%
Home and Durable Medical Equipment (HME/DME)	8,424	51.0%
Home Health (HH) Services	8,068	48.9%
Prescribed Drugs Services	7,766	47.0%
Transportation Services	7,471	45.2%

Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS, SFY 2016. Total waiver enrollees based on unique number of participants in SFY 2016.

The two tables below list the top A&D waiver services based on expenditures and based on utilization. The waiver service with the largest Medicaid expenditures in aggregate and based on the per member per month calculation was attendant care at $71.1 million spent in SFY 2016, followed by assisted living services at $42.1 million. Case management was the most common service delivered based on measures of utilization.

Top Waiver Services by Total and Per Member Per Month (PMPM) Expenditures for A&D Waiver Enrollees Age 22+, SFY 2016

Service Type	Total Expenditures	Per Member Per Month (PMPM) Expenditures
Attendant Care	$71,098,611	$471
Assisted Living	$42,109,732	$279
Case Management	$14,349,401	$95
Home Delivered Meals	$11,526,479	$76
Homemaker	$10,791,116	$71
Respite Care (Home Health Aide, Nursing, Other)	$10,743,317	$71

Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS, SFY 2016.

Top Waiver Services by Utilization for A&D Waiver Enrollees, Age 22+

Service Type	# of Participants Using Service in SFY 2016	% of Total Waiver Enrollees (n=16,514)
Case Management	16,239	98.3%
Attendant Care	8,908	53.9%
Emergency Response	8,494	51.4%
Home Delivered Meals	7,560	45.8%

Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS, SFY 2016. Total waiver enrollees based on unique number of participants in SFY 2016.

Assisted Living

Assisted living is a service available under the A&D waiver. The service definition includes personal care, homemaker services, chores, attendant care and companion services, medication oversight (to the extent permitted under State law), and therapeutic social and recreational programming provided in a home-like environment in a congregate, residential setting.

There is no legal definition or licensure of assisted living in Indiana. The A&D waiver currently requires that providers of assisted living services are licensed as residential care facilities. Other communities in Indiana that use the term assisted living only need to submit a housing with services disclosure form to the DA; however these providers are not currently permitted to participate in the Medicaid waiver program.

In SFY 2015, nearly 80% of the assisted living population in the waiver was over the age of 65 and 94% was dually-eligible for Medicare and Medicaid. The majority (64.7%) of A&D waiver enrollees using assisted living services were above 100% FPL suggesting that many of the participants using assisted living services have benefited from the expanded eligibility afforded by the waiver (From 100% FPL for the aged, blind, disabled population to 300% FPL).

Characteristics of Assisted Living and Non-Assisted Living A&D Waiver Enrollees, SFY 2015

	Assisted Living	Non-Assisted Living
Number Enrolled SFY 2015	1,882	12,896
Age 65+	80%	56%
Dually-Eligible	94%	85%
150%+ FPL	30%	13%
Cognitive Impairment	24%	12%

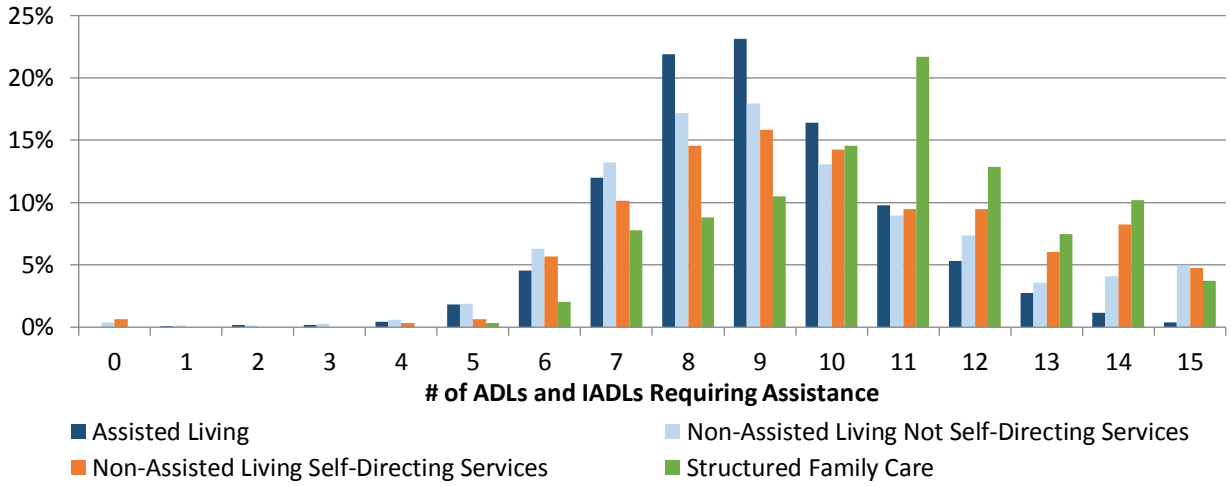
Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS and Eligibility Screen data from SFY 2015

Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) are used in the Eligibility Screen to measure functional limitations. ADLs include bathing, dressing, eating, toileting, ambulation, and transferring; IADLs include grooming and personal hygiene, medication management, light housework, shopping, transportation, telephone assistance, financial management, and meal preparation. The chart below shows the distribution of the number of ADL and IADL impairments for the A&D waiver population, organized by services

used: structured family care, self-direction, assisted living, and all others. Those who opted for the structured family care benefit have the highest functional need with a median of 11 ADL and IADL impairments combined. Those who self-direct their services had a median of 10 ADL and IADL impairments. All others in the A&D waiver (including those in assisted living) had a median of 9 ADL and IADL impairments.

While assisted living enrollees appear to have fewer physical function impairments compared to those who self-direct their services and those in structured family care, they were significantly more cognitively impaired. Approximately 24.1% of assisted living enrollees had a cognitive impairment that required supervision 24 hours a day compared to only 12.4% of non-assisted living enrollees. More than half (52%) of Indiana's assisted living enrollees were also assessed with memory impairments requiring at least daily cueing.

ADL and IADL Support Needed Among A&D Waiver Enrollees, SFY 2015



Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS and Eligibility Screen data from SFY 2015

While survey results indicate that people prefer to remain in their own homes, there are many times when the combination of needs and availability of informal caregivers make living on their own more challenging. As a result, having an array of community-based options can go a long way in offering choices to people in need of LTSS. Building upon services provided in congregate settings, like assisted living/housing with services and adult day services, may offer people another set of options to support opportunities for socialization with peers and efficiencies in service provision. Some older adults prefer such settings where they are around others of similar age and interests. Congregate settings also create shared staffing options that can reduce costs overall and provide for more flexible scheduling options. The ability to serve multiple persons in a limited physical location with fewer staff also helps to address direct care workforce shortages.

In January 2014, CMS issued a final federal rule with qualities that HCBS providers must have to meet eligibility for Medicaid reimbursement. The regulation defines what states can classify as HCBS to create consistency in HCBS delivery across states. Assuring the HCBS characteristics of these settings also enhances the quality of HCBS by ensuring people in these settings are integrated in the community and by providing them greater protections.

The goal of assisted living in the A&D waiver, as noted in the waiver provider manual, is to provide an "alternative to nursing facility admission for Medicaid-eligible persons age 65 and older, and persons of all ages with disabilities". **Implementing a new Medicaid residential service option that is more focused on the coordination of housing with service supports or housing with services as described in IC 12-10-15 can better align the existing assisted living service with the HCBS settings rule and expand the pool of available providers.** Several states have implemented housing with services certification and monitoring processes with the goal of differentiating assisted living facilities from other medical or nursing facilities.

The AARP Public Policy Institute investigated the experience of four states that used an alternative certification process for assisted living facilities and found that the removal of assisted living licensure requirements provided benefits that are very much in line with Indiana's goals for redesign: a broader range of housing options, a more home-like environment, increased access to services for people with low incomes living in subsidized apartments, and the increased ability for people to live in an assisted living environment even if they need a high level of services.

With support from multi-family housing revenue bonds and Low Income Housing Tax Credit equity, several providers in Indiana have recently developed new affordable housing for low income adults that offer co-located support services including meals, housekeeping, and medication assistance, "affordable assisted living." Expanding affordable housing options and housing with services can provide additional LTSS options for moderate and low-income persons.

While Indiana already provides services to assisted living enrollees with Alzheimer's or dementia, the state is required to amend its administrative code to ensure compliance with the Medicaid HCBS Settings Rule. Indiana also has the opportunity to **enhance the current dementia care or specialty care competencies. Examples from other states with dementia care or specialty care requirements include considerations such as program advertising, environmental design, staffing ratios, assessment and service planning, and staff training requirements**.

Indiana's adult day services offer person-centered supports to persons who want to remain in the community despite a chronic condition, providing care givers peace of mind knowing their loved ones are looked after during the day. Adult day services provide stability for caregivers and can allow them to continue working. It can also aid in maintaining a person's mental and physical

capabilities and delay their admission to a nursing facility. Adult day services can be a viable community-based option as Indiana strives to rebalance its LTSS system.

Assisted living is an option that addresses two other prevalent service needs: housing and transportation. There are other ways to addresses these needs and doing so is critical to offering people options to address their particular needs and preferences. These topics are addressed in the next section.

Housing

Nursing facility rates include room and board costs. Outside of nursing facilities, Medicaid is generally prohibited from paying for room and board expenses thus participants in HCBS maintain responsibility for housing expenses. Participants continue to pay their rent, or mortgage, and/or continue to bear the expenses associated with maintaining their home. This underscores the importance of affordable, accessible housing to sustaining community living for persons with disabilities.

People lose their housing for a variety of reasons. They may have to sell their house, or cease making rent or mortgage payments in order to meet Medicaid requirements for nursing facility care, leaving them nowhere to transition to at a later date. Further, an individual's home may not be safe, accessible, or otherwise appropriate to meet their needs once they have declined in their function or developed a disability due to age or illness. The loss of housing is a critical factor in a person's risk of residing long term in nursing facilities.

In Indiana, a person with a disability in 2014 received Supplemental Security Income (SSI) benefits equal to $721 per month. Statewide, this income was equal to 20.8% of the area median income. According to Cooper and colleagues with the Technical Assistance Collaborative, Inc., a person with a disability receiving SSI would have to pay 67% of their monthly income to rent an efficiency unit and 80% of their monthly income for a one-bedroom unit, leaving as little $33/week for food, transportation, clothing and other necessities. Within Indiana's federally defined housing market areas the cost of a one-bedroom rental unit ranged from a low of 66% of SSI payments in the Greene County housing market area to a high of 94% in the Columbus housing market area.

The low-income housing tax credit (LIHTC) program provides a federal tax credit to incentivize housing developers to create affordable housing. Indiana Housing and Community Development Authority's (IHCDA) current LIHTC portfolio (counting properties that are currently operational and those that are funded and under construction) includes over 750 developments consisting of over 52,000 affordable units statewide.

A recent trend has been the use of LIHTC along with multifamily tax exempt bonds to create "affordable assisted living." Since 2014, IHCDA has funded 12 affordable assisted living developments that will result in 1432 units. In addition, almost 200 of the developments in

IHCDA's LIHTC portfolio are age-restricted using the Housing for Older Persons Act of 1992 definition. This represents over 9200 units of age-restricted housing throughout the state, not counting the above-mentioned assisted living.

As noted previously, 94.9% of online survey respondents indicated that remaining in their own home as they age was very important to them. Modification of existing housing may enable a person to remain safely in their current home. Such modifications can range from simple assessment for things like trip hazards and the installation of grab bars, to the construction of ramps or more comprehensive modifications such as bathroom remodels to ensure safe bathing conditions. Home, or environmental modification is a service available under the A&D waiver.

Environmental modifications are minor physical adaptations to the home, as required by the participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant, enabling the participant to function with greater independence in the home, and without which the participant would require institutionalization. In state fiscal year 2016, 696 waiver recipients received modifications including accessible showers, ramps, and door widenings totaling $3,163,507.

IHCDA receives approximately $2,700,000 in annual Community Development Block Grant funds which are used for the Owner-Occupied Rehabilitation (OOR) program. Under the OOR program, a local unit of government applies to IHCDA to receive a grant and then identifies low-income homeowners in the community that are in need of home repairs. Up to $25,000 can be awarded to an individual home. IHCDA's scoring process gives preference to serving households in which at least one person has a disability, at least one member is elderly, or for families with children under six years of age.

In 2016 IHCDA launched a special version of the OOR program focused exclusively on installing ramps for homeowners with disabilities to increase accessibility in and out of the home. This special program, called Ramp Up Indiana, awards up to $25,000 in grants to non-profit entities. The non-profits then identify households in need of ramps and are responsible for undertaking the installation/construction of the ramp. $600,000 was allocated for this program and $550,000 remains available as of August 1, 2017.

Housing for seniors and other special needs populations has been an area of focus for the Indiana Housing and Community Development Authority. DA has recently begun to collaborate with IHCDA to develop solutions to some housing challenges. This collaboration has included the formation of a housing workgroup; increased promotion and utilization of housing vouchers in support of Money Follows the Person to aid people in transitioning out of nursing facilities, and the development of "affordable assisted living".

DA plans to continue to collaborate with IHCDA to develop and promote the availability of affordable and accessible housing stock. **We would suggest that all of FSSA participate in a**

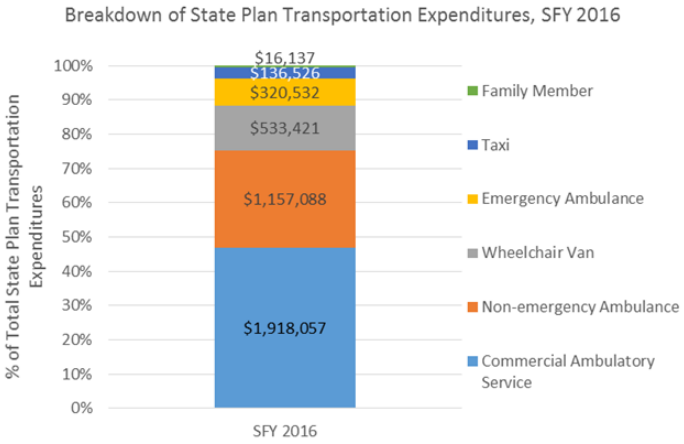
coordinated collaboration with IHCDA to create a State Plan on special needs housing. Further education is needed for options counselors on housing options and how consumers can retain their own home in a safe fashion, or to access other housing solutions. Some states have paired PACE (Program of All Inclusive Care for the Elderly) programs with housing developments; this approach may be considered in Indiana as well.

The Ramp Up Indiana program is a good example of an ADRC partnership that could result in more persons receiving targeted community based services that reduces their risk of institutionalization; however ADRC participation is limited. The DA and IHCDA hope to partner to promote the update of this program across the ADRC network and increase access to modifications that can preserve a person's ability to remain at home.

The US Department of Housing and Urban Development (HUD) recently started the Supportive Services Demonstration to test a promising housing and services model for low-income seniors to age in their own homes and delay or avoid the need for nursing home care based on the Support and Services at Home (SASH) demonstration in Vermont. This demonstration enhances the HUD service coordinator position and adds a wellness nurse to support highly vulnerable older adults in HUD-assisted housing.

Transportation

Transportation for medical appointments is a Medicaid State Plan service available to all qualified Medicaid recipients. Non-medical transportation is a service offered through the A&D waiver. Non-medical transportation under the waiver is intended to enable waiver participants to gain access to waiver and other community services, activities, and resources, specified by the service plan.



Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS, SFY 2016.

In state fiscal year 2016, there were $4,081,760 in Medicaid State Plan expenditures transportation services for 7,471 A&D waiver recipients, representing 45.2% of adults on the waiver.

In online stakeholder surveys and meetings with providers, the following transportation challenges were identified:

- Non-emergency ambulance transportation is not available in many areas of the state;
- There is an unmet need for transportation on weekends;

- Providers are unable transport people across county lines;
- People experience difficulty in coordinating medical versus nonmedical appointments; and
- There are a lack of options for persons in wheelchairs.

Results from the 2016 NCI-AD survey indicate that 84% of surveyed A&D waiver participants received transportation to medical appointments and 62% received non-medical transportation.

Transportation challenges may be under-reported by waiver participants because their transportation needs are being met by family caregivers, or by others, even service providers, who are not compensated for transportation expenses.

Stakeholder comment: People can get to the doctor's office, but can't stop at the pharmacy to pick up the prescription on the way home. – AAA Director

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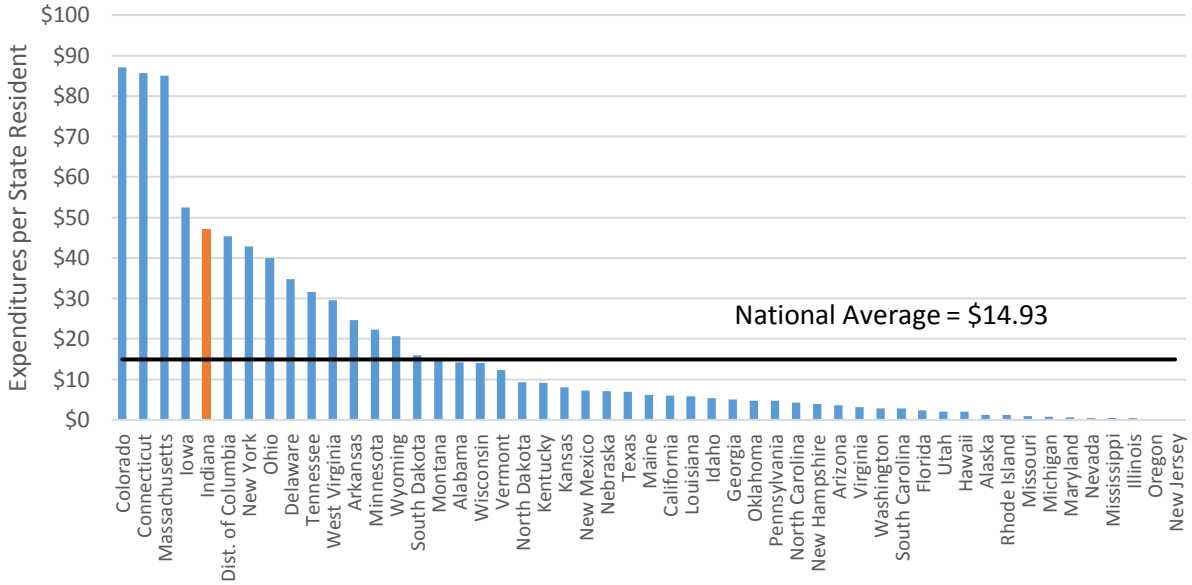
Home Health

The A&D waiver offers home health services only when used as respite. If there is no primary caregiver or the caregiver is working, attending school, or sleeping, then respite is not appropriate. However, qualified Medicaid recipients, including A&D waiver participants receive home health services under traditional Medicaid State Plan services. While Indiana is ranked near the bottom in overall HCBS spending when compared to other states, Indiana has the fifth highest level of Medicaid-funded home health spending across all states, with spending totaling over $310 million in FY 2015. Average home health spending per resident was $46.94, also among the highest in the nation.

Home Health Expenditures Per Resident by State, FY 2015



Data Source: Truven Health Analytics Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015 Report.

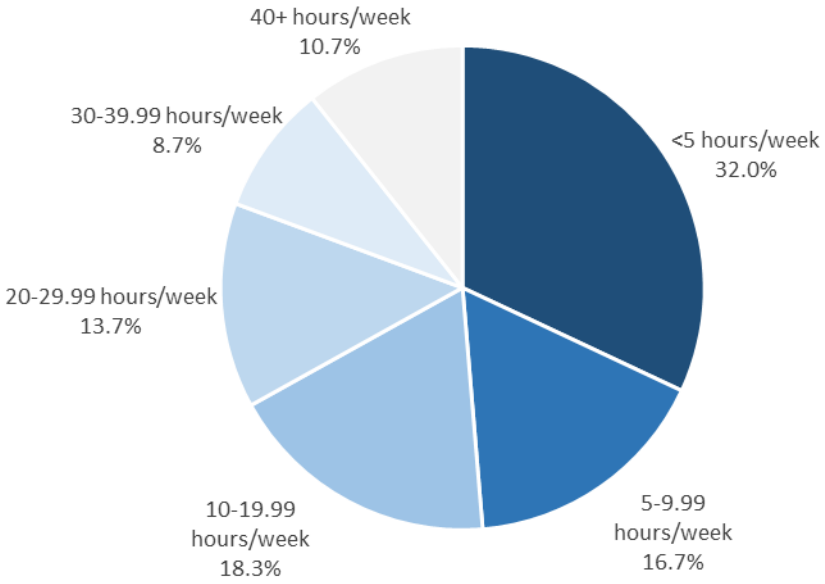
Home health spending among A&D waiver enrollees was nearly $157.5 million in state fiscal year (SFY) 2016 with A&D waiver enrollees accounting for over 70% of all home health spending. 8,068 A&D waiver participants, or nearly 49% of all adults on the waiver, used State Plan home health services in state fiscal year 2016. They averaged $1,043 per month in State Plan home health services. The majority (51.4%) of these participants used more than 10 hours per week of home health.

Home Health Expenditures By Enrollment Category, SFY 2015-2016

	SFY 2015		SFY 2016	
	Total Expenditures	**Percent of Expenditures**	**Total Expenditures**	**Percent of Expenditures**
A&D Waiver Enrollees	$211,823,062	67.6%	$209,154,449	71.2%
Other Waiver and State Plan HCBS Enrollees (TBI, FSW, CIH, 1915(i) State Plan options)	$56,013,101	17.9%	$58,357,678	19.9%
Other Medicaid Non-Waiver Enrollees	$45,653,429	14.6%	$26,315,159	9.0%
Total Home Health Expenditures	**$313,489,593**	**100.0%**	**$293,827,286**	**100.0%**

Data Source: SFY 2015 Milliman Quarterly Financial Review (June 2015) and SFY 2016 Milliman Quarterly Financial Review (June 2016).

Number of Home Health Hours Used Per Week Among A&D Waiver Enrollees, SFY 2016



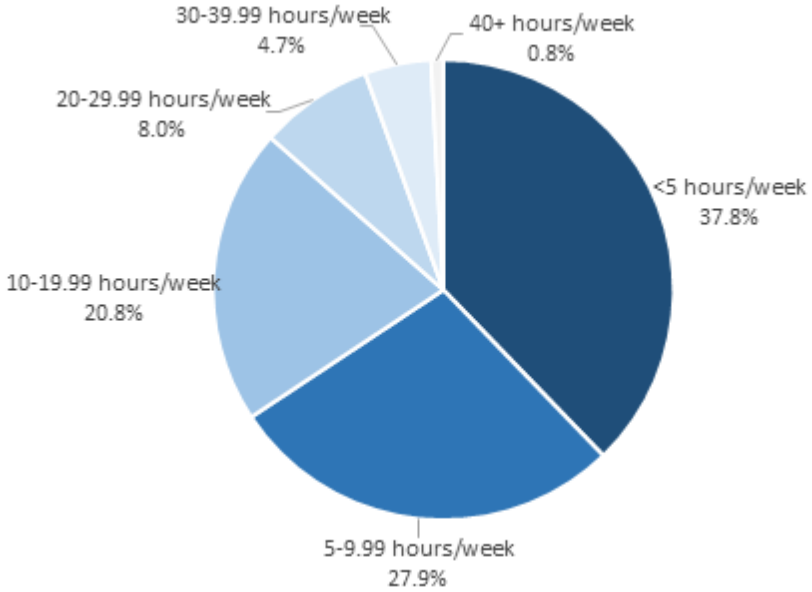
Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS from SFY 2016.

Attendant Care

Attendant care is a service available through a number of HCBS funding sources including the A&D waiver. Attendant care provides what is commonly referred to as "unskilled" assistance with activities such as bathing, dressing, toileting, etc. as well as with instrumental activities of daily living such as shopping, running errands, and other homemaking tasks. Attendant care services are provided by a licensed home health agency but this is not required. This service is also provided by a personal services agency, either one licensed through ISDH or unlicensed if serving less than seven individuals.

There were $71,098,611 in SFY 2016 expenditures for attendant care services ($471 per participant per month). In

Number of Attendant Care Hours Used Per Week Among A&D Waiver Enrollees, SFY 2016

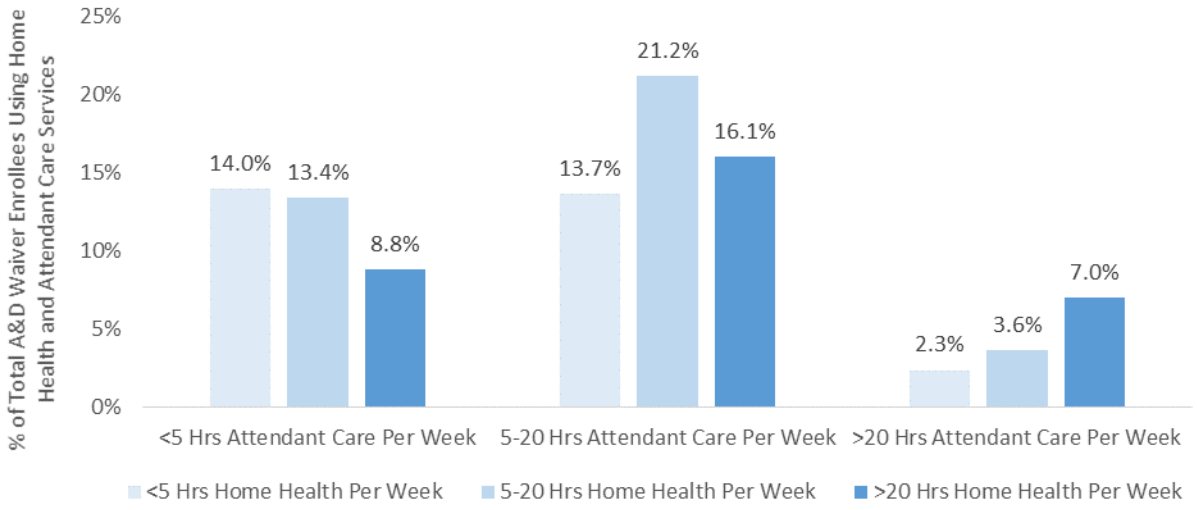


Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS from SFY 2016.

total, nearly 54% of all adults on the A&D waiver utilized attendant care services (8,908 participants). Nearly two-thirds of these participants, 65.7%, used less than 10 hours per week of attendant care.

5,182 participants, or 31.4% of all A&D waiver adults used both attendant care and State Plan home health services. In SFY 2016, this group spent 60.1% of all home health expenditures and 61.2% of all attendant care expenditures for A&D waiver enrollees. Of the participants using both State Plan home health and attendant care services the majority (62.3%) used less than 20 hours per week of both services. Only 7% used more than 20 hours per week of both services.

Distribution of Home Health and Attendant Care Use Among A&D Waiver Recipients Using Both Services, SFY 2016



Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS from SFY 2016.

Given the high cost of non-waiver services for A&D program participants, there are potential opportunities for savings through better coordination between 1915(c) waiver, Medicare (for dual-eligible participants), and State Plan services.

As discussed previously, waiver participants are heavy users of State Plan home health services. Increased coordination in the authorization and approval process of State Plan home health and waiver services could better manage utilization of these services. Savings may be realized with increased coordination coupled with a review of scope of practice regulations to assure uniform interpretations across the oversight and monitoring entities. Focusing the use of home health on those with the greatest medical need and using attendant care for those with less complex need will not only realize cost savings but will help to maximize the available workforce as well.

To bring about this sort of utilization management, plans of care must be coordinated across payer sources, to avoid over-utilization of services and LTSS must be part of a fully integrated

and coordinated approach to sustaining people in the community that prevents or reduces expenditures associated with hospital and nursing facility utilization.

Federal regulations require that waivers are payers of last resort after State Plan benefits have been maximized. Fragmentation in regulation and oversight creates conditions where interpretation of this requirement may result in unnecessary utilization of home health. Prior authorization of home health services is conducted outside of the person-centered, needs-based assessment and care planning process required for waiver participants**. Combining the waiver service and State Plan home health prior authorization processes would improve coordination of services, reduce duplication, and allow for appropriate levels of service provision.**

In light of the significant presence of Medicare-Medicaid eligible participants among those enrolled in the A&D waiver, this might include examining opportunities to maximize the use of Medicare home health benefits prior to authorizing Medicaid home health benefits. **Reviewing the use of Medicare home health hours as part of the State Plan home health prior authorization process would assure that these benefits are fully utilized before Medicaid services.**

Additional strategies to control home health spending can include putting service controls on the benefit (e.g. cap on the number of days initially authorized) or instituting cost limits for the services rendered (e.g. not exceeding certain benchmarks related to institutional cost of care or bundling payments on an episode basis).

The use of State Plan home health or nursing and waiver respite and waiver attendant care can be complicated by scope of practice issues. Interpretations can vary in what each service can provide in terms of skilled care. Indiana's Nurse Practice Act (NPA) allows registered nurses to delegate duties to licensed practical nurses and other "prepared, qualified, or licensed" individuals, although there is no additional guidance as to who other appropriate individuals might be. The nurse delegation requirements in Indiana's NPA do allow delegation, but there is no expressed protection for nurses who do delegate health maintenance tasks. States have taken some different approaches to nursing delegation:

- Oregon and Washington have included clear language in their NPAs that exempts nurses from professional liability as long as they follow NPA requirements for delegation.
- Per New Jersey Administrative Code (13:37-6.4), New Jersey has implemented a person-centered approach to delegation of medication administration, ensuring individuals' health and safety while reducing the state's risk of liability by:
    - Conducting training for the attendant worker that is specific to the medication needs of each individual;
    - Delegating the medication administration task to the attendant worker after successfully completing the training; and

    - Periodically monitoring how well medications are administered to the individual and requiring additional training when an individual's condition and medications change significantly.
- A few states have modified their Nurse Practice Acts to specifically permit otherwise qualified non-licensed personnel to perform certain health maintenance tasks (i.e., medication administration, tube feeding, bowel and bladder care, respiratory/vent care including suctioning). Per New York Code (Article 139), New York has the most advantageous Nurse Practice Act related to the provision of consumer-directed care including health maintenance activities.

It is possible that changes to the NPA may help to ease workforce challenges. However, even without those changes, a review of current Indiana statute and administrative rules might lead to opportunities to offer clarifications to language to align the perspective of oversight agencies. **A shared, flexible understanding of scope of practice regulations, particularly those defining the difference between home health and attendant care could lead to more appropriate utilization of clinical services and opportunities to expand the workforce available for HCBS.**

Other State Plan benefits that contribute to waiver participant costs include their primary health care needs. Emergency room visits, hospitalizations, and nursing facility admissions can increase these costs dramatically. Exploring care coordination models such as transitional case management to support people transitioning from hospital to home, the Financial Alignment Initiative for Medicare-Medicaid eligible enrollees, and integrated primary care behavioral health settings for people with behavioral health needs can lead to efficient and effective planning to meet the needs of the "whole person". Better coordination between the waiver program and the primary care physician may reduce these costs, or more importantly, may improve outcomes for the participant. **One approach would be to increase the utilization of the health care coordination benefit available through the A&D waiver. The health care coordination benefit allows for medical coordination by a registered nurse to manage the health care needs of the enrollee, including physician consultation, medication ordering, and development and oversight of a health care support plan.**

In a 2017 amendment to the A&D waiver, the flexibility of the healthcare coordination service was increased by allowing any entity, such as the enrollee's physician practice, with a licensed registered nurse or nurse practitioner to provide the service. Increasing the use of the healthcare coordination service on the A&D waiver through outreach and education efforts with case managers and primary care physicians will produce improved opportunities for care coordination across funding sources and across LTSS and healthcare arenas. The DA has begun the process of evaluating how best to coordinate waiver HCBS with participants' primary care physician, using a variant of the GRACE (Geriatric Resources for Assessment and Care of Elders) model, an integrated care model supporting in-home assessments for low-income seniors.

Currently the only physician involvement with waiver services is the collection of the Physician Certification Form, or the 450B form, that is required before a person can be approved to receive waiver services. The 450B does not promote coordination of care or physician collaboration. This can be accomplished more effectively through the service of health care coordination. Plus the elimination of the form may streamline the eligibility process.

Case Management and Coordination of Care

According to the Case Management Society of America, case management is defined as "*a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes*."

All participants on the A&D waiver receive case management services. The components of case management on the waiver are:

- Initial level of care (LOC) assessment;
- Development of service plans including coordination of formal and informal supports;
- Implementation of the service plan;
- Assessment and care planning for discharge from institutionalization;
- Bi-annual and ongoing reassessments of LOC;
- Quarterly assessment of individual's needs, per 90-Day Review tool;
- Periodic updates of service plans;
- Monitoring the quality of home care community services;
- Determining and monitoring the cost effectiveness of providing HCBS;
- Information and assistance services;
- Enhancement or termination of services based on need;
- Administrative guidance; and
- Participation in Medicaid Fair Hearing process.

Approximately 95% of waiver case management is provided by case managers who are employed by the AAAs throughout Indiana. There is a high degree of inconsistency, with no defined measures of quality, or desired outcomes. As seen above, case management performance is currently assessed only against compliance with meeting required waiver administrative timelines. Many stakeholders in Indiana characterize waiver case management as a largely administrative function, relating more to oversight and compliance. Waiver case managers have no role in the request or approval process for State Plan home health services. They rely on home health agencies to provide information about these services. As noted earlier, State Plan home health services are often a significant portion of the waiver participant's care. The waiver case manager also does not have a formal link to the participant's primary care physician.

Manageable caseload is one key to the ability of case managers to perform their functions appropriately; however there is little shared understanding of what an appropriate case load might be. Caseloads vary widely among case management entities. The majority (58.2%) of case managers shared that the typical caseload for a full-time case manager is more than 60 participants and 46.5% noted that the number of participants on their case load do not give them the time to meet the needs of the participants they serve.

Case management entities are paid a monthly fee for each participant on their case load. Prior to July 2013, case management was paid on a unit reimbursement basis – each unit of case management equated to a 15-minute time block. The monthly fee was calculated on average units of service claimed by case management providers. This methodology resulted in winners and losers, based solely on time spent on a case, not quality or outcomes. While predictability in expenditures was achieved, it is unclear that this change resulted in an incentive structure that positively impacted outcomes.

As reported by Truven, in 2015, Indiana spent $0.89/resident on case management services. The average across the United States for this same time was $8.06. While there was growth in total case management expenditures from 2013 through 2015, this growth is attributed to the increase in the number of participants on the Aged & Disabled Waiver. Options counseling is a variant of case management, for persons entering the LTSS system, and is included in these figures.

In the Medicaid HCBS Rule, effective March 2014, CMS specifically requires that service planning for participants under 1915(c) and 1915(i) authorities must be conducted in a "person-centered planning process that addresses health and long-term services and supports needs in a manner that reflects personal preferences." The necessity for case manager involvement in an ongoing person-centered planning process that meets the requirements of the CMS Rule will place considerable strain on the current case management system.

Adding to that strain is the requirement that states mitigate conflicts of interest in the provision of HCBS. In 2016, the DA took steps to limit conflicts of interest in the provision of direct services to Medicaid waiver participants by the AAAs.

In conjunction with the changes mentioned previously for healthcare coordination, changes will be needed in the case management service to encourage true service coordination. These enhancements could include, but may not be limited to:

- Encourage primary care physicians to participate as health care coordination providers;
- Require regular communications between the primary health care provider and waiver case manager;
- Require coordination of service authorizations, both waiver and State Plan home health services;

- Modify the case management service definition to be less administrative in nature and more focused on participant outcomes, such as reduced ER visits, hospitalizations and nursing facility stays;
- Modify case management reimbursement to limit caseloads and better incentivize quality outcomes;
- Continue development of person-centered thinking and practices to support increased requirements placed on case managers by the 2014 CMS HCBS Rule.

Raising the standards for case managers and the expectations for levels of coordination between care providers will help Indiana to manage care and outcomes to achieve the objectives of improving the participant's experience, securing better health outcomes, and reducing costs. Telehealth expansion may also aid in increased care coordination particularly in more rural areas of the state or other areas with insufficient transportation options.

Since 2011, CMS has increased requirements for states to assure that their Medicaid case management is free from conflicts of interest. This generally means that entities who perform eligibility determinations cannot also engage in the provision of direct services. Steps were taken by the DA in 2015 to limit these conflicts in the direct provision of other waiver services, most notably home delivered meals; however, work remains to alleviate conflicts of interest that may exist through the co-location of the functional eligibility assessment with the provision of ongoing case management. In states with MLTSS programs, managed care organization (MCO) contracts have stipulations on complying with Federal conflict of interest requirements and ensuring care coordination providers are not also direct service providers.

Consumer-Directed Care

The state currently offers a consumer-directed option under the A&D waiver. The Consumer-Directed Attendant Care (CDAC) program offers participants employer authority for attendant care services only. As such, participants or their authorized representative, as appropriate, assume responsibility for performing the employer tasks (such as recruiting, hiring, establishing work schedules, and training, paying, supervising, and dismissing workers) with the exception of setting the rate of pay for their attendants (set by DA) and performing the human resources and payroll functions performed by the fiscal intermediary (FI) engaged by the State. The State projected enrollment for the CDAC program at 375 participants per year for 2013-2017. Approximately 238

HCBS in Action

Linda is 60 years old and lives with her son and daughter-in-law in a mobile home. She is diagnosed with congestive heart failure, chronic obstructive pulmonary disease (COPD), asthma, chronic bronchitis and diabetes which is controlled by medication and diet. Her daughter-in-law is her primary caregiver and quit her job to assist with bathing, dressing, transfers, medication reminders, and ambulation. Linda is enrolled in the Structured Family Care service under the waiver. The agency providing this service employs her daughter-in-law to provide care. The agency also provides a monthly supervisor visit by a home care manager. In addition, a nurse visits Linda once a month. Linda's daughter-in-law maintains electronic notes about her condition and the care provided.

participants or 2% of all A&D waiver enrollees used CDAC services in June 2016. Notably, the highest proportion of A&D waiver participants choosing to self-direct receive their case management in AAA regions, 5 and 7. Approximately 80% of the population who self-direct are dually-eligible for Medicare and Medicaid.

A variant on consumer-directed care is structured family care. Live-in caregivers, usually a family member, receive a monthly stipend, to provide care and support: assisting with personal care, aiding in compliance with medical appointments, and providing appropriate social supports within the community. The caregiver completes a daily check-in to a multi-disciplinary support team, who provide coaching, technical support and intervene as needed when circumstances warrant. The caregiver may be a nonfamily member or a family member who is not the participant's spouse, the parent of the participant who is a minor, or the legal guardian of the participant.

Necessary support services are provided by the principal caregiver (family caregiver) as part of structured family caregiving. Only agencies may be structured family caregiving providers, with the structured family caregivers being approved, supervised, trained, and paid by the approved agency provider. The provider agency must conduct two visits per month to the home – one by a registered nurse and one by a structured family caregiving home manager. The provider agency must keep electronic daily notes.

Waiver and State Plan Expenditures Among Structured Family Care Enrollees, SFY 2016

	Structured Family Care Enrollees	Per Enrollee Per Month
Waiver	$10,825,030	$1,680
State Plan	$3,807,623	$591
Total	$14,632,653	$2,271

Data Source: Lewin analysis of Medicaid claims data from Indiana's MMIS, SFY 2016

Structured family care was first offered as a waiver service in 2013. In state fiscal year 2016, 674 A&D waiver recipients participated in structured family care. Expenditures for structured family care services in state fiscal year 2016 totaled $9,588,563. Structured family care participants typically have lower monthly costs than other waiver participants. The greatest difference is in utilization of State Plan home health services. Overall A&D waiver participants average $1,609 per enrollee per month in State Plan expenditures compared to $591 for those using the Structured Family Care benefit.

Stakeholder Comment: Who wouldn't prefer to personally select the person who will accompany you into your bathroom each morning? – Advocate

Consumer-directed HCBS liberates a nontraditional workforce (neighbors, friends, relatives) that would not have become direct service workers in the absence of the relationship with the person

in need of support services. Consumer-directed care can help address the shortage of direct service workers, the need for culturally and linguistically appropriate direct service workers, and the availability of services for participants residing in rural areas, as well as potentially mitigate transportation challenges. **Expanding the use of consumer-directed care including consumer-directed attendant care and structured family care can help to address the state's workforce challenges.**

According to Brown and colleagues, participants enrolled in consumer-directed programs are more likely to receive their assessed attendant worker hours than participants utilizing agency-based attendant care, a trend identified in the evaluation of the Cash and Counseling program. As noted previously, FSSA received public testimony from a caregiver using the agency based model who reported 20 different agency workers over a six-month period of time. Consumer-directed HCBS provides participants with more staffing stability including permanent or close to permanent assignment of attendant care workers in many cases.

Indiana's existing CDAC program does not allow participants to set or adjust the wage rate for the attendant workers they hire. Doing so may result in a strong indicator of joint employment for the State based on the Department of Labor Economic Realities Test as described in Department of Labor (DOL) Administrator Interpretation 2014-2. As such, the state is responsible for overtime wages when a worker provides more than 40 hours of services per week to any Medicaid waiver enrollees.

Providing participants with budget authority and allowing them to determine their attendant workers' wage rates within a range can give participants the ability to pay higher wages to their attendant workers. Allowing participants to pay higher wages can enhance the receipt of quality services and reduce attendant worker turnover. It also provides the participant, as the common law employer of their attendant workers with a high level of choice and autonomy.

Fragmentation in oversight & monitoring

LTSS are administered across multiple entities in Indiana state government. The result is a system that is perceived as fragmented and inconsistent, difficult for people to navigate, confusing and administratively burdensome to providers, and challenging to coordinate. The Office of Medicaid Policy & Planning (OMPP) is the Medicaid policy and oversight entity for all of Indiana's Medicaid programming, both State Plan and waiver. DA is the operational entity for programs that serve the aged and physically disabled. The Indiana State Department of Health (ISDH) is the regulatory entity for the majority of providers of services to waiver participants.

As described previously, A&D waiver participants are heavy utilizers of State Plan services, primarily home health. Consumers of care have little understanding of the differences between State Plan and waiver services, or the fact that their services require different types of authorization and redetermination. As discussed in the previous section on care management,

there is currently no central individual who is responsible for coordinating the total plan of care; this is one factor influencing the high rate of home health utilization.

There is regulatory fragmentation as well. The ISDH and Medicaid have different regulatory processes and definitions. Providers of personal services, hospice, and home health have expressed concerns that they face penalties for duplication of services that are very similar in scope, leading them to utilize higher certified personnel than may be required, or to withdraw services, leading to unmet needs.

A similar dynamic plays out at the organizational level. All waiver participants utilize some level of State Plan service dollars, but the lack of organizational cohesion and coordination detracts from the agency's ability to manage the program in a way that improves health outcomes, or controls expenditures effectively.

The assisted living waiver benefit is provided in licensed residential care facilities. According to ISDH residential care facilities are intermediate level health care facilities, providing limited nursing care. According to this definition, persons with nursing facility level of care are not appropriate to receive care in these settings because the facility is not licensed to provide care at that level. As noted previously, waiver participants are required to have nursing facility level of care in order to receive waiver services. This conflict has been highlighted since 2014 after the promulgation of the CMS HCBS Final Rule. DA is attempting to resolve this conflict through the development of new rules, policies and service definitions to ensure continued and expanded access to a critical service.

The oversight and monitoring of HCBS providers and service provision is fragmented among the operating divisions of FSSA, OMPP and their enrollment and prior authorization contractors, and the Indiana State Department of Health. **A workgroup could be convened to review areas of overlap in the process, clarify roles and recommend changes to the oversight process, or organizational structures.** The workgroup should also develop quality measures for HCBS and a system of tracking and sharing these measures across divisions, agencies, providers, and with the general public.

Indiana's Medicaid waiver programs are currently aligned with populations based largely on diagnosis groupings. This means that there are mental health service waivers, waivers for persons with intellectual or developmental disabilities, a waiver for those with traumatic brain injury (TBI), and waivers for older adults and those with physical disabilities. People's needs don't always fit neatly into those programmatic buckets. Older adults have mental health issues. People with intellectual disabilities and mental health issues age. The current structure creates challenges to implement true person-centered practices. These challenges are most visible in the children served with Medicaid waivers.

Indiana has higher than the national average of children with special health care needs. These children are served in a plethora of programs administered by multiple agencies including DA,

the Division of Disability and Rehabilitative Services (DDRS), the Division of Mental Health and Addiction (DMHA), the Office of Medicaid Policy and Planning (OMPP), ISDH, and the Department of Children's Services (DCS).

Creating a separate children's program may reduce fragmentation and enhance awareness of and access to children's HCBS across Medicaid waiver authorities, Medicaid State Plan services, state and federally-funded programs, and local community resources. Developing a stand-alone children's services program can allow for better coordination of services tailored to a child's needs and development and afford children and their families informed choice of setting, supports, and services.

Additionally the TBI waiver is a very small program and individuals may obtain the same supports through other DA or DDRS waiver programs. Adding these individuals to other waivers, even if additional services need to be added, can not only provide for more person-centered care but also reduce administrative burden associated to each waiver program. Documents have to be prepared and submitted to CMS for each waiver. And updates, amendments, renewals, quality assurance reports, financial reports are all waiver specific. **Exploring ways to create more universal waiver programs could reduce administrative burden across FSSA divisions and provide more efficient and effective LTSS services for individuals who have issues that do not fit neatly into the populations around which waiver programs are currently built.** Moving TBI participants into A&D and other waiver options as well as the creation of a children's services waiver would be a good first step on that path.

Stakeholder Comment: "It is SOOO hard to meet the needs of clients with mental health or developmental disabilities. They don't fit nice and neat in the box for aging services, but they often qualify." – Case Manager

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One program that reduces or eliminates participants' experience of fragmentation is the Program of All-Inclusive Care for the Elderly (PACE). PACE serves individuals who: are ages 55 or older; certified by their state to need nursing home care; able to live safely in the community at the time of enrollment; and live in a PACE service area. While all PACE participants must be certified to need nursing home care to enroll, only about seven percent of PACE participants nationally reside in a nursing home.

PACE functions like a managed care program with all care being provided by the PACE provider who receives a capitated per member per month rate through Medicare and/or Medicaid for eligible individuals. The PACE provider must cover all of their home and community based support needs as well as their medical care. If a PACE enrollee needs nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care.

Indiana has two PACE provider organizations and three sites. In 2016, the DA funded a statewide feasibility study to support the expansion of PACE programs. The DA is also collaborating with IHCDA to facilitate the coordination of PACE with affordable senior housing.

Addressing Service Gaps

As DA seeks to modernize and redesign the delivery of publicly-funded HCBS in Indiana, various opportunities and challenges exist in the pursuit of any new or amended federal authorities. Some states use different federal authorities to set different levels of functional eligibility for institutional LTSS and HCBS to divert persons with lower acuity needs from higher cost settings. Indiana currently provides HCBS to older adults under the 1915(c) waiver authority. Participants in 1915(c) waiver programs must meet the same level of functional eligibility as persons seeking admission to institutional care ("nursing facility level of care").

Section 1115 demonstration waivers afford states flexibility to test policy innovations that improve care coordination, expand access, and reduce cost. Currently according to Kaiser Family Foundation, 16 states are using Section 1115 waivers for delivery system reform, 7 for Medicaid expansion, 12 for MLTSS, 12 to enhance behavioral health services, and 15 states for expanding eligibility and providing additional services for targeted populations (e.g. persons with HIV/AIDS, pregnant women and children affected by the Flint water supply crisis). Of the 12 states using Section 1115 waivers to provide MLTSS, more than half are using the waiver to expand HCBS eligibility including supporting persons at risk of institutionalization and offering a higher asset limit for HCBS. Section 1115 waivers can be used in both managed care and fee for service systems.

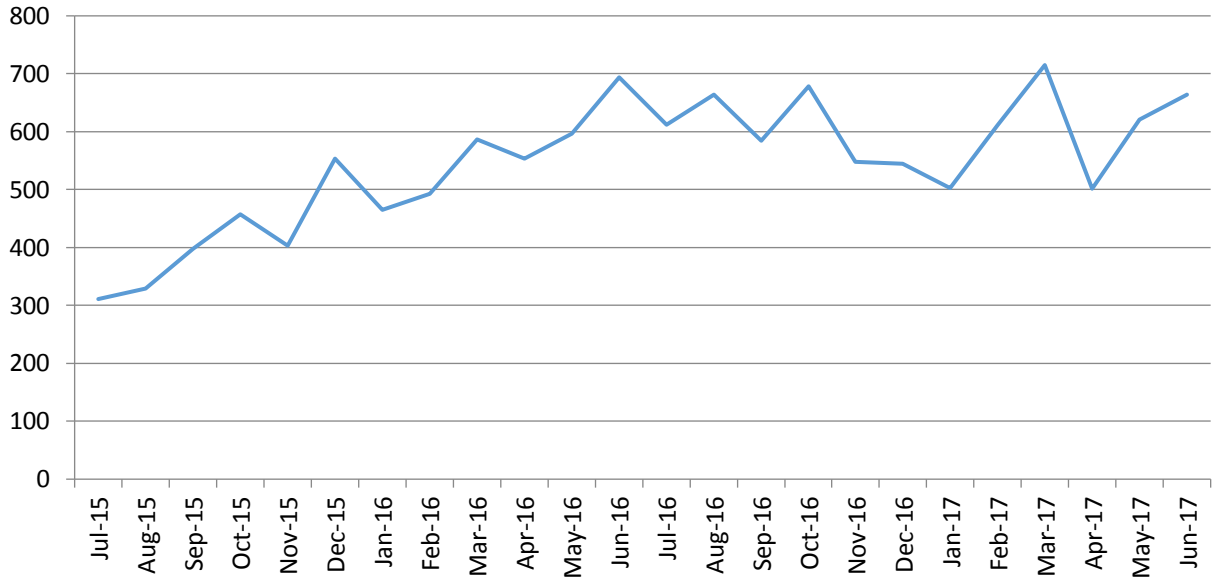
1915(i) authority establishes State Plan HCBS options and allows states to set needs-based criteria that are less stringent than institutional level of care in the belief that serving people at risk of institutionalization in less expensive settings can delay or divert s from more costly institutional services. An environmental scan conducted for DA by the Lewin Group, identified only one state (Connecticut) using the 1915(i) authority for older persons.

Washington developed a new Medicaid benefit under an 1115 demonstration waiver for persons eligible for Medicaid, but not currently receiving Medicaid-funded LTSS. This provides another option for clients and their families to choose from--primarily supporting unpaid family caregivers--avoiding or delaying the need for more intensive Medicaid-funded services. The state will also establish a new eligibility category and limited benefit package termed Tailored Supports for Older Adults (TSAO). TSAO will be for persons "at risk" of future Medicaid LTSS use and who do not currently meet Medicaid financial eligibility.

A concern frequently cited as states consider expanding HCBS is the "woodwork effect" whereby persons might access benefits they would have not otherwise prior to becoming eligible for them. Studies have shown that the woodwork effect does exist. However, well-established and managed HCBS programs can implement appropriate eligibility criteria and utilization

controls to mitigate the woodwork effect. It is evident that, as the Baby Boomer population continues to age and the state continues to rebalance the LTSS system, demand for HCBS will increase and it will be important to manage expenditures appropriately. This is another consideration in the evaluation of available federal authority options. Indiana has realized an increase in the submission of new A&D service plans over the past two years. While it is uncertain what is causing the growth, the trend does exist and continues to increase the numbers of participants over original estimates.

Submissions of New A&D Waiver Service Plans



Data Source: DA Case Management System

The development of a Medicaid HCBS program focused on at-risk individuals not yet at the nursing facility level of care could provide an effective system to ensure individuals have HCBS options as they become eligible for nursing facility care and would act to delay that decline in functional ability with targeted supports. Those supports may include consumer directed care options and family caregiver training and support, including respite. Services and/or service plan dollars would be limited as compared to the A&D waiver. Risk criteria could be identified to target those most at risk of declining functional abilities and minimize any woodwork effect. A strong, person-centered, needs-based assessment and intake process can also provide appropriate utilization control. CHOICE is a funding source currently serving this population that might be leveraged with federal Medicaid dollars, extending the ability of this state funding source to serve more individuals.

Family caregivers play an integral role in providing the day-to-day care and support that keeps people in their homes and communities. Absence or loss of a caregiver is a key risk factor for institutionalization. This suggests that the investment of resources to support caregivers may be worthwhile.

Assessment of caregivers for persons receiving CHOICE-funded services was mandated by recent legislation (HEA 1287). Supports may then be offered to maintain those caregivers in a variety of ways. **Selection and implementation of an evidence-based caregiver assessment tool and new caregiver support services will support those familiar caregivers that are contributing so much to keeping their family members at home.** Washington offers a Medicaid Alternative Care (MAC) benefit package for persons eligible for Medicaid but not currently receiving Medicaid-funded LTSS to help them avoid or delay more intensive Medicaid funded services by supporting their unpaid caregivers. Such services could be part of the 1115 demonstration waiver noted earlier. The MAC service package for caregivers includes the following services:

- Caregiver assistance services;
- Training and education;
- Specialized medical equipment and supplies; and
- Health maintenance and therapy supports (e.g. adult day health, evidence-based exercise programs, etc.).

Waiting lists and enrollment caps are allowed under the 1915(c) waiver. These have been the traditional means by which states manage HCBS expenditures. The 1915(c), 1915(i), and 1115 authorities all allow states to define and limit the target group served. A wait list for the A&D Medicaid waiver would effectively shut down access to HCBS for the nursing facility level of care population. Those in need of supports would have no real alternative to nursing facility care. **Maintaining more than adequate approval levels to assure that all those who qualify can access A&D Medicaid waiver services will provide for accessible HCBS as an alternative to institutional care.**

Reimbursement

Reimbursement considerations include service definitions, rate methodology, as well as rate sufficiency and sustainability. CMS allows each state significant flexibility in not only service

delivery, but also in reimbursement options. Per the CMS published guidance, "Rate Methodology in a FFS HCBS Structure" a variety of reimbursement methods have been approved by CMS. The most commonly developed and accepted methods of reimbursement are as follows:

- Fee schedule;
- Negotiated market rates;
- Tiered rates;
- Bundled rates; and
- Cost reconciliation.

The box inset to the right describes each of these methods in more detail.

Determination of the best rate setting methodology to adopt for each service depends upon accurate analysis that includes consideration of each methodology's advantages and disadvantages. States may also use a combination of these methods for different services within a single waiver. For adoption of a combination approach, states must detail all rate methodologies utilized in the development of their waiver services, the services that use each rate methodology approach, and how those methodologies are maintained over time. In determining the appropriate methodology, states generally need to consider the following factors, amongst others:

- Administrative burden to both the state and provider community;
- Level of complexity/transparency the state and provider community are willing to accept;
- Cost associated with monitoring the rate methodology;

Accepted Rate Methodologies

Fee Schedule
Establishes a fixed, pre-determined amount per unit for a single unit of service; the majority of HCBS waiver rates are set using this methodology; many states develop these rates using a modeled rate approach; the objective of this approach is to quantify or estimate all salary expectations, benefits, productivity adjustments, product cost, and other overhead considerations necessary to provide one unit of service; salary expectations can be derived from wage data from the Bureau of Labor Statistics (BLS), state survey information, or the actual cost experience of similar state services.

Negotiated Market Rate
Establishes the reimbursement rate at the market price of the service; there may be some negotiation on a provider by provider basis, prior to reaching an agreed-upon market price; many times, states will institute a market rate maximum (or ceiling) or annual expenditures cap for these services; HCBS types such as assistive technology, home modifications, and personal emergency response systems (PERS) typically utilize this methodology approach.

Tiered Rate
Varies payment for a service by identified characteristics of the beneficiary, the provider, or a combination of the two; the most common form of tiered rates are developed to recognize cost differences based on the acuity level of the beneficiary, by geographic region of the provider, or both.

Bundled Rates
Establishes a pre-determined rate for a fixed amount of time and includes the delivery of multiple (bundled) services; this method is useful when multiple services are difficult to separate by component, and each service contained in the bundled rate must be performed each time the initial service is received.

Cost Reconciliation
Providers receive an interim reimbursement rate for providing services; providers must file a cost report or complete a cost survey which is used to determine service cost; that cost is then reconciled against interim reimbursement and a settlement payment that is due to or from the provider is calculated; this method of reimbursement has been utilized both for State Plan and waiver services for many years, and is highly accurate but much more labor intensive to maintain for both the state and the provider community.

- Ability of the state to monitor fiscal integrity and ensure beneficiaries are actually receiving the services under the chosen methodology; and
- Determination on whether the methodology matches the service delivery method and service need.

The federal requirement is to ensure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population. CMS has identified several methods of measuring sufficiency, including benchmarking waiver rates to rates for comparable services; 2) measuring changes in provider capacity; and 3) collecting evidence from waiver appendix D "Quality Improvement: Service Plan, Sub-assurance d".

Rate sustainability measures involve keeping service type reimbursement rates in line with service provision cost over time, while also equitably distributing available funding to the service provider community. Waiver applications are approved and renewed by CMS for five-year periods, therefore waiver language must address how reimbursement rates will be paid and modified throughout the entire five-year period. The two most prevalent sustainability categories relate to provider or beneficiary characteristic rate adjustments (geographic, acuity, or specialized population rate adjustments), and inflationary or other trending adjustments.

Myers and Stauffer reviewed Indiana's reimbursement structures for six A&D waiver services:

- Assisted Living;
- Attendant Care;
- Case Management;
- Home-Delivered Meals;
- Homemaker; and
- Respite Home Health (In-Home Respite).

These six services were selected because they account for over 90 percent of A&D waiver expenditures on an annual basis. While the waiver contains a number of other vital services that are not directly addressed by this review, the areas of consideration for improvement noted in this report may be applicable to the A&D waiver program as a whole. The review included rate methodology and service definition as well as rate sufficiency and sustainability.

Each of the six A&D waiver services is reimbursed through a fixed fee schedule methodology, with the only exception being assisted living, which uses a fixed three-tier reimbursement structure based on the acuity of the participant. All A&D waiver reimbursement methodologies are commonly accepted methodologies by CMS. Information and supporting documentation related to the development of the reimbursement rates was limited in nature and was noted as one area of opportunity for improvement for FSSA.

Each A&D waiver service reviewed was compared to similar services from the five other states in CMS Region 5 (Illinois, Michigan, Minnesota, Ohio, and Wisconsin). For most services, there was at least one state with services comparable to those within the Indiana A&D waiver. The results of these comparisons can be viewed in Appendix E of this report. Most of the other five states utilized a fixed fee schedule approach for their reimbursement rates, similar to that used by Indiana. Also similar to Indiana, several other states included in the review had limited information and supporting documentation related to reimbursement rate development. For states that did have formal rate methodology, a modeled rate approach was the most common.

To benchmark A&D waiver rates against comparable services, reimbursement rate information was collected from the CMS Region 5 states. Indiana rates compared favorably in many cases. Two notable exceptions are home delivered meals and case management, which appear to have rates below other Region 5 states. For the respite home health (in-home respite) service, an additional step was taken to reconcile reimbursement rates to those for the Indiana home health agency service type due to the similar nature of the services.

To measure changes in provider capacity, claims information was compiled for a multi-year period (SFY 2013 – 2016) for the major A&D waiver services. From this data compilation the provider turnover percentage and the percentage of newly enlisted providers were determined by state fiscal year for each service type. These metrics can be viewed in Appendix F. For each of the six services, the percentage of provider turnover was relatively similar across services. Approximately 90 percent of service providers remained consistent between state fiscal years, and generally the increase of newly enlisted providers exceeded the number of providers who terminated service. These results indicate that current reimbursement rate levels continue to attract new providers, retain a sizeable consistent core of providers, and even grow service type provider capacity in most years.

The A&D waiver document "Quality Improvement: Service Plan, Sub-assurance d" describes the requirement that services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency of service. If states fail to meet this sub-assurance, it is possible that insufficient reimbursement may be impacting the state's ability to obtain adequate provider capacity, and therefore limiting appropriate access to services for beneficiaries. Indiana developed A&D waiver Appendix D, performance measure D.5 to meet the required sub-assurance. At the time of each beneficiary's 90-day review, Indiana case managers document whether the beneficiary believes that his/her service needs are being met. Should the beneficiary respond that needs are not being met, the case manager initiates a corrective action plan to remediate the identified issues. Traditionally, less than a one percent rate of beneficiaries require remediation, which far exceeds the required 86 percent compliance threshold. Current provider capacity and reimbursement rate levels do not appear to affect the ability of beneficiaries to receive services in accordance with their service plan.

Indiana A&D waiver services do not presently provide for automatic inflationary or trending adjustments of reimbursement rates. Changes to waiver fixed-fee schedule rates have historically been determined through targeted legislative budget appropriations. Assisted living is the only service type that has incorporated rate adjustments based on beneficiary characteristics, with a three tiered acuity-based payment structure. A&D waiver Appendix I-2-a, specifies the FSSA oversight activities for reimbursement rates. These oversight activities include performing biannual reviews of waiver reimbursement rates, and conferring with service specific provider associations prior to rate changes. The state recognizes there are opportunities for improvement in this process, and the state will consider establishing formal policies, procedures, and supporting documentation requirements for these oversight activities.

CMS Region 5 states were also reviewed for their methods of rate sustainability (see Appendix E). There were no consistent trends noted amongst the states. States were not consistent in applying cost-of-living or other inflationary adjustments or committing to updating reimbursement rates on an annual basis.

Indiana may want to consider revising the current rate methodology to use or benchmark rates against a model of projected service expenditures. A modeled reimbursement would use known sources of wage information, productivity adjustments, benefits cost estimates, staffing ratios and requirements, overhead cost estimates, and other service support cost estimates to develop a reimbursement rate for a service. In this process, it would be sensible to align the respite home health and respite nursing waiver services to those for the applicable State Plan services.

Formal policies, procedures, and supporting documentation requirements for the reimbursement rate oversight process need to be included in administrative rule. The process for the reimbursement rate methodology to account for increases in service costs over time, including benchmarking rates to known national or local cost and wage sources, or implementation of an inflationary index factor must also be documented.

It may be necessary to conduct service-specific provider surveys of cost experience, staffing ratios, and other cost drivers and concerns raised by stakeholders to assist in rate development and benchmarking purposes. While the reporting and collection of actual cost experience may not be the rate methodology selected, it is still advisable for any new rate methodology to be benchmarked against current provider cost levels to ensure that base reimbursement rates incorporate appropriate cost coverage. Any proposed changes in reimbursement rate methodology would be part of a waiver renewal process and subject to public comment. Advance conversations with stakeholders would be advisable as changes are being considered.

The purpose of this report is to support expansion of HCBS options in Indiana. The older adult population will experience significant growth over the coming years due to the Baby Boomers reaching age 65 and beyond. Older adults are the primary users of LTSS. Additionally persons with physical disabilities, intellectual disabilities, and mental health issues are living longer than

in previous generations. This all means that expenditures for LTSS are going to increase. That is not avoidable.

Eligibility Policies & Processes

In this report we focus on the eligibility policies and processes for the A&D waiver. See Appendix G for details on eligibility criteria for other HCBS funding sources.

HCBS Funding Sources for Individuals with Physical Disabilities and Older Adults

Medicaid Waiver:

- Aged and Disabled Medicaid waiver (A&D)
- Traumatic Brain Injury Medicaid waiver (TBI) Services no more than 200 people annually.

Grant funds distributed to the AAA/ADRC organizations:

- Community and Home Options to Institutional Care for the Elderly (CHOICE)
- Older Americans Act (OAA)
- Social Services Block Grant (SSBG)

Eligibility is primarily age determined (age 60 or older) but there are also targeting criteria permitted in order to direct limited funds to persons deemed most at risk for institutional placement. These criteria include advanced age, rural settings, minority status, poverty level, and dementia. CHOICE is an entirely state funded program. Eligibility standards were recently changed by legislation in the 2017 session. Eligibility requires impairments in activities of daily living, like bathing, dressing, ambulation, etc. or other factors like recent hospitalizations, falls, or loss of a caregiver that create greater risk of institutional placement.

There are two elements of eligibility for the A&D waiver: functional eligibility and financial eligibility. Functional eligibility is the determination of whether a person meets nursing facility level of care. This is the standard for the waiver as well as for Medicaid coverage of nursing facility services. Waiver recipients must also meet the financial eligibility standards of full coverage Medicaid participation. The financial eligibility standards for the waiver are identical to that for nursing facility services. For both nursing facility residents and A&D waiver recipients, there are two special rules applied in Medicaid determinations. The special income limit allows a person to qualify for Medicaid with a monthly income of up to 300% of SSI. Additionally, spousal impoverishment protections allows for the community spouse or non-waiver spouse to retain a portion of the shared assets.

Providers of waiver services are not authorized to start providing services until they receive a Notice of Action, upon completion of both the functional and financial eligibility determinations. Persons seeking Medicaid funded nursing facility care experience a more streamlined process. Many are already in the nursing facility, using other payers or their personal financial resources first before accessing the Medicaid benefit. Nursing facilities sometimes admit others based on the facility's evaluation of functional and financial eligibility criteria, because payment will be made retroactive to the date of Medicaid application, as long as the person is deemed eligible on that date.

Indiana's Financial Eligibility Process

The financial eligibility determination process is conducted by the Division of Family Resources (DFR) within FSSA. The Medicaid application process is automated and paperless on the state's side, but for people and their families it is a paper-driven process. People can apply for assistance online, via phone, or request a paper application. The paper version of the application is 18 pages long. A person can also access their case electronically via the on-line Benefit Portal. The Benefit Portal was developed to allow people to have access to the case 24/7, review documents received, print eligibility confirmation, check the redetermination date, and report changes.

DFR contacts the individual or the authorized representative (AR) to schedule an interview within 10 days of the submission of a valid application. A family member or even a waiver case management entity can be identified as the AR if the individual completes the appropriate form. The AR may act on behalf of the applicant throughout the application and ongoing process and receive copies of notices if the proper authorization forms have been submitted. Interviews are either conducted in person in the local county office or, more commonly, via telephone. Interviews are generally conducted within 11 days of the application date. The interview appointment notice includes a list of documents that might be needed to complete the interview. DFR determines eligibility after the interview has been completed and all eligibility factors have been verified. Per federal guidelines, DFR has 45 days from the application date to issue an eligibility determination. The average processing time for Medicaid for the Aged is 30 days and 34 days for Medicaid Disability. The overall approval rate for the Aged category is under 40%. Approved individuals average 1.65 denials each before being approved for services, the majority for issues relating to documentation. Appendix H contains a detailed flow chart of the Medicaid application process.

Many find applying for services to be difficult and complex; 65% of NWD stakeholder survey respondents disagreed with the statement that applying for services was simple and nearly 60% of survey respondents found it difficult to find the help they needed. In addition, the majority of survey respondents (58%) felt that a confusing system that is difficult to navigate was a "big problem" in accessing services and supports. Stakeholders have specifically expressed difficulty in navigating the Medicaid application process and understanding eligibility guidelines for different programs and services.

Providers highlighted the challenge of identifying resources to address short-term or emergency events for persons who need immediate care, but are waiting for approval of a Medicaid application and/or authorization for services. In some regions of the state, the local AAA may make non-Medicaid funds available to provide services during this period of time, but this practice is not consistent across the state. Many AAAs have wait lists for non-Medicaid HCBS funding sources and are not consistently able to use funds in this way.

To simplify processing of Medicaid applications for waiver applicants, an interface exists between the Medicaid waiver case management system and the DFR system; information about the waiver status of people is passed to the DFR system nightly. At one time, the DFR had a dedicated LTSS/waiver unit specialized in Medicaid applications for those in nursing facilities or on the waiver. That unit was dissolved many years ago and now all DFR staff are trained and capable of processing LTSS cases. However, DFR has a team of specialists identified in every region with extensive knowledge in the area of LTSS processing guidelines for more complex cases. Additionally the DFR is now working with a vendor to electronically obtain asset verifications instead of asking people to obtain copies of their assets (i.e., bank statements, mortgages, vehicles). Expected implementation is the second quarter of 2018.

Timely access to LTSS and other Medicaid benefits is critical for people in crisis or those discharged from hospitals to prevent undesired or unnecessary nursing facility admissions. On multiple occasions, stakeholders have inquired about establishment of presumptive eligibility (PE) for persons in need of LTSS.

Presumptive eligibility allows uninsured or underinsured individuals and their families to obtain temporary coverage quickly. PE allows providers to be reimbursed for services covered by the benefit package provided immediately after PE approval. Individuals must still complete a full application to determine eligibility for continued coverage. The groups automatically covered under this provision are those whose eligibility was simplified under the Affordable Care Act (ACA) to be based on modified adjusted gross income (MAGI). These PE requirements do not apply to eligibility groups where MAGI is not used to determine eligibility — such as the aged, blind, and disabled categories who make up the majority of waiver participants.

Some states have developed programs to allow "PE like" immediate temporary coverage for individuals in their aged, blind and disabled populations. These programs require waiver authority and have different mechanisms for state and federal funding.

Participants in Ohio may receive services on a presumptive basis for up to ninety days, funded entirely by the state. If a participant is subsequently found ineligible for services, the state does not recoup the cost of services rendered. In FY 2014, 0.17% of presumptive eligibility cases resulted in no final Medicaid eligibility determination. The 0.17% figure includes consumers who were found not to meet formal Medicaid financial eligibility, as well as participants who moved, withdrew their application, died, or moved into a nursing facility before the determination was made.

Washington has a state-funded Fast Track process that allows participants to receive services while their eligibility is being verified (maximum of 90 days if person applies for waiver services within first ten days of 90-day period). Washington also has a presumptive eligibility process for both its 1115 demonstration waivers. The cost of providing services to people who are ultimately found to be ineligible for Medicaid was exceeded by savings generated from diverting

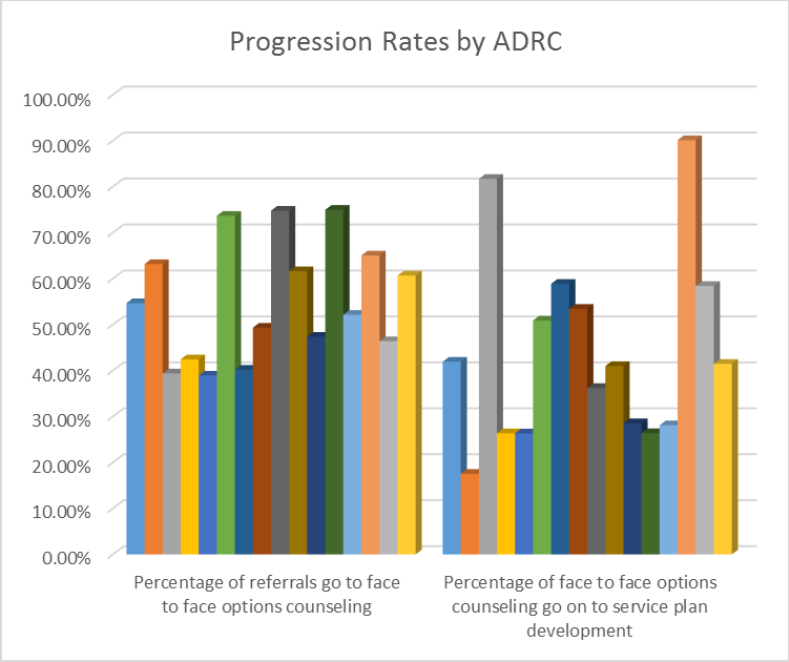
participants from institutions. As of 2006, the presumptive eligibility program cost for participants ultimately found not eligible was only $100,000.

Error rate in states (MI, NE, OH, PA, WA) allowing presumptive eligibility for HCBS enrollees is less than 2%. **Indiana might evaluate establishing a more streamlined process that allows persons to access home and community based services while the financial eligibility determination process is occurring.**

Indiana's Functional Eligibility Process

Functional eligibility determination is made by Indiana's network of ADRCs. In Indiana, all of the AAAs are designated as ADRCs, and all of Indiana's ADRCs are AAAs. These networks are synonymous. The ADRCs are the intake point for all of the HCBS programs overseen by DA.

While the formal waitlist for the A&D waiver ceased in July 2013, anecdotal evidence of functional waitlists existed throughout the state, due to the fact that many individuals had to wait weeks or months for the face-to-face visit with the case manager. The growing reliance on HCBS as an alternative to nursing facility care has created pressures on this network to act in a more timely and consistent fashion.



Until recent years, standardization of processes was not an expectation of the ADRCs, nor was there compensation that promoted the improvement of performance around timelines and consistency. In July 2016 the DA implemented ADRC contracts that utilized federal participation dollars to reimburse ADRCs for options counseling and intake processes for Medicaid-funded HCBS. The contracts contain financial incentives that promote consistency through defined activities and timeline requirements, referred to as "pay points". The DA leveraged CHOICE dollars previously used for reimbursement of some waiver intake expenses with new federal Medicaid administrative funds. The results of these contracts and the implementation of the pay points was mixed. Some ADRCs transformed their organizational structures and business processes to fully achieve the incentive payments contained in the contracts. Others did not make those changes. Additionally, there was wide variation from

ADRC to ADRC in the progression of referrals through the pay point processes. The DA attributes this variation to the variation in practices across ADRCs, and note that reliability and predictability cannot be achieved without consistency.

Plans of care must be reviewed and approved by DA staff before the waiver slot is assigned. Implementation of an "ACE" (Accuracy, Consistency, Efficiency) philosophy has allowed the DA to grow the capacity of the internal care consultant team to meet the increased pace of waiver enrollment without adding new resources. Delays may still occur in this process, if DA staff must make requests for additional information (RFIs) about the level of care determination or elements of the care plan being submitted. Substantial variation exists in the rate of need for RFIs and the response rate to RFIs among the ADRCs. Additionally, some elements in the process, such as the procurement of the 450B form (physician certification), have proven to be significant barriers to the timely approval and start of service plans. See Appendix I for more details on the functional eligibility process.

For many decades the eligibility tool for nursing facility level of care is the Eligibility Screen or E-Screen (Appendix J). The Eligibility Screen records difficulties persons have with performing ADLs and IADLs. Skilled medical needs are also evaluated in the determination of nursing facility level of care. If a person requires long-term assistance with a skilled medical need or with three or more ADLs (due to a medical condition), they are considered to have long-term nursing facility level of care resulting in eligibility for the A&D waiver. While the Eligibility Screen, per Indiana code, remains the eligibility determination tool, in July 2016, the interRAI-HC assessment tool was added to the process. The interRAI-HC assessment tool serves multiple purposes:

- It guides the assessor in gathering more detailed information about the person than the Eligibility Screen alone, which can be used for care planning and resource management;
- As an evidence-based tool, it is reliable and consistent and supports the more equitable determination of eligibility and subsequent service needs;
- The data are comparable to that which is collected by nursing facilities through the Minimum Data Set (MDS) assessment tool, which can support monitoring of ongoing level of care compliance as well as allowing for comparisons of the populations and policy planning for a large portion of the LTSS population;
- The increased clinical element of the interRAI-HC aids in the ability of the case manager to work more closely with healthcare partners to address the person's needs;
- interRAI-HC is part of a suite of assessments tools that can be expanded to other populations or to address other needs (e.g. mental health needs) in the older adult population, or persons with physical disabilities;
- It provides for Clinical Assessment Protocols (CAPs) that can assist the case manager in identifying and addressing areas of risk (not yet implemented); and

- It can support the establishment of a methodology for resource allocation, similar to nursing facility Resource Utilization Groups (RUGs).

Options Counseling

When the ADRC receives a referral from someone, the first step is to gather preliminary information, generally by phone. The focus is on assessing the person's needs through person-centered practices. Eligibility should not be the primary focus when a call is first received. Most people in need of LTSS do not need publicly funded supports, at least at first. They need information and supported decision making tools. They need options counseling.

The most significant service provided by the ADRCs is options counseling. Derived from work performed by the Administration for Community Living (ACL) to develop national standards, options counseling is defined as "*an interactive process where individuals receive guidance in their deliberations to make informed choices about long-term supports."* ACL has identified four elements of the process: a face-to-face personal interview, a supported decision-making process, development of an action plan, and quality assurance and follow up. This is a very person-centered process in which the individual's strengths, values, and preferences are identified and respected, and one that includes exploring the individual's own resources, financial and otherwise. The decision process aids in identifying all LTSS options available to the person, who should be given the information in order to make an informed decision.

Options counselors support people in understanding their LTSS options regardless of their income and financial assets and regardless whether they need waiver-funded services, informal supports, or other community resources. Options counselors may also facilitate connections to community resources, or provide less expensive, more targeted interventions that can prevent nursing facility placement, or premature Medicaid eligibility. Options counseling certainly may benefit all persons seeking LTSS at all income levels. However, the reality is that there are limited resources available along with an ever-growing need for LTSS. Therefore, based on ACL draft guidance, it is important that options counseling is "targeted for persons with the most immediate concerns, such as those at greatest risk for institutionalization."

A person with $25,000 in resources who is admitted to a nursing facility for a long term stay, will spend through their personal resources and could be eligible for Medicaid in less than six months (calculated at the average Medicaid facility expenditures cited earlier in this report). High quality options counseling can help them identify how best to use their personal resources to remain in their community and delay Medicaid enrollment for a much longer period of time. That same $25,000 in resources might support that person in the community for more than nine months, or even longer.

A pilot project recently demonstrated the value of options counseling as a service to maintain individuals in their communities. Four ADRCs tested the use of a needs-based, person-centered approach to options counseling and assessment, using expanded eligibility criteria for the state-

funded CHOICE program. The theory of the pilot was, despite the expanded functional and financial eligibility criteria, that per capita expenditures and waitlists for services could be reduced. A highly person-centered and needs-based approach was paired with referrals to community resources, and with the implementation of targeted interventions or short-term action plans to reduce a person's risk of institutionalization.

Results reflect that the pilot areas did see reduced per capita expenditures and nearly eliminated waitlists for CHOICE services; however there were significant challenges in overcoming deeply entrenched eligibility-focused approaches to interacting with people. Another key lesson learned in the pilot was the importance of standardization of business processes.

HEA 1287, another key piece of legislation this year related to LTSS, modernized CHOICE funding, based on lessons learned in the pilot program discussed earlier in this report. Functional eligibility criteria were reduced from two ADLs to one ADL, or even none, if there is evidence of a targeted need that creates risk of institutionalization. Financial eligibility was updated to increase financial participation by those with assets over $250,000. The legislation also introduced a requirement for a caregiver assessment. With these changes, CHOICE could become a significant funding source for options counseling and other ADRC activities.

One project currently underway in the DA is a collaborative workgroup that is developing consistent business processes to support the modernized CHOICE funds. This project also seeks to incorporate the Medicaid waiver intake contractual pay points into a consistent and fully integrated needs-based and person-centered approach to options counseling and assessment. All persons receiving publicly-funded services and supports must meet the eligibility criteria associated with each funding source, but one of the learnings from the pilot was that the needs-based and person-centered approach leads to less expensive plans of care, expanding the overall capacity of all public funding sources.

Stakeholder Comment: "The area that is the biggest barrier is the lack of knowledge of available services. This also leads into the access and difficulties with the eligibility process. It is a complex and sometime convoluted process for our families. Families don't care about the titles of the waivers they just want to find someone help with the immense responsibility of caring for another person" – HCBS Provider

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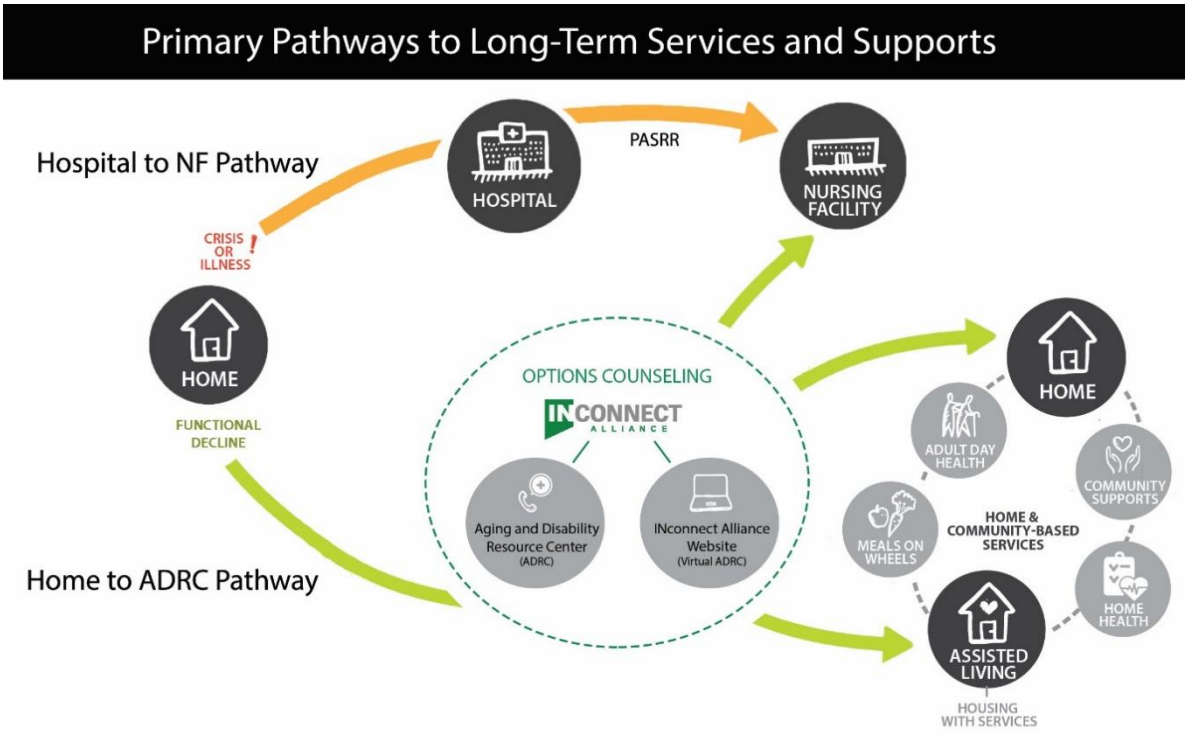
Pathways to Services

There are many doors through which people could access information and LTSS but in reality, there are two dominant pathways in Indiana: through hospitals and through the ADRC network. Both have issues. If hospital discharge planners perceive barriers to the timely availability of

HCBS options, the result is nursing facility placement. This situation is exacerbated by the pressure on hospitals to discharge people quickly, and as a result, many require post-acute or rehabilitative care following a discharge and often get that care in a skilled nursing facility. The ADRC network pathway is well versed in HCBS; however this pathway lacks visibility and is challenged in Indiana by the lack of consistency and efficiency.



The hospital pathway and PASRR

Preadmission Screening and Resident Review, or PASRR, refers to the federal requirement that persons seeking admission to any Medicaid certified nursing facility must be screened for any potential mental health or intellectual/developmental disability. A Level I screening identifies the potential diagnoses and then if findings are positive requires the completion of a Level II assessment prior to admission. The Level II assesses the possibility of diversion to HCBS and/or the need for specialized services in the nursing facility if placement is appropriate. The PASRR process presents an opportunity to engage persons in understanding HCBS options prior to potential placement in a nursing facility.

Data from 2003 to 2015 indicate a steady growth in pre-admission screens occurring in hospital settings. Many of the screens pertain to admissions for short-term rehabilitation stays and reflect people who are not in need of LTSS. To further support this trend, more than 100,000 Level I screenings were completed on nearly 81,300 persons in the PASRR process during state fiscal year 2017; 85% of whom were in hospitals at the time. Many of those admitted to a nursing

facility for short term rehabilitation and returned home soon thereafter with no ongoing LTSS needs.

Stakeholder feedback gathered in 2015 indicated concern that hospital discharge planners were not always informed of all available LTSS and unable to support persons in making informed choices about their supports and services. As a result of legislation in 2015, DA automated and streamlined the PASRR process. The new process became effective on July 1, 2016. The recently-updated process, and new Medicare requirements for discharge planners create an opportunity to improve this pathway.

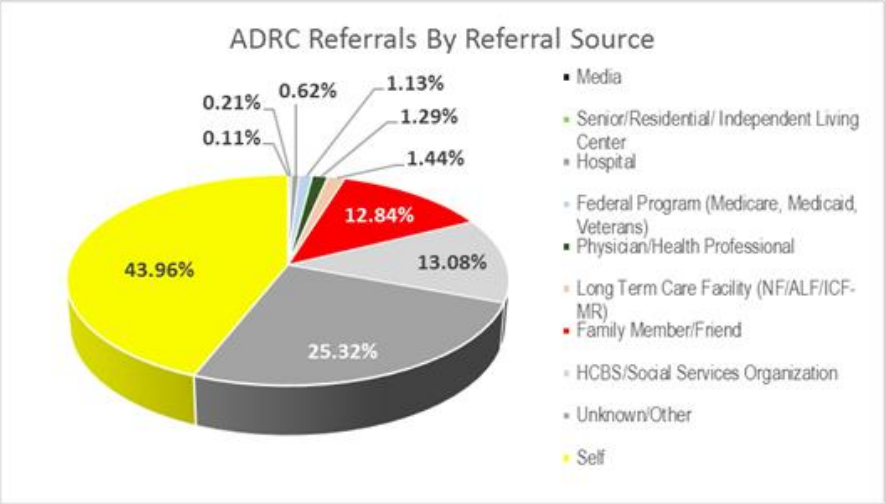
Providing robust options counseling at the point of entry into LTSS is beneficial in reducing the number who enter and remain "stuck" in a facility. Today, the vast majority of nursing facility admissions in Indiana are only for short-term rehabilitation stays that are often covered by Medicare or private insurance. For this majority, the risk of long-term nursing facility placement is low. While 95% of Medicare-only persons admitted to nursing facilities return home after their short-term rehab stay, approximately 5% remain long enough to spend down their resources to eligibility for Medicaid. Most of those remain in the nursing facility long after their rehabilitation. Data from Lewin also indicate that Medicare-Medicaid enrollees are twice as likely to remain in a nursing facility six months after admission.

Implementing the new technology solution for Indiana's PASRR program has enabled DA to identify persons at-risk who could benefit from person-centered options counseling. **Implementing an options counseling trigger based on evidence based risk factors at the point when continued nursing facility stays are requested may prevent short-term nursing facility stays from becoming long-term stays.**

Given that almost 40% of NWD survey respondents learn about support services through their medical providers (hospital, nurse, discharge planner) and that the majority of preadmission screenings occurs in hospitals, it is recommended that partnerships are developed with acute care hospitals and their staff. **Training medical staff and discharge planners to educate people about all LTSS options can divert people from nursing facilities when appropriate.**

Until Indiana's system is able to effectively divert people on a routine basis, short term institutional services may be necessary in some case. However, targeted options counseling must be provided to prevent long term institutionalization. Transitions from institutional settings are critical to assure that HCBS alternatives are made available to all persons who could reside in the community with those supports.

The ADRC pathway



Data Source: Lewin ADRC Evaluation 2017

The second way older adults and persons with physical disabilities enter the LTSS system is through referrals to an ADRC. Referrals come through a variety of sources (e.g., individuals and their family members, providers) but approximately 44% are documented as self-referrals. Community referrals such as these rely on the visibility of the ADRC and an awareness of its role as an entry point for home and community based services. Ideally, this pathway leads to a very different experience, but that experience and outcomes associated with that experience vary widely across the state.

DA recognized the importance of a high-functioning ADRC network and recently contracted with the Lewin Group to conduct site visits and evaluation activities on all of Indiana's ADRCs. This review consisted of individual ADRC data review, local level standard operating protocols (SOPs) review, site visit and community organization interviews and secret shopper calls and website reviews. The results indicated a number of opportunities for improvement.

General findings from this evaluation of individual ADRC organizations include:

- Data review showed a lack of consistent, shared understanding of how to count persons served, referrals made, etc.;
- Websites and other materials are not yet consistently reflecting new statewide INconnect Alliance branding;
- While some ADRCs do have standard operating protocols for key intake and referral processes, there is a lack of statewide consistency in these processes and sometimes a lack of consistency within the ADRC;
- Secret shopper calls revealed significant challenges in connecting with a live person;
- While ADRCs generally have good local relationships with other community organizations, there was a lack of warm handoffs, or even standardized, streamlined handoffs to community partners; and
- Initial phone assessments in secret shopper calls were too focused on eligibility driven inquiries and missed opportunities to identify personal and community supports that were already in place or could be put in place.

No Wrong Door – Streamlining Access to Long Term Services and Supports

Information from ACL indicates that the needs of 80% of persons seeking LTSS can be met with options counseling, information about how best to use their personal resources or connection to community resources. An effective "No Wrong Door" system can help people connect to that information and those resources, with referrals to the ADRC network for options counseling. There are drivers in the current system that often make nursing facility care the path of least resistance, making it the default much of the time. Often people and their families do not consider their LTSS needs until they are in an urgent, crisis situation.

In 2016, DA completed a two-year process to create a plan for a "No Wrong Door" system of access to information and resources. Indiana's No Wrong Door (NWD) plan outlines a vision to provide all Hoosiers along with their family members and caregivers, regardless of where they live or who pays for their care, access to more information and improved opportunities to make informed choices about their services and supports.

Indiana has already started to lay the groundwork for a NWD system including:

- Developing a new statewide aging and disability resource center (ADRC) brand – INconnect Alliance – to shift the perception of the ADRCs as separate and individual organizations to a statewide network of entry points into the LTSS system. All 15 ADRCs in Indiana are members of the INconnect Alliance.
- Developing a "virtual ADRC", a web-based information source and a point of entry to all of FSSA's programs and services. This includes the FSSA INconnect portal, as well as a web-based source and toll-free number for LTSS information, the INconnect Alliance website
- Establishing a designation and governance structure for the INconnect Alliance membership, to ensure high levels of consistency, reliability, and predictability for persons seeking information and resources through this network.
- Leveraging technology to facilitate better "hand-offs" of persons through the system and to limit the number of times that people have to "tell their stories". This includes the implementation of an integrated case management system, Case Management for Social Services (CaMSS), to provide a centralized location for inquiry and screening, eligibility determination, service plan development, and ongoing case management.
- Implementing a series of person-centered thinking (PCT) trainings to help create and maintain a person-centered and directed NWD system. The PCT trainings provide case managers and options counselors with the tools and skills to support people in balancing the preferences and values that are important to them with the health and safety needs and social expectations that are important for them.
- Redesigning the Pre-Admission Screening and Resident Review (PASRR) process to better identify and meet people's needs and preferences outside of nursing facilities.
- Continuous evaluation and monitoring of quality and outcomes.
- Ensuring that the ADRCs have sustainable funding for the provision of high-quality, person-centered, needs-based options-counseling.

Indiana's ADRC network, now re-branded as the INconnect Alliance, is a key component of Indiana's NWD strategy to streamline access to public programs and provide consistent and high quality information. The INconnect Alliance provides access to information, referral & assistance (I&R/A), options counseling, and intake for DA Medicaid waiver HCBS programs.

Stakeholders perceive their local ADRC as strong and effective resources in the community. Nearly 45 percent of NWD survey respondents learned about supportive services in their communities through their local ADRC. However, statewide stakeholders noted a lack of consistency across different ADRCs with staff sometimes providing conflicting information. Each ADRC has its own unique identity, brand, and logo, which also causes confusion. In addition, the lack of coordination between organizations results in people not getting the information they need, especially if they start at a "wrong door" in the system.

Stakeholders participating in the NWD planning process also emphasized a lack of education and awareness among people and providers on the types of LTSS available. Approximately, 65% of NWD stakeholder survey respondents disagreed with the statement that applying for services was simple and nearly 60% of survey respondents found it difficult to find the help they needed. In addition, the majority of survey respondents (58%) felt that a confusing system that is difficult to navigate was a "big problem" in accessing services and supports. Several NWD survey respondents specifically expressed difficulty in navigating the Medicaid application process and understanding eligibility guidelines for different programs and services. NWD listening session participants expressed the need to simplify information into language easily understandable by all persons in need of support and recommended the use of common forms and shared information across different programs and services.

Nursing facilities are another door through which persons may enter HCBS. The Money Follows the Person program currently funds diversion activities for persons who have received at least 90 days of Medicaid-funded nursing facility services. With the approaching end of that program in 2020, **amending Indiana's State Plan to add services such as targeted case management and other transition supports will enable continued transition activities post 2020**.

Substantial achievement of this plan began in 2016; considerable work remains, but is underway:

1. **Continued marketing to increase visibility and awareness of the INconnect Alliance brand throughout the state, particularly within the healthcare system because it is the largest "door";**
2. **Explore the feasibility of partnering with Indiana 211 to live answer INconnect Alliance toll-free calls;**
3. **Continue the development of the INconnect Alliance website to a fully functioning "virtual" ADRC, with a statewide resource database, a comprehensive self-assessment that supports personal decision making, and referrals as needed to providers and community resources;**

4. **Develop and implement designation and governance process that support required levels of consistency and standardized business process, and ADRC access statewide.**

The DA vision for the INconnect Alliance website is for that website to become a "virtual" ADRC. This includes the **establishment of a comprehensive resource site for family caregivers, including links to training resources, such as videos of helping safely with transfers, or training in how to communicate to meet the needs of a person with dementia**. The DA must continue the work necessary to realize this vision.

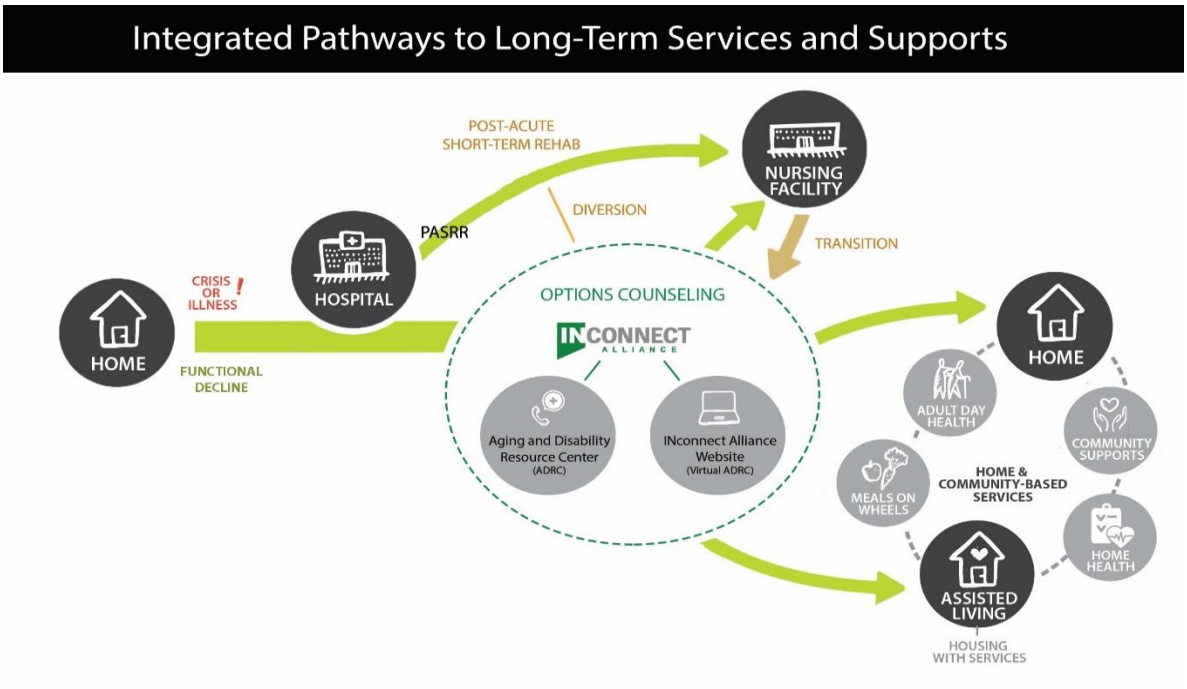
Establishment of sustainable funding for all ADRC related activities may be available through leveraging of federal Medicaid dollars to current state dollars already being spent. Some NWD system activities such as, outreach, application assistance, program planning, training, continuous quality improvement and administrative activities which support functional screening processes are related to the "efficient administration of the (Medicaid) State Plan" and are claimable as Medicaid Administrative Claiming (MAC). Conducting functional eligibility assessments is considered a service under the Medicaid State Plan and reimbursement through Federal Medicaid Assistance Percentage (FMAP) is potentially available. **Pursuing FMAP and MAC reimbursement can help to ensure a fully functional and robust options counseling mechanism.**

ADRCs in Maryland receive reimbursement based upon their total percent of time spent on Medicaid-related activities and their costs associated with conducting those activities. Wisconsin uses both MAC and FMAP reimbursement. FMAP is used for conducting functional eligibility assessments and MAC is used for the following activities:

- Medical Administrative Activity – Outreach and Eligibility (Medicaid Outreach, Facilitating an Application for Medicaid Program);
- Medical Service Coordination (Referral, Coordination, and Monitoring of Medical Services, Program Planning, Policy Development, and Interagency Coordination Related to Medical Services);
- Functional Screen: Administrative Activity (Input Functional Screen); and
- Functional Screen: Other Activity (Updates to Functional Screen, Functional screen training time, Quality monitoring of Functional screen).

Ohio uses MAC reimbursement for screening activities, especially for persons entering the LTSS delivery system. Claimable activities include screening, options counseling, and helping with Medicaid applications.

An effective NWD system will help Indiana integrate the pathways to LTSS. Persons who are seeking information, resources, or services will be more likely to get what they need at the time that they need it. The objective is to facilitate people in accessing the right resources, at the right time, and in the right place. A more integrated pathway is illustrated in the diagram below.



Conclusion

This report attempts to create a vision for expanding access to HCBS to meet the LTSS needs of Indiana's aging population and persons with disabilities, and to prepare Indiana's system for the needs and preferences of the Baby Boomer generation. The demographics of aging, and the evolving legal and regulatory requirements to provide services in less restrictive settings, combined with the fact that HCBS may be more cost-effective than institutional care for many individuals, create a sense of urgency in this effort.

FSSA has accomplished much in recent years to lay the foundation for a system transformation. This report outlines more concrete steps that may be taken in coming years to continue this work. The leading tenets of this work are:

- Provide for high quality and cost effective HCBS options as alternatives to nursing facility placement;
- Support caregivers' ability to provide ongoing informal supports;
- Mitigate direct care workforce challenges;
- Reduce fragmentation in systems of access and oversight.
- Promoted informed decision making and improved social and health outcomes through needs-based, person-centered practices.

It is our hope that effort and engagement resulting from this report brings this alignment and supports action toward a system that ensures the full participation of all people in community life, the same as people without disabilities. FSSA DA is committed to collaborating with stakeholders throughout the system to take the next steps in this effort.

	High Level Goals					Implementation Considerations				
Suggested Action Steps (in order of appearance, with page number)	**Provides for availability of HCBS options**	**Supports caregivers**	**Mitigates workforce challenges**	**Reduces fragmentation**	**Informed decision making/person-centered**	**Legislation Change Required**	**Indiana Administrative Code Change Required**	**Waiver or State Plan Change Required**	**Estimated timeline to implement**	**Already in progress**
25. New Medicaid service option for support services in congregate settings, i.e. housing with services as described in IC 12-10-15. (p. 26)	•		•	•		•	•	•	9 months	•
26. Enhance the current dementia care or specialty care competencies. (p. 26)	•				•		•	•	9 to 18 months	
27. Create a State Plan on special needs housing. (pp. 28-29)	•			•					12 months	
28. Combine the waiver service and State Plan home health prior authorization processes. (p. 34)	•		•	•			•	•	12 months	
29. Review the use of Medicare home health hours as part of the State Plan home health prior authorization process. (p. 34)			•	•					6 months	
30. Align understanding of scope of practice regulations (p. 35)			•	•	•		•	•	6 to 9 months	
31. Increase the use of the healthcare coordination service on the A&D waiver. (p. 35)	•			•	•		•	•	9 months	•
32. Raise the standards for case managers and the expectations for levels of coordination between care providers. (p. 38)	•			•	•		•	•	9 months	•
33. Expand the use of consumer-directed care and structured family care. (p. 40)	•		•		•		•	•	9 to 18 months	
34. Convene a workgroup to review overlap in process, clarify roles, identify changes to the oversight process, or organizational structures. (p. 41)				•					6 months	
35. Explore ways to create more universal waiver programs – children's services waiver; roll TBI into existing waivers. (p. 42)	•			•	•		•	•	18 to 24 months	•

36. Develop a Medicaid HCBS program focused on at risk individuals not yet at nursing facility level of care. (p. 44)	●	●	●	●	●		●	●	18 to 24 months	●
37. Select and implement an evidence based caregiver assessment tool and new caregiver support services. (p. 45)	●	●			●		●	●	18 to 24 months	
38. Maintain more than adequate approval levels to assure that all those who qualify can access A&D Medicaid waiver services. (p. 45)	●								ongoing	●
39. Establish a more streamlined process that allows persons to access HCBS while the financial eligibility determination process is occurring. (p. 53)	●			●	●	●	●	●	18 to 24 months	
40. Implement an options counseling trigger for individuals staying longer in nursing facilities. (p. 58)	●				●		●		6 months	●
41. Train medical staff and discharge planners to educate individuals about all LTSS options. (p. 58)	●				●		●		6 months - ongoing	●
42. Amend Indiana's State Plan to add services such as targeted case management and other transition supports. (p.61)	●				●		●	●	12 months	
43. Continue marketing and branding of INconnect Alliance brand (p. 61)	●	●		●					ongoing	●
44. Build partnership with Indiana 211 for community resources and I&A support. (p.61)	●			●				●	6 months	●
45. Expand functionality of the INconnect Alliance website. (p. 61)	●			●	●				6 to 24 months	●
46. Strengthen designation requirements for INconnect Alliance members/ADRCs. (p. 62)	●			●	●		●		12 months	●
47. Create a comprehensive resource site for family caregivers, including links to training resources. (p. 62)		●			●				6 months	●
48. Pursue FMAP and MAC reimbursement for ADRC functions. (p. 62)	●				●		●	●	9 to 18 months	●

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List of Appendixes

Appendix A - Mitigation Strategies for Transfer of Individuals

Possible HCBS expansion efforts might call for the creation of a new waiver or merging two waivers together or even adding State Plan services that might allow individuals to access the necessary support without a waiver. In all of these cases the Centers for Medicare and Medicaid Services (CMS) requires the state to provide a transition plan for the transfer of individuals impacted by the change. The impact of such changes should be considered in planning any of these program changes. In planning for any new waiver, the state will need to consider how individuals will be served in relation to their current service plans. CMS provides guidelines on the content of any transition plan the state would submit in this circumstance. In the transition plan, the state must:

- Describe the similarities and differences between the services covered in the approved waiver and those covered in the new or renewed/amended waiver;
- When services in the approved waiver will not be offered in the new or renewed/amended waiver or will be offered in lesser amount, describe how the health and welfare of persons who receive services through the approved waiver will be assured;
- State whether persons served in the existing waiver also are eligible to participate in the new waiver;
- When the new or renewed/amended waiver includes limitations on the amount of waiver services that were not included in the approved waiver, the plan must describe how the limitations will be implemented;
- When persons served in the approved waiver will not be eligible to participate in the new or renewed/amended waiver, the plan describes the steps that the state will take to facilitate the transition of affected individuals to alternate services and supports that will enable the individual to remain in the community;
- Include the time table for transitioning individuals to the new waiver; and
- Describe how the participant is notified of the changes and informed of the opportunity to appeal.

Appendix B - Stakeholder Engagement Activities

House Enrolled Act (HEA) 1493 called for the development of a report articulating broad proposals for long-term care transformation guided by stakeholder engagement. To support the state's development of this report, DA led a multi-pronged stakeholder engagement effort to identify opportunities to modernize the home and community-based services (HCBS) system in Indiana. The state seeks to make home and community-based services more accessible, increase awareness of all long-term care options, and create a more person-centered long-term care system. The table below summarizes the multi-pronged stakeholder engagement effort.

Method	Stakeholder Groups Represented	Total # of Participants
Provider Listening Sessions	Providers Area Agencies on Aging	270
Public Hearings – Oral and Written Testimony	Area Agencies on Aging Providers and Provider Associations Individuals Caregivers Advocates Case Managers Health Insurance Providers	34
Online Stakeholder Survey	Individuals Receiving Services (All Ages) Individuals Not Receiving Services (All Ages) Caregivers HCBS Providers Case Managers	1,234
Phone Stakeholder Survey	Individuals Receiving Waiver Services (Age 85+) Individuals Receiving CHOICE and Older Americans' Act Services (Age 85+) Caregivers of Individuals Receiving Services Age 85+	998

Provider Listening Sessions

Between May 1, 2017 and June 7, 2017, DA conducted 15 listening sessions, one at each of the state's Area Agencies on Aging (AAA). The listening sessions sought to better understand provider perspectives on the current long-term services and supports system (LTSS). The most common types of providers represented included personal service agencies and home health agencies. Summary of listening session comments can be found on DA's Long-Term Care Transformation Project webpage.

AAA Region	# of Participants
Region 1 – Northwest Indiana Community Action Corporation	39

AAA Region	# of Participants
Region 2 – REAL Services Inc.	17
Region 3 – Aging and In-Home Services of NE Indiana	21
Region 4 – Area IV Agency on Aging & Community Action Programs Inc.	4
Region 5 – Area Five Agency on Aging & Community Services Inc.	12
Region 6 – LifeStream Services Inc.	12
Region 7 – Area 7 Agency on Aging and Disabled West Central Indiana	17
Region 8 – CICOA Aging & In-Home Solutions	30
Region 10 – Area 10 Agency on Aging	11
Region 11 – Thrive Alliance	35
Region 12 – LifeTime Resources Inc.	11
Region 13 – Generations Vincennes University Statewide Services	20
Region 14 – Lifespan Resources Inc.	9
Region 15 – Hoosier Uplands/Area 15 Agency on Aging and Disability Services	17
Region 16 – SWIRCA & More	15
Total	**270**

Public Hearings

DA held public hearings on July 17, 2017 and July 18, 2017 to gain input from stakeholders regarding the opportunities for change in the existing HCBS system to better serve older adults and persons with disabilities of all ages who come into contact with the HCBS system. A total of 34 individuals or organizations provided oral or written testimony for the public hearings. Copies of written testimonies shared during the public hearings are posted on DA's Long-Term Care Transformation Project webpage.

Stakeholder	Oral Testimony	Written Testimony
AARP – Sarah Waddle		●
Aging & In-Home Services of Northeast Indiana – Beth Krudop		●
Anita Harden	●	
Anthem Blue Cross and Blue Shield – Kristen Metzger and Aimee Brake	●	●
Area 2 AAA REAL Services – Joan Cuson	●	●
Caregiver Homes – Jennifer Trowbridge	●	●
Center for At-Risk Elders (CARE) – Marc Sherman	●	
CICOA – Orion Bell	●	●
Families First – David Siler	●	●
Franciscan Senior Health and Wellness PACE – Susan Waschevski	●	●
Generations Area 13 AAA – Laura Holscher		●
Hoosier Owners & Providers for Elderly (HOPE) – Terry Miller		●

Stakeholder	Oral Testimony	Written Testimony
Indiana Assisted Living Association (INALA) – Liz Carroll		●
Indiana Association for Adult Day Services (IAADS) – Leah Jones	●	●
Indiana Association for Adult Day Services (IAADS) and Adult Day Center Manager – Vicki Maynard	●	●
Indiana Association for Home and Hospice Care (IAHHC) – Evan Reinhardt	●	
Indiana Association of Area Agencies on Aging (IAAAA) – Kristen LaEace	●	●
Indiana Chapter of the National Academy of Elder Law Attorneys (INNAELA) – Keith Huffman	●	●
Indiana Health Care Association/Indiana Center for Assisted Living (IHCA/INCAL) – Zach Cattell	●	●
IPMG – Jennifer Lantz		●
IU School of Medicine – Chris Callahan	●	●
Jowanna Peterson	●	●
LeadingAge Indiana – Mike Rinebold		●
Margaret Smith	●	
Maxim Healthcare – Chani Feldman	●	●
Meridian Medical Services – Else Cole	●	
Nancy Griffin	●	●
Saint Joseph PACE – Stacey Newton		●
Samantha Carpenter	●	
Shawn Pogue		●
Silver Birch Living, LLC – David J. Cocagne and Mark Laubacher		●
State LTC Ombudsman Program – Karen Gilliland		●
Sunny Miller		●
The Generations Project – John Cardwell	●	●

Stakeholder Surveys

DA fielded the online stakeholder survey from July 18, 2017 to August 11, 2017 and the phone stakeholder survey from July 24, 2017 to August 11, 2017. A compendium of survey responses are included on DA's Long-Term Care Transformation Project webpage.

Online Survey

Category	# of Participants
Individuals currently receiving services (all ages)	506
Individuals not receiving services (all ages)	226
Caregivers	212
Case managers	127
HCBS provider	112

Other*	51
Total	**1,234**

*Other survey respondents included other professionals (paramedics, elder law attorneys, psychologists), options counselors, and nursing facility providers.

Phone Survey

Category	# of Participants
Individuals currently receiving waiver services living in an assisted living facility (age 85+)	166
Individuals currently receiving waiver services living in their own home or another community setting (age 85+)	166
Individuals currently receiving non-waiver (CHOICE or Older Americans' Act) services (age 85+)	332
Caregivers of individuals currently receiving services age 85+	333
Total	**998**

Appendix C - Information on Caregiver Support in Other States

Washington	Washington offers a Medicaid Alternative Care (MAC) benefit package for individuals eligible for Medicaid but not currently receiving Medicaid-funded LTSS to help them avoid or delay more intensive Medicaid funded services by supporting their unpaid caregivers. The MAC service package for caregivers includes the following services: • Caregiver assistance services • Training and Education • Specialized medical equipment and supplies • Health maintenance and therapy supports (e.g. adult day health, evidence-based exercise programs, etc.)
South Carolina	South Carolina requires health plans to support caregivers for their beneficiaries, going as far as requiring each health plan implement a quality improvement project related to caregivers to ensure caregiver needs are being met to enable them to support the care receiver in the home. • Requires health plans to track the percentage of enrollees receiving home- and community based services who experience an increase or decrease in the authorization of respite hours. • Uses a standardized health assessment with an integrated caregiver self-assessment questionnaire to identify caregiver capacities, qualifications and risks. • Health plans must provide a range of health promotion and wellness activities including adult day health services, transportation, HCBS such as home-delivered meals, and respite care. o Healthy Connections Prime, one health plan in South Carolina, trains care coordinators in "Dementia Dialogues" in an effort to communicate effectively with families dealing with dementia and appropriately respond to challenging behaviors. o Molina Healthcare provides caregiver toolkits, checks-in with the member and interacts regularly with the caregiver. To provide temporary around-the-clock relief for caregivers, the program will pay for respite care in an institutional setting for up to 14 days per year. Similar to other states, South Carolina has a "Family Caregiver Support Program (FCSP)" run through local AAAs that provide counseling, supplemental services, support groups, and trainings. Care coordinators are trained on how to integrate the caregiver in their support efforts. Training includes building and updating care plans, interviewing skills, and regular updates on available community resources.
California	The state leverages resources within their Dementia Cal MediConnect Project and Alzheimer's Greater Los Angeles to train care coordinators to work with family caregivers in supporting the care recipient. To further support caregivers, the state developed a Toolkit for Dementia Care Management which includes tools used by trained coordinators for identifying a caregiver, care needs assessment tool, caregiver stress/strain instrument, and care plans for various situations. One health plan, Molina Healthcare, received a grant to provide a paid training to caregivers incorporating content related to integrated care management.
Tennessee	TennCare Medicaid amended its contract with managed care organizations in 2015 to require that at initial member enrollment and at least annually thereafter, the caregiver's role be determined, health and well-being assessed, and training and other needs identified. In 2016, TennCare added an additional requirement that the care coordinator must ensure that the identified family caregivers have the care coordinator's contact information. Similar to other states, care coordinators assess care givers, including their own health and well-being, stress levels, identification of their needs for training in knowledge and skills, and identification of any service and support needs.
District of Columbia	The District of Columbia Caregivers' Institute (DCCI) is a non-profit organization for residents of the District of Columbia that provides services and support to unpaid primary caregivers of

	seniors who have limited functioning due to a physical or mental condition. Through this program, caregivers may receive help making important decisions about present and future situations, create and apply a plan of support, and recharge by participating in activities. The aid given via DCCI is flexible and integrates a variety of support, enabling caregivers to better handle the circumstances of caregiving, including the ability to take care of themselves, along with the senior for which they are providing care. Caregivers learn to more efficiently solve problems, improve practical daily skills, as well as to better deal with change. A Caregiver Flex Account allows caregivers to be reimbursed for expenses related to caregiving. However, these expenses must be approved in advance. The District of Columbia Office on Aging funds and administers the services available via the DCCI. Services and resources available include: • In home assessments • Caregiver flex account • Telephone support • Educational program • Caregiving counseling program

Appendix D – HCBS Services Grid

Home & Community-Based Services (HCBS)	Medicaid Waiver	Medicaid	Medicare	PACE*	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	X	
Homemaker	X			x	X	X	X	X	
Personal Emergency Response	X			x	X	X	X	X	
Handyman/chore					X	X	X	X	
Home Health Care		X	X	x				X	
Respite-Aide	X			x	X	X	X	X	
Respite-skilled	X	X		x				X	
Home delivered meals	X			x	X	X	X	X	
Congregate meals				X			X		
Transportation	X	X		x	X	X	X	X	X
Senior Centers							X		
Adult Day Services	X			x	X			X	
Adult Family Care	X								X
Assisted Living	X			x					X
Structured Family Care	X			x					
Home Modifications	X			x				X	
Vehicle Modifications	X	X		x				X	
Community Transitions	X			x					X
Health Care Coordination-RN	X			x					X
Nutritional Supplements	X			x					
Legal Assistance							X	X	
Ombudsman							X		X
Specialized Medical Equipment	X	X	X	x				X	X
Pest Control	X			x	X	X	X	X	

ACCESS & CARE COORDINATION
IN-HOME SERVICE DELIVERY
COMMUNITY BASED SERVICES
ALTERNATIVE RESIDENTIAL

OTHER SERVICES

* PACE, Program of All-Inclusive Care for the Elderly, covers medical care as well as home and community based services. This includes, primary physician, emergency room, hospitalizations, nursing facility, dental, eye care, pharmacy costs, therapies, etc.

Appendix E – A&D Waiver Services: Rate Information

Attendant Care						
State	**Service Modifier**	**Fee Schedule vs. Provider Rate**	**Geographic Rate Adjustment**	**Index/ Inflation Factor**	**Other Rate Information**	**Rate**
Indiana	Agency	Fee Schedule				$4.79/15 min
	Non-Agency					$2.91/15 min
	Self - Directed					$2.75/15 min
Illinois	Provider - Directed	Fee Schedule		✓		$3.25/15 min
	Self - Directed					Negotiated
Michigan	Provider - Directed	Fee Schedule				$4.25/15 min
	Self - Directed					Negotiated
Minnesota	1:1 Ratio	Fee Schedule		✓	Modeled Rate	$4.28/15 min
	1:2 Ratio					$3.21/15 min
	1:3 Ratio					$2.82/15 min
Ohio	Personal Care Service [Passport Waiver]	Fee Schedule			Modeled Rate	$4.49/15 min
	Personal Care Aide (Agency) [Home Care Waiver]					$23.12 Base 1st hour $3.84/15 min after
	Personal Care Aide (Non-Agency) [Home Care Waiver]					$18.64 Base 1st hour $2.95/15 min after
Wisconsin	Provider-directed (Max Rate)	Fee Schedule				$4.02/15 min
	Self-directed					Negotiated

Homemaker						
State	**Service Modifier**	**Fee Schedule vs. Provider Rate**	**Geographic Rate Adjustment**	**Index / Inflation Factor**	**Other Rate Information**	**Rate**
Indiana	Agency	Fee Schedule				$3.78/15 min
	Non-Agency					$2.45/15 min
Illinois	Homemaker service definition includes activities outside the scope of Indiana's service					
Michigan	Homemaker service definition includes activities outside the scope of Indiana's service					
Minnesota	Homemaker service definition includes activities outside the scope of Indiana's service					
Ohio	Provider - Directed	Fee Schedule	✓	✓		$3.84/15 min
	Self - Directed					Negotiated
Wisconsin	No distinct Homemaker service noted during review					

Home Delivered Meals						
State	**Service Modifier**	**Fee Schedule vs. Provider Rate**	**Geographic Rate Adjustment**	**Index / Inflation Factor**	**Other Rate Information**	**Rate**
Indiana	Provider – Directed	Fee Schedule				$5.43/meal
Illinois	Provider – Directed	Fee Schedule				$7.50/meal
Michigan	Provider – Directed	Provider Rate (Bid)				Bid/meal
Minnesota	Provider – Directed	Fee Schedule				$6.53/meal
Ohio	Provider – Directed (Passport Waiver)	Fee Schedule	✓			$6.60/meal
	Provider – Directed (HC Waiver)					$6.99/meal
Wisconsin	Provider – Directed	Provider Rate (Bid)				Negotiated

Respite – In Home						
State	**Service Modifier**	**Fee Schedule vs. Provider Rate**	**Geographic Rate Adjustment**	**Index/ Inflation Factor**	**Other Rate Information**	**Rate**
Indiana	RN	Fee Schedule				$9.93/15 min
	LPN					$6.83/15 min
	Home health aide					$5.12/15 min
Illinois	Non-Agency CNA	Fee Schedule			Rate Based on Other Service	$4.00/15 min
	HH-Agency CNA					$3.44/15 min
	Non-Agency LPN					$5.75/15 min
	HH-Agency LPN					$6.37/15 min
	Non-Agency RN					$7.44/15 min
	HH-Agency RN					$7.39/15 min
	Homemaker					$4.29/15 min
	Personal Assistant					$3.25/15 min
Michigan	Michigan In-Home Respite Care was not a comparable service to that of Indiana.					
Minnesota	In home	Fee Schedule		✓	Modeled Rate	$5.42/15 min
Ohio	In-Home Respite was not an identified service. Only out-of-home respite was included in waiver services.					
Wisconsin	Self-directed	Provider Rate	16,736	2,836	96.4	Negotiated

Case Management						
State	**Service Modifier**	**Fee Schedule vs. Provider Rate**	**Geographic Rate Adjustment**	**Index / Inflation Factor**	**Other Rate Information**	**Rate**
Indiana	Provider - Directed	Fee Schedule				$100/month
Illinois	Provider - Directed	Fee Schedule				$138.10/month
Michigan	Case Management Provided as part of capitated services under management care entity arrangement (no standard rate noted)					
Minnesota	Case management provided on 15 min increments, and therefore not comparable to Indiana service.					
Ohio	Competitive bid process for case management agencies. Expense Claimed as an administrative service by the state (No published FFS rates)					
Wisconsin	Case Management Provided as part of capitated services under management care entity arrangement ($$341 PMPM for Frail Elderly)					

Assisted Living						
State	**Service Modifier**	**Fee Schedule vs. Provider Rate**	**Geographic Rate Adjustment**	**Index / Inflation Factor**	**Other Rate Information**	**Rate**
Indiana	Level 1 – Basic	Fee Schedule			Modeled Rate	$71.71/day
	Level 2 – Enhanced					$78.54/day
	Level 3 – Intensive					$86.68/day
Illinois	Provider - Directed	Fee Schedule	✓		Rate Based on Another Service	60% of Medicaid nursing facility daily rate ($76.56/day)
Michigan	No assisted living service type offered under Medicaid program					
Minnesota	No assisted living service type offered under Medicaid program					
Ohio	Tier 1	Fee Schedule			Modeled Rate	$49.98/day
	Tier 2					$60.00/day
	Tier 3					$69.98/day
Wisconsin	No assisted living service type offered under Medicaid fee for service program					

Appendix F – A&D Waiver Services: Provider Metrics

A&D Waiver Services: Provider Metrics							
Procedure	**Year**	**Total Units Allowed**	**Total Number of Providers**	**Provider Turnover Rate**	**New Provider Rate**	**Percent Change in Allowed Units**	**Percent Change in Provider Total**
Attendant Care (Agency) (S5125-U7-UA)	2013	11,413,861	366	10%	N/A	N/A	N/A
	2014	13,024,078	388	10%	15%	14%	6%
	2015	14,328,346	397	8%	12%	10%	2%
	2016	14,400,833	403	N/A	10%	1%	2%
Case Management, (Monthly) (S5170-U7)	2013	145	9	N/A	N/A	N/A	N/A
	2014	129,563	23	0%	N/A	N/A	N/A
	2015	147,116	27	4%	15%	14%	17%
	2016	159,255	31	N/A	16%	8%	15%
Home Delivered Meals (S5170-U7)	2013	1,296,417	23	0%	N/A	N/A	N/A
	2014	1,681,817	26	8%	12%	30%	13%
	2015	2,024,102	25	4%	4%	20%	-4%
	2016	2,170,651	32	N/A	25%	7%	28%
Homemaker (NOS) (S5130-U7-UA)	2013	2,484,966	293	7%	N/A	N/A	N/A
	2014	2,844,050	325	10%	16%	14%	11%
	2015	3,062,508	326	10%	10%	8%	0%
	2016	2,883,054	325	N/A	10%	-6%	0%
Respite Care Services (RN) (S5170-U7-UA-TD)	2013	557,113	109	17%	N/A	N/A	N/A
	2014	691,507	105	10%	13%	24%	-4%
	2015	755,451	115	15%	17%	9%	10%
	2016	615,011	115	N/A	15%	-19%	0%
Respite Care Services, (LPN) (S5170-U7-UA-TE)	2013	894,933	118	8%	N/A	N/A	N/A
	2014	999,592	129	10%	16%	12%	9%
	2015	980,074	130	10%	11%	-2%	1%

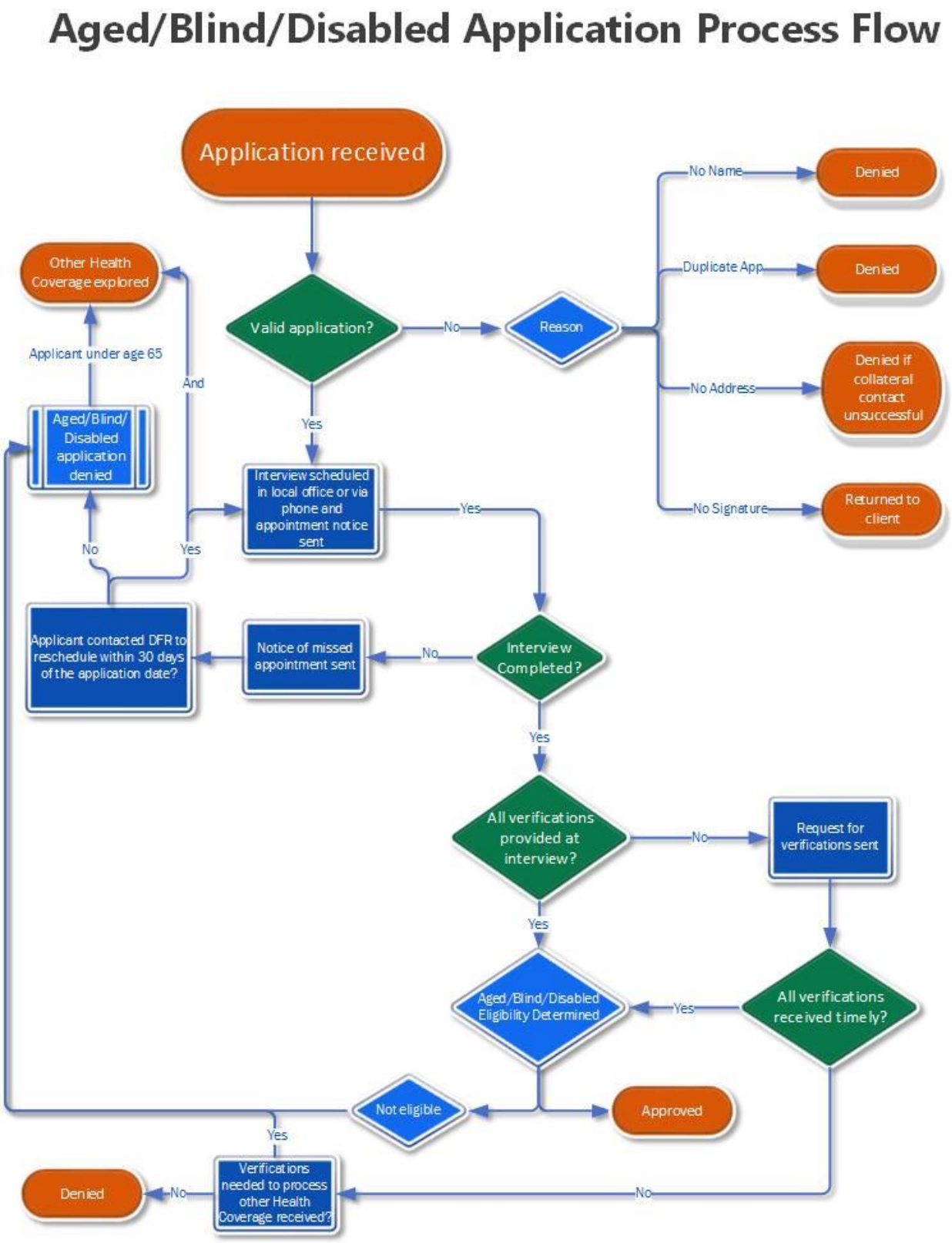
	2016	993,028	135	N/A	13%	1%	4%
Unskilled Respite Care (Not Hospice) **(S5130-U7-UA-U9)**	2013	1,524,351	160	9%	N/A	N/A	N/A
	2014	1,670,058	162	8%	10%	10%	1%
	2015	1,672,002	166	10%	10%	0%	2%
	2016	1,538,711	168	N/A	11%	-8%	1%

Appendix G – Eligibility Criteria by Funding Source

Funding Source/ Eligibility Criteria	Older Americans Act (OAA)	OAA Family Caregiver	SSBG	CHOICE - pre-7/1/17	CHOICE - post 7/1/17	A&D Waiver	TBI Waiver
Age Requirements	60 plus - note some special situations under Other	55 plus - note some special situations under Other	none	none	none	none	none
Residency	resident of Indiana	resident of Indiana	resident of Indiana	resident of Indiana	resident of Indiana	resident of Indiana	resident of Indiana
Income Limits	No	No	300% of federal poverty level	No	No	Medicaid	Medicaid
Asset Limits	No	No	No	$500,000	$250,000	Medicaid	Medicaid
Cost Share?	No	No	No	yes	yes	No	No
Medicaid eligibility required?	No	No	No	No	No	Yes - specified aid categories only	Yes - specified aid categories only
Level of care requirements	none	none - note that for this funding source the recipient is the caregiver not the care recipient	at risk of institutional placement - very broad	difficulties in two or more activities of daily living (ADLs on page 2 of the escreen)	reference documents provided earlier - can be 1 ADL with other risk factors or a combination of other risk factors	nursing facility level of care	nursing facility level of care or institutional level of care for individuals for intellectual disabilities
Diagnosis requirement	none	none	none	none	none	none	traumatic brain injury
Other	spouses or adult children with a disability living with the eligible participant may also receive Title III home delivered or congregate meals (no other service, just meals)	•Adult family members or other informal caregivers age 18 and older providing care to individuals 60 years of age and older; •Adult family members or	none	none	none	none	none

		other informal caregivers age 18 and older providing care to •individuals of any age with Alzheimer's disease and related disorders; •Grandparents and other relatives (not parents) 55 years of age and older providing care to children under the age of 18; and •Grandparents and other relatives (not parents) 55 years of age and older providing care to adults age 18-59 with disabilities.					

Appendix H – Medicaid Application Process



Appendix I – Accessing HCBS through an ADRC – Functional Eligibility

Accessing HCBS Through an Aging and Disability Resource Center (ADRC)		
	**Phone screening** – However the person comes to be referred to the ADRC, the first step is generally a phone screening with the person and/or a family member.	Current standards require this step to be completed within two business days of the referral.
	**Face to face assessment** – Options counselor will visit with the person in their home (or hospital or nursing facility if that is their current location) and begin the assessment process; options counselor will	Current standards require the face to face assessment to occur within 10 business days of the referral.
	**Service plan development** – InterRAI assessment is fully complete at this stage; options counselor works with person and their circle of support to develop a person-centered service plan that meet their needs and select providers. A physician certification form, called a 450B, must be obtained before the plan can be submitted.	Current standards require that the service plan be submitted to the Division for review within 20 business days of the referral.
	**Division of Aging reviews service plan** – A Care Management Consultant reviews every initial service plan to check for compliance with waiver requirements, complete documentation and appropriateness of services.	Typically the Division of Aging reviews initial plans within about 5 business days; if information is incomplete or there are questions, a request for information may be issued before a decision can be made.
	**Medicaid application completed** – If the person is not already a full coverage Medicaid recipient, they will need to complete the Medicaid application process before their HCBS plan can start; if they meet traditional Medicaid income and asset requirements, that process can run parallel to the assessment and service plan process; if they need the special income limit or spousal impoverishment protection available to waiver participants, then they have to wait to apply for Medicaid until the Division of Aging has approved the service plan.	The Division of Family Resources (DFR) has 45 days per federal guidelines to complete their review once a completed application is received. If a person is under 65 and does not yet have a disability determination, that can take longer. Per the DFR, the average disability determination is currently 34 days.
	**Start of plan is confirmed** – Once all pending issues, such as Medicaid or nursing facility placement, are resolved, the options counselor/case manager confirms the start date of services and submits it to the Division of Aging.	The confirmation information is sent to the Division of Aging; acceptance is automatic unless there is an issue with Medicaid status, such as managed care enrollment.
	**Notification sent to providers** – Once the confirmed plan is approved, generally an automated process, the providers selected receive a notice that authorizes them to provide the needed HCBS.	Notice of action is sent to providers via email as soon as the confirmed service plan is approved through an automated process.

Appendix J – Eligibility Screen

ELIGIBILITY SCREEN
State Form 45528(R4/05-01) / BAIS 013

*THIS STATE AGENCY IS REQUIRING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER PER IC 4-1-8-1. THE INFORMATION OBTAINED ON THIS FORM IS CONFIDENTIAL UNDER STATE AND FEDERAL REGULATIONS. THIS INFORMATION WILL NOT BE RELEASED EXCEPT AS PERMITTED OR REQUIRED BY LAW OR WITH THE CONSENT OF THE APPLICANT.

Applicant Name	Screening Date	Date of Birth	Social Security Number
Address (street, city, state, zip code)			

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

Section 1: Severe Medical Conditions - See Description

The focus of this section is on the need for nursing facility care as determined by **unstable complex** medical conditions.

1. Direct assistance (see definiton #1) from others is needed with any of the following conditions at least five (5) days per week:
   - ☐ A. Treatment of extensive (stage 3 or 4) Decubitus Ulcers (see definition #2)
     Note: Describe size and stage in the comments section.
   - ☐ B. A Comatose condition (see definition #3)
   - ☐ C. Management of severe pain (see definition #4) requiring frequent injections
2. Direct assistance (see definition #1) from others is required with any of the following prescribed medical equipment/ interventions at least three (3) days per week:
   - ☐ A. Ventilator / Respirator (see definition #5)
   - ☐ B. Suctioning (see definition #6)
   - ☐ C. Tube feeding/Gastrostomy care (see definition #7 & #8)
   - ☐ D. Central venous access or I.V. (see definition #9)
3. Direct assistance (see definition #1) from others is required for special routines or prescribed treatments that must be followed at least five (5) days per week:
   - ☐ A. Tracheostomy (see definition #10)
   - ☐ B. Acute rehabilitation condition (see definition #11) requiring Physical Therapy, Occupational Therapy, and/ or Speech Therapy. **General strengthening exercise programs are excluded.**
   - ☐ C. Administration of continuous oxygen (see definition #12) for a new or recent condition when the individual's overall condition requires the significant involvement of skilled nursing personnel.
4. ☐ Direct assistance (see definition #1) from others is required to administer physician prescribed medicine (excluding vitamins) by intramuscular, intravenous, or subcutaneous injection (see definitions #9A, #14 & #15) more than one (1) time per day, other than insulin injections for an individual whose diabetes is under control.
5. ☐ Medical observation and physician assessment due to a changing, unstable physical condition is required more often than every thirty (30) days.
   Note: Assessor must document the specifics.
6. ☐ Direct assistance (see definition #1) from others is required for the safe management of an uncontrolled Grand Mal seizure disorder (see definition #6) (i.e., at least weekly seizure activity)

☐ Nothing in Section 1 applies

If one (1) or more conditions exist in Section 1, then the applicant is eligible for Nursing Facility Admission and may be eligible for Medicaid Waiver Services under the Aged and Disabled, Medically Fragile Children's Waiver, or TBI Waiver.
To be eligible for CHOICE, there must also be (2) or more conditions existing in Sections 2A or 2C.
If no conditions exist in either of those sections, then applicant may be eligible for CHOICE if justification for at least 2 or more impaired age-appropriate daily activities is described in the Section 2A or 2C comments.

Applicant Name	Screening Date	Date of Birth	Social Security Number

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Section 2A: Substantial Medical Conditions Including Activities of Daily Living - See Description

1. ☐ The person has experienced a significant deterioration in overall condition of health in the last six (6) months.
   Note: Assessor must document the specifics, including time frames and dates.
2. ☐ The person requires daily recording of the kind and amounts of fluids and solids intake and output.
   Note: Assessor must document reason this is required. (example: significant weight loss, unstable blood sugar, fluid restriction).
3. ☐ The person requires direct assistance (see definition #1) with the administration of oxygen (either continuous or as needed) for a chronic or stable condition.
4. ☐ The person requires supervision and direct assistance (see definition #1) on a daily basis to ensure that physician prescribed medications (see definition #13) is taken correctly.
5. ☐ The person requires 24 hours a day supervision and/or direct assistance (see definition #1) to maintain safety due to confusion and/or disorientation that is not related to or a result of mental illness.
6. ☐ The person requires direct assistance (see definition #1) with turning or repositioning every 2-4 hours to prevent skin breakdown per medical plan of care.
7. ☐ The person requires passive range of motion exercise (see definition #17) on a daily basis per medical plan of care.
8. ☐ To maintain a stable medical condition, the person requires monitoring of the health care plan on a 24 hour a day, seven day a week basis by a licensed nurse.
9. ☐ The person is unable to eat without direct assistance (see definition #1).
   Note: This does not include meal preparation.
10. ☐ The person is unable to transfer from a bed or chair without direct assistance (see definition #1).
11. ☐ The person is unable to change clothes without direct assistance (see definition #1). This does not include needing help with tying their shoes or grooming.
    Note: If the individual is able to perform this activity with adaptive equipment (i.e., velcro closures or stocking pullers), do not check.
12. ☐ The person is unable to bathe without direct assistance (see definition #1).
    Note: This does not include needing help with washing back, feet, or grooming.
13. ☐ The person is unable to manage bowel and/or bladder function without direct assistance (see definition #1).
    Note: If able to self catheterize or self apply and change an incontinency product, do not check.
14. ☐ The person is unable to ambulate or use a wheelchair without direct assistance (see definition #1). This includes the individual who is currently experiencing frequent falls despite the use of an assistive device (cane or walker).
    Note: If able to safely ambulate with an assistive device, or appropriately self propel a wheelchair, do not check.

☐ Nothing in Section 2a applies

If three (3) or more conditions exist in Section 2A, then the applicant is eligible for Nursing Facility Admission or Medicaid waiver services under the Aged and Disabled Waiver, the TBI Waiver, or the AL Waiver. If two (2) or more conditions exist in Section 2A, then the applicant is eligible for CHOICE.

Applicant Name	Screening Date	Date of Birth	Social Security Number

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Section 2B: Substantial Mental Health Condition

1. ☐ The person requires daily supervision and/or direct assistance (see definition #1) to maintain safety due to confusion, disorientation, and/or behaviour as a result of a mental illness.
2. ☐ The person has experienced a substantial mental health condition within the last six (6) months as evidenced by a least one (1) of the following:
   - ○ Has a diagnosis of a major mental illness limited to schizophrenia, schizoaffective disorders, psychotic disorders not otherwise specified (formerly atypical psychosis), delusional (formerly paranoid) disorder, and mood (formerly affective) disorders of the bipolar and major depressive type; or
   - ○ Required hospitalization for a psychiatric condition; or
   - ○ Required outpatient treatment or partial hospitalization for a mental health condition.

☐ Nothing in Section 2b applies

If two (2) conditions exist in Sections 2A & 2B or 2B & 2C, then the applicant is eligible for CHOICE Program services only.

Section 3A: Informal Supports

1. ☐ The person has no friends or relatives who are able or willing to provide needed assistance, support, and personal or chore services.
2. ☐ Friends or relatives who have been providing needed assistance are no longer able or willing to continue to provide help.
3. ☐ Friends or relatives who have been providing needed assistance are not able or willing to increase the amount of help needed to meet changing conditions.

☐ Nothing in Section 3a applies

Section 3B: Instrumental Activities of Daily Living

Assistance is needed because the person is unable on a consistent basis to do the following tasks independently due to a serious physical, emotional, or mental health problem:

- ☐ A. Take care of nutrition, including preparing a light meal (e.g., snack or T.V. dinner)
- ☐ B. Light work around the house, such as washing dishes
- ☐ C. Shop for Groceries
- ☐ D. Travel in a van, taxi, bus, or car
- ☐ E. Take medicines
- ☐ F. Answer the telephone even with special equipment
- ☐ G. Call the telephone operator even with special equipment
- ☐ H. Take care of grooming and personal hygiene
- ☐ I. Financial management of basic necessities (e.g., food, clothing, shelter)

☐ Nothing in Section 3b applies

Sections 3A & 3B do not determine eligibility for CHOICE, Nursing Facility Admission, or Medicaid Waiver Services. However, if one (1) or more conditions exist in Section 3A and/or Section 3B, then the applicant may qualify for other state and federal programs.

Applicant Name	Screening Date	Date of Birth	Social Security Number

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Applicant Eligibility Level:

- ☐ SECTION 1
- ☐ SECTION 2
- ☐ SECTION 3

Applicant's Preference for Care:

- ☐ INSTITUTIONAL CARE* ☐ No Preference
- ☐ HOME AND COMMUNITY-BASED CARE
- ☐ OTHER

Comments: Additional information on nature and extent of client impairment.
(Comments only may be continued on additional pages if needed.)

*Any individual with mental illness or a developmental disability applying for admission to a Medicaid certified Facility must also undergo a Level II Assessment prior to admission.

Case Manager Signature _____ Date _____