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

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

2) an analysis of

A) past policies implemented in Indiana; and

B) other states' approaches;

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

3) An analysis of demographic trends by:

A) payor sources; and

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

Statewide and by county or other geographic setting.

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

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

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

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

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

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

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

Executive Summary

[coming soon…]

GLOSSARY (link back to the glossary entry here from text)

Activities of Daily Living (ADLs) are things people normally do in daily living including any self-care activity such as feeding ourselves, bathing, dressing, grooming, work, homemaking, and leisure. The ability or inability to perform ADLs can be used as a very practical measure of ability/disability in many disorders.

Administration on Aging –

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

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

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

Aged and Disabled Waiver Services

Assisted Living (AL) is defined as personal care, homemaker, chore, 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 residential facility that is licensed by the Indiana State Department of Health. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and provides supervision, safety, and security.

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

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

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

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

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

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

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

****Environmental Modification Assessment** is a service which determines the scope and specifications for environmental modifications necessary to enable an individual to function with greater independence within their home, and without which they would require institutionalization. The Assessor reviews the feasibility and writes the specifications that serve

as the criteria for obtaining and evaluating bids. Upon completion of the work, the Assessor conducts a post-project inspection to assure project completion.

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

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

***Gerontology Counseling** is the process of helping older individuals to overcome losses, to establish new goals while in the process of discovering that living may be limited in years but not necessarily in quality, and to reach decisions based on the importance of being in the present as well as looking for future opportunities.

***Habilitation Day Group** is assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting that is separate from the home or facility in which the individual resides.   Services are normally furnished four (4) or more hours per day on a regularly scheduled basis for one (1) or more days per week unless provided as an adjunct to other day activities included in an individual's care plan.

***Habilitation Day Individual** is assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting that is separate from the home or facility in which the individual resides. Services are normally furnished four (4) or more hours per day on a regularly scheduled basis for one (1) or more days per week unless provided as an adjunct to other day activities included in an individual's care plan.

Handy Chore are minor home maintenance activities, that are planned and monitored, that are essential to an individual's health and safety. They can include plumbing, heating, storm door, window, and screen repairs; gutter and roof patching; heavy cleaning; broken step repair; installation of health and safety equipment such as handrails, ramps, deadbolts, fire extinguishers, smoke detectors, locks. Ground maintenance is also included and can be lawn moving, snow removal, and minimal hard cleanup to assure safe entrance and departure from premises.

Health Care Coordination includes medical coordination provided by a Registered Nurse to manage the health care of the individual including physician consults, medication ordering, and development and nursing oversight of a healthcare support plan. Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act. The purpose of Health Care Coordination is stabilization; prevention of deteriorating health; management of chronic conditions; and/or improved health status.

Home and Community-Based Services (HCBS) -

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

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

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

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

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

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

Long-Term Services and Supports (LTSS) -

Nursing Facility Level of Care (NFLOC) -

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

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

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

Older Americans Act -

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

Options Counseling --

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

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

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

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

Respite services are those services that are provided temporarily or periodically in the absence of the usual caregiver. Service may be provided in an individual's home; the private home of the caregiver, or in a Medicaid-certified nursing facility. For those individuals receiving the service of Adult Family Care, funding for respite is already included in the per diem amount and the actual service of respite may not be billed. The level of professional care provided under respite services depends on the needs of the individual. An individual requiring assistance with bathing, meal preparation and planning, specialized feeding, such as an individual who has difficulty swallowing, refuses to eat, or does not eat enough; dressing or undressing; hair and oral care; and weight bearing transfer assistance should be considered for respite home health aide under the supervision of a registered nurse. An individual requiring infusion therapy; venipuncture; injection; wound care for surgical, decubitus, incision, ostomy care; and tube feedings should be considered for respite nursing services (RNUR).

Specialized Medical Equipment & Supplies are medically prescribed items required by the individual's Plan of Care/Cost Comparison Budget, which are necessary to assure the health, welfare and safety of the individual, which enable the individual to function with greater

independence in the home, and without which the individual would require institutionalization. Individuals requesting authorization for this service through the waiver must first exhaust eligibility of the equipment or supplies through the Indiana Medicaid State Plan. There should be no duplication of services. Maintenance is limited to $500 annually for the repair and service of items that have been provided though the waiver.

*Structured Day Program is assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, which takes place in a non-residential setting, separate from the home in which the individual resides. The services are normally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

**Structured Family Caregiving is a service through which a participant receives care in their own home or the home of a principal caregiver. The principal caregiver cannot be the participant's spouse, the parent of a participant who is a minor, or the legal guardian of the participant. Only agencies may offer Structured Family Caregiving. All Structured Family Caregiving settings must be approved and supervised by the provider agency and all paid caregivers are trained and paid by the provider.

*Supported Employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported Employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. The service includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

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

Traumatic Brain Injury Waiver -

Vehicle Modifications are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to be safely transported in a motor vehicle. Vehicle modifications, as specified in the Plan of Care/Cost Comparison Budget, may be authorized when necessary to increase an individual's ability to function in a home and community based setting to ensure accessibility of the individual with mobility impairments. These services must be necessary to prevent or delay institutionalization. The necessity of such items must be documented in the plan of care by a physician's order. Vehicles necessary for an

individual to attend post-secondary education or job-related services should be referred to Vocational Rehabilitation Services. Maintenance is limited to $500 annually for repair and services of items that have been funded though the waiver, and there is a $15,000 lifetime cap.

* TBI waiver service only

** A&D waiver service only

*** SSBG services only

History/Background

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

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

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

Fast forward nearly twenty years and by 2003, the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) were launching the Aging and Disability Resource Center (ADRC) initiative. This was part of a nationwide effort to restructure services and supports for older adults and younger persons with disabilities to complement other long-term care system activities designed to enhance access to community living.

LTSS Milestones

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

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

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

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

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

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

2006—Older Americans Act required the Administration on Aging to establish ADRCs in all states.

2010—P.L. 111-149, the Patient Protection and Affordable Care Act appropriated $10 million for ADRCs for each of FYs 2010 through 2014 (O'Shaughnessy).

Review of all current long term care services available in Indiana, including regulated and unregulated methods of service delivery

Long-term services and supports (LTSS) available in Indiana include a variety of health and health-related assistance needed by persons who lack the capacity to care for themselves due to physical, cognitive or mental, disabilities or conditions. These LTSS range from those that occur in community settings and focus solely on nutrition, socialization, and recreation to home-based personal care and nursing services to the traditional long-term care settings referred to as nursing facilities or skilled nursing facilities, and many service types and levels of need-for-care in between. Mental and physical disabilities and/or chronic conditions can result in the need for hands-on assistance or supervision over an extended period of time, and one's need for LTSS can change over time as his or her needs or conditions shift.

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

Current Data

Between the traditional Older Americans Act services, CHOICE and Social Services Block Grant funds, and the Medicaid waivers for persons determined eligible both financially and by level of inability to perform ADLs, services were provided to nearly 40,000 older adults and persons with disabilities in Indiana during 2014.

DECEMBER, 2014 FY 2015 Y-T-D

YTD services	CHOICE	SSBG	TITLE III	TITLE III-E	A&D	TBI	MFP-A&D	MFP-TBI	NON-MAW	MAW	TOTAL
TOTAL	2828	15008	10815	990	14096	184			25198	14464	37842
Unduplicated clients	2824	14990	10803	986	14069	183	279	1	24505	14464	37659

Statewide these federal (Non-Medicaid Waiver) and state funding sources provided the following services in the following number of units:

HCBS Service Type	2014 Units
Adult Day Care	41,370
Case Management	255,870

Chore	33,639
Congregate Meals	929,719
Home-Delivered Meals	1,236,776
Homemaker	254,003
I&A	254,679
Legal Assistance	15,850
Nutrition Education	78,235
Other Services	77,461
Outreach	20,458
Personal Care	651,906
Transportation	512,956
TOTAL	4,362,922

Funding Sources (Attachment B)

Indiana is divided into regions for the delivery of Medicaid and other support services for older adults and persons with disabilities. Home and Community-Based Services (HCBS) are provided through the aging network via the AAAs. Longer-term rehabilitative and skilled care services are provided through a network of licensed health providers while residential options are available through both licensed and non-licensed Assisted Living settings, residential care facilities, and combinations of continuing care communities. All these services—whether in the home or the community in a residential setting or a nursing facility—contribute to the definition of Long Term Services and Supports (LTSS), and each service is critical to the continuum of care for a very diverse aging and disabled population's needs.

Using OAA's funding, Indiana's sixteen AAAs are critical initial access points for transportation, outreach, and information and assistance services. Their assistance and brokering of services is greatly enhanced by financial support from the state-funded CHOICE program, the Social Services Block Grant (SSBG) funds, and perhaps most importantly, the Medicaid Waiver Aged and Disabled and Traumatic Brain Injury funds.

Medicaid Waiver Services

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

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

and 3) be financially eligible. The Division of Aging (DA) oversees two waivers: the Aged and Disabled (A&D) waiver and the Traumatic Brain Injury (TBI) waiver.

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

Adult Day Services (ADS)

Adult Family Care (AFC)

Assisted Living (AL)

Attendant Care (ATTC)

Case Management

Community Transition Services

Environmental Modifications

**Environmental Modification Assessment

Health Care Coordination

Homemaker

Home Delivered Meals

Nutritional Supplements

Personal Emergency Response Systems (PERS)

Pest Control

Respite

Specialized Medical Equipment & Supplies

**Structured Family Caregiving

Transportation

Vehicle Modifications

*** A&D waiver service only*

Traumatic Brain Injury (TBI) Waiver

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

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

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

In Indiana, TBI waiver services include most of the services listed above for the A&D waiver (except where marked by **), in addition to the following:

Behavior Management/ Behavior Program and Counseling

Residential Based Habilitation

Structured Day Program

Supported Employment

Social Services Block Grant (SSBG)

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

Block grant funds are given to states to achieve a wide range of social policy goals, which include promoting self-sufficiency, preventing child abuse, and supporting community-based care for the elderly and disabled (Lynch – CRS). Indiana uses SSBG funding for the following in-home, community-based, and/or facility-oriented services for low-income older adults and persons with disabilities:

Attendant Care

Adult Day Services

Auditory Therapy

Family Care Assistance

Family Care Information

Gerontology Counseling

Habilitation Day Group

Habilitation Day Individual

Handy Chore

Home Health Aide

Homemaker

Individual Counseling

Information Assistance

Legal Assistance

Nutrition Counseling

Nutrition Education

Physical Fitness

Pest Control

Personal Emergency Response System (PERS)

Outreach

Respite

Specialized Medical Equipment and Supplies

Transportation

Other Long Term Services and Supports in Indiana

There are multiple formal and informal, regulated and unregulated services that may provide supports and care to at-risk populations. Some of the most commonly needed and used are:

Transportation services

- Rural transportation grants
- Community transportation services
- Medicaid vouchers, PA and limited waiver funds

Housing Assistance:

- Section 8
- Vouchers
- Senior Apartments
- Residential Care facilities including county homes and group homes which are licensed by ISDH

- Continuing Care Communities, which allow Aging-in-place from residential to assisted to skilled care, and is also licensed by ISDH
- Assisted Living facilities have both licensed and unlicensed facilities
- Rehabilitative facilities licensed by ISDH are often considered short-term and funded by Medicare based upon age and short-term rehab potential
- Skilled Nursing facilities are licensed by ISDH. Short-term stays are funded by Medicare based upon age, diagnosis, and rehab potential, otherwise private pay or Medicaid-funded as assets are diminished.

Money Follows the Person (MFP)

The MFP program was developed to help states move individuals from institutional settings to home and community-based settings and is funded through a grant from the Centers for Medicare and Medicaid Services. Indiana's MFP program is designed specifically as a transition program that assists individuals living in an institution to move safely back into the community, and to ensure a safe adjustment to community living. It is not a permanent funding source and can fund a participant for only 365 days. Indiana was approved for the MFP program in 2007, and since that time has focused on assisting eligible persons to leave institutional care by providing services for individuals to live safely in their community.

Discussion

An effective system of LTSS is essential for enabling older adults and persons with disabilities to live independently in their homes and communities. As the baby boom generation ages, the demand for high quality LTSS is expected to grow. More than three million people in the United States rely on Medicaid for LTSS. In 2009, Medicaid spending on community-based LTSS totaled $51 billion and accounted for 44.8 percent of total LTSS spending. Even though the federal government shares Medicaid costs with the states, the burden on states is substantial and certain to increase (Woodcock, National Governors Association 2011).

More work must be done to increase knowledge and planning capabilities on care alternatives and available programs and benefits for consumers who cannot cope with the complexity of LTSS. These issues become especially significant when people are trying to make critical decisions when they're at a crisis point, such as being discharged from a hospital and needing help transitioning to home or to a care facility, or living at home but finding they are no longer able to fully care for themselves. Another important area of focus are the persons currently living in nursing or rehabilitation facilities who want to go back home with supportive care; they face significant challenges navigating access to community services.

As with most large systems, barriers exist. According to a 2010 report by the National Health Policy Forum, many describe the process of accessing LTSS akin to wandering through a maze. Even for persons knowledgeable about caring for older adults and younger people with disabilities, the national LTSS system has been referred to as a "labyrinth of complicated

services, programs, funding streams, and eligibility requirements." And deciphering eligibility and program coverage requirements for the multitude of institutional and home and community-based services and benefits can be overwhelming. For example, Medicaid is the major federal financing source for LTSS whether services are provided in the home, community or long-term care settings. However, its program eligibility criteria are highly complex and services may be limited to only those meeting strict income and asset tests.

In 2013, the National Research Center conducted and evaluated a statistically valid sample of older adults' self-assessments across Indiana and compared our state's results with national study findings. The *Community Assessment Survey for Older Adults* (CASOA) findings were consistent with other states' concerns about transportation, housing, and a general lack of knowledge of how to get help when needed. In Indiana, a higher percentage of older adults identified health concerns, lack of knowledge of services and access to services as a greater concern for them when compared with other states. Overwhelmingly, nearly nine out of ten people (88%) also indicated they plan to stay in the community where they currently reside, and wish to age in place. To enable that choice of access to home and community-based services is critical, but potentially not well understood by those respondents.

One concern reported in this study indicated that over half (about 60%) of the respondents were not aware of what services are available to them. Information is key for an aging and disabled population needing a continuum of LTSS, and that lack of knowledge impacts access to services. The CASOA study gauged current availability and the means for accessing information so an aging population can make plans and decisions for themselves when reviewing current options and making plans for a continuum of service needs.

One of the vital key information systems to aid an individual's decision making are the Aged and Disabled Resource Centers (ADRCs) managed by Indiana's sixteen Area Agencies on Aging (AAAs). As the CASOA study identified: access to information is critical and "there is a need not only to increase knowledge about services offered by government, but also information about services by other organizations."

In further evaluating the nation's LTSS, a 2013 report by AARP, the Commonwealth Fund, and the Scan Foundation was reviewed in which a framework for assessing LTSS system performance was established:

INTRODUCTION Exhibit 5

Framework for Assessing LTSS System Performance
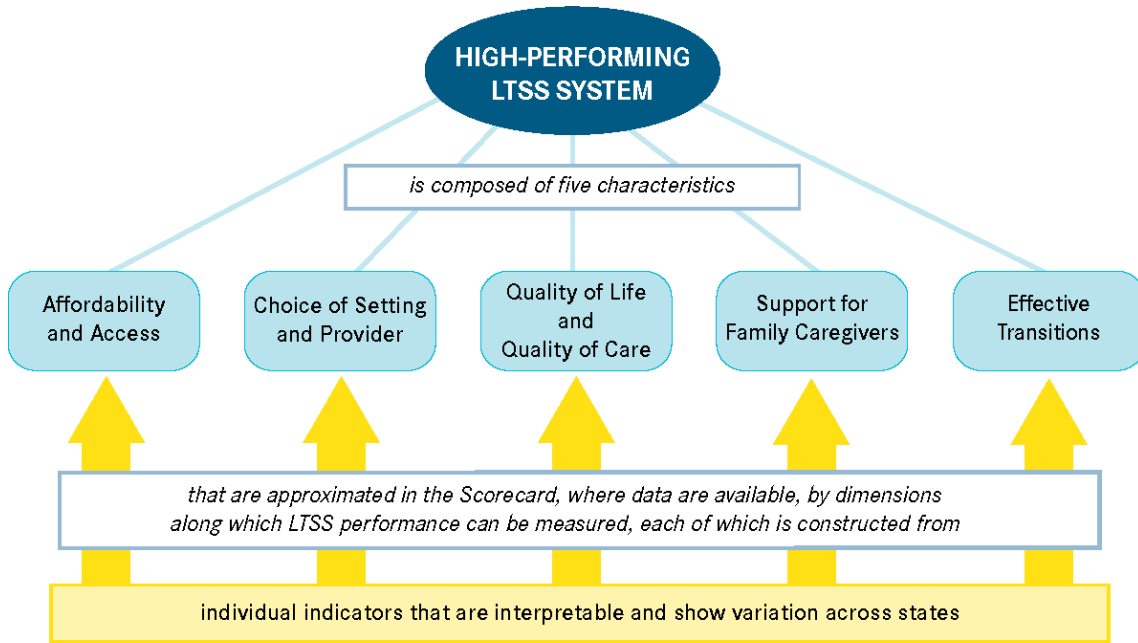
Source: State Long-Term Services and Supports Scorecard, 2014.

The aforementioned analysis of 2011 data indicate that Indiana lags behind other states in the development of a wide range of LTSS. Indiana consistently scored in the lowest quartile with an overall ranking of 47th among all states and District of Columbia.

Exhibit 6

State Ranking on LTSS System Performance by Dimension

Overall Rank*	State	Affordability & Access Rank	Choice of Setting and Provider Rank	Quality of Life & Quality of Care Rank	Support for Family Caregivers Rank	Effective Transitions Rank
50	Alabama	47	51	44	47	46
5	Alaska	38	3	2	4	8
21	Arizona	31	24	33	23	7
40	Arkansas	28	23	47	16	49
9	California	14	2	24	24	22
4	Colorado	5	14	7	16	11
12	Connecticut	4	22	6	30	39
29	Delaware	27	47	18	26	14
11	District of Columbia	1	29	30	2	35
43	Florida	35	41	43	40	14
36	Georgia	26	44	36	5	40
6	Hawaii	2	36	9	1	9
22	Idaho	38	9	27	42	3
15	Illinois	9	21	28	10	43
47	Indiana	44	42	45	51	33
13	Iowa	19	27	4	20	38
17	Kansas	11	10	20	35	37
51	Kentucky	51	50	50	46	42
37	Louisiana	24	30	41	7	51
10	Maine	23	12	23	29	6
23	Maryland	6	45	16	33	20
18	Massachusetts	17	14	15	41	26
31	Michigan	32	13	26	44	18
1	Minnesota	3	1	1	3	12
49	Mississippi	49	48	42	28	50
35	Missouri	21	11	46	32	34
26	Montana	41	18	11	49	10
20	Nebraska	37	25	10	18	25
41	Nevada	32	40	40	24	32
32	New Hampshire	29	39	13	38	19
26	New Jersey	13	37	21	22	36
14	New Mexico	12	6	38	37	17
25	New York	22	20	34	6	45
28	North Carolina	24	19	35	31	21
33	North Dakota	48	34	3	27	29
44	Ohio	42	32	39	39	27
45	Oklahoma	45	27	51	9	48
3	Oregon	20	5	13	14	1
42	Pennsylvania	46	25	37	36	28
38	Rhode Island	36	38	31	19	31
34	South Carolina	29	35	29	34	16
24	South Dakota	40	43	5	13	24
48	Tennessee	43	49	31	48	44
30	Texas	10	16	49	11	47
39	Utah	34	46	25	50	2
6	Vermont	15	8	17	12	5
19	Virginia	8	17	22	45	23
2	Washington	7	4	19	7	4
46	West Virginia	50	30	48	43	41
8	Wisconsin	18	7	7	14	13
16	Wyoming	16	33	12	21	30

*Final rank for overall LTSS system performance across five dimensions.
Source: State Long-Term Services and Supports Scorecard, 2014.

It is notable that Transitions from nursing facilities ranked in the third quartile, which evaluated the ease of transfer in and out of facilities, transfers back to the community, and transfers from hospital to facility.

However, one individual score in which Indiana succeeded was in its early development of its Aged and Disability Resource Centers (ADRCs) to help inform consumers regarding home and community-based service options, and provide other information. To enable the state to manage increasing numbers of older adults and disabled persons, the Division of Aging believes the system must further expand to identify and quantify unmet LTSS needs to aid efforts in long-term planning. Eventually, the ADRC network must: 1) expand its visibility and accessibility to allow for the broadest network of available information on the range of services regardless of payer sources, 2) allow an individual or family member to interact directly with the network for self-referral to do their own planning and determination of care needs and options, and 3) alert consumers to wider ranges of services beyond the traditional model of aging services.

Each of Indiana's sixteen Area Agencies on Aging (AAAs) has been awarded the designation as an Aging and Disability Resource Centers (ADRC) and operates as a visible and trusted resource within its own multi-county geographic area (see Attachment A – the AAA state map). And as envisioned by the Older Americans Act amendments, the Administration on Aging, and the Centers for Medicare and Medicaid Services, Hoosier ADRCs exists to help persons of all ages, disabilities, and income levels access LTSS more easily through single points of entry, make more efficient use of care options, and maximize the services available.

To be most effective, ADRCs must function as part of a statewide network of organizations and systems that provide access to LTSS across all populations and payers. That statewide network has to connect with each other, and the way to do that is through building community partnerships and moving from a focus on eligibility and presenting an applicant with a set menu of services, to a proactive, consumer-focused approach of needs assessment. This model is currently being tested in HEA 1391's pilot projects located in four areas of the state.

To function effectively the ADRCs must be prepared to assist individuals of all ages and income levels, along with providing comprehensive options counseling to identify needs and offer service alternatives across the continuum of care and across a funding continuum of donated services, federal and state services along with private pay options.

The Division of Aging recently recognized an opportunity for improving the overall functioning and effectiveness of our ADRC network, and released a Request for Proposals to its ADRCs to apply for a one-time grant opportunity to address two targeted areas: building community partnerships and building a local resource database for the state's future network development.

In the fall of 2014, the Division of Aging was awarded funding for a one-year planning grant from the U.S. Administration for Community Living, the Centers for Medicare & Medicaid Services and the Veterans Health Administration to *develop a plan* to implement a **No Wrong**

Door System of Access to Long Term Care Services and Supports for All Populations and All Payers (NWD). The rationale behind NWD is to make it easy for people of all ages, disabilities, and income levels to learn about and access the services and supports they need. The NWD system also provides states with a vehicle for better coordinating and integrating the multiple access functions associated with their various state-administered programs that pay for LTSS.

The Division of Aging views NWD as a chance for Indiana to look across the entire system and determine how we can adjust to meet our consumers' needs, placing them at the center of the very systems that serve them. We know there is a growing need for LTSS as our population ages and there are not sufficient resources to fund existing "doors" to handle the demand. We are also aware that tools and trainings to prepare the individuals and organizations that manage those doors to provide assessment and supported decision-making to consumers and their families.

Our NWD planning is an opportunity for true organizational change in order to rebalance Indiana's LTSS. We plan to support rebalancing of public expenditures to LTSS by reducing or eliminating the highly fragmented systems of accessing those services and we anticipate that within three to five years, the ACL/CMS/VHA vision of NWD will be fully implemented in Indiana, including:

- an efficiently integrated and customizable suite of web-based technology products including a customer portal, which will connect information and referral systems statewide and serve as a genuine "No Wrong Door;" and
- all Hoosiers and their families/caregivers, regardless of where they live in the state or who pays for their care, will have the ability to make informed choices about their long-term care needs, enabling them to receive the right care, in the right place, at the right time, and in the least restrictive setting.

Numerous formal meetings have been held over the past six months with a variety of stakeholder groups affiliated with state government, healthcare, aging, and persons with a disability, as well as other advocacy groups, in efforts to obtain acceptance and a willingness to support the NWD concept. Key players in the planning process include not only the Division of Aging (DA), but also other divisions within Indiana's Family and Social Services Administration (FSSA): the Office of Medicaid Policy and Planning (OMPP), Division of Mental Health and Addiction (DMHA), and Division of Disability and Rehabilitative Services (DDRS), as well as the Indiana's Commission on Aging, and CHOICE (Community and Home Options to Institutional Care for the Elderly and Disabled) Board, the Pre-Admission Screening (PAS) Work Group, the Indiana Hospital Association, Home Care Task Force, Alzheimer's Task Force, and representatives from all sixteen of Indiana's Aging and Disability Resource Centers (ADRCs). Information will continue to be posted on the DA's website: http://www.in.gov/fssa/da/4936.htm.

An analysis of
Past policies implemented in Indiana; and other states' approaches;
To serve individuals in a home and community-based setting and in an institutional care setting more efficiently and cost-effectively through the use of emerging technologies, including telemedicine and remote patient monitoring.

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

Telemedicine provides numerous ways in which to improve health outcomes through the use of two-way, real-time interactive communication between the patient and a physician or medical practitioner located at a remote site, and uses audio and video equipment at a minimum. The federal Centers for Medicare and Medicaid Services (CMS) sees telemedicine as an economical service delivery alternative to the more traditional in-person provision of medical care that states can choose to cover under Medicaid. This definition is modeled on Medicare's definition of telehealth services (42 CFR 410.78). However, the federal Medicaid statute does not currently recognize telemedicine as a distinct service (Medicaid.gov http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html).

Past Indiana Telemedicine Policies
During the 2015 legislative session, the introduced version of SB 358 (Medication therapy management and Medicaid) is the only bill to include the idea of telehealth. However, the word "telehealth" was deleted from the bill's language by the end of January 2015.

House Bill 1258, or the Telehealth services bill introduced in January 2014, required Indiana's Medical Licensing Board to establish a pilot program to allow treatment (including issuing a prescription), without the creation of a typical in-person patient/physician relationship, as well as the establishment of physician standards and procedures for such a program. The bill wound its way through several iterations through the House and Senate to finally include not only assurance of the safety of patients' electronic medical records but compliance with the Health Insurance Portability and Accountability Act (HIPAA), as well as a report back to the legislature on the pilot program's measurable outcomes no later than February of 2015. House Enrolled Act No. 1258 was signed by Governor Pence on March 24, 2014, and added as Chapter 14 to Indiana Code 22-22.5.

The bill added the word "treatment" to the definition of "telehealth" services, which now carries the meaning to the use of telecommunications and information technology to provide access to

health assessment, diagnosis, intervention, consultation, treatment, supervision, and information across a distance.

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

[Cannot find the telehealth services pilot program report with Professional Licensing Agency]

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

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

Indiana Medicaid provides Personal Emergency Response Systems (PERS) as a telecommunications device under the home and community-based waivers and the Social Services Block Grant (SSBG) funding for eligible individuals who live alone or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and would otherwise require extensive supervision. The PERS are not reimbursable when the individual requires constant supervision. Additionally, the Medicaid program provides electronic monitoring for residential settings under the waivers administered by the Division of Disability and Rehabilitative Services.

The use of telephone transmitters for monitoring, or a telephone or any other means of communication for provider-to-provider consultation were not included in SEA No. 544. Additionally, the Office of Medicaid Policy and Planning (OMPP) was to reimburse Medicaid providers that were appropriately licensed home health agencies for telehealth services, while

reimbursing [all] federally qualified health centers and rural health clinics for telemedicine services.

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

Serving individuals in a home and community-based setting and in an institutional care setting more efficiently and cost-effectively

The Veterans Administration (VA) first implemented a three-year telehealth-based care pilot program in 2000 for 800 veterans. Upon its initial success, that telehealth pilot became a fully-functioning program in 2003, and was seen as a viable option for the delivery of high quality health care to many veterans. According to Wennergren et al, telehealth services are now fully integrated into nearly all aspects of care as an essential component within the VA health care system. In 2012, the VA provided care to 500,000 veterans using 1.4 million telehealth-based consultations delivered from 150 VA medical centers and 750 outpatient clinics. Of those, 148,000 veterans participated in home-based consultations, 119,000 received telehealth care directly in their homes, and 76,000 received telemental health consultations. This type of care coordination has resulted nationwide in a 58% decrease in hospital bed days and a 38% reduction in admissions (p. 714).

A significant need in Long Term Care Services and Supports (LTSS) relates to chronic disease. According to the Institute of Medicine, nearly one-hundred million Americans with chronic diseases account for about seventy-five percent of health care expenditures. Traditionally, chronic disease is managed through an episodic office-based model rather than a care management model, which uses frequent patient contact and regular physiologic measurement.

Use of technologies for chronic disease care management has been associated with reductions in hospitalizations, readmissions, lengths of stay, improvement in some physiologic measures, high rates of satisfaction, increased adherence to medication, and overall cost of care. Studies of home monitoring programs have shown specific improvements in the management of hypertension, congestive heart failure, and diabetes. (IOM).

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

It is projected (Frisch, BMJ) that the number of primary care physicians will fall by 91,000 over the next 10 years leading to decreased access to care, and telemedicine is an evolving technology pioneered to address these projections by providing improved access to care without compromising quality medical care.

A recent report shows that by the year 2018, the use of telehealth services will increase from its current level of around $230 million per year to $1.9 billion per year with an increase in the number of patients using this technology to around 3.2 million, up from 250,000 in 2013. This increase is led in part to recent changes enacted by the Affordable Care Act (ACA). With a projected 32 million additional Americans entering the health system and the baby boom generation coming of age and using Medicare services, many are beginning to realize that telemedicine will help to address the problem of providing timely access to healthcare for this subset of the population particularly even more challenging as we are also faced with shortages in primary care providers along with ever increasing costs of providing health care." (p. 715, Wennergren et al)

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

According to the American Telemedicine Association, the last three years have seen the number of states with telemedicine parity laws – those laws requiring that private insurers cover telemedicine-provided services comparable to that of in-person – double. Further, many state Medicaid agencies are transforming payment and delivery methods for this developing technology, resulting in 47 state Medicaid agencies that provide some type of coverage for

telemedicine services. As of 2014, Connecticut, Iowa, and Rhode Island are the only states without coverage for telemedicine under their Medicaid plans. Nineteen states and the District of Columbia have enacted full parity laws. (Thomas and Capistrant, State Telemedicine Gaps Analysis Coverage & Reimbursement, 2014).

Pennsylvania was one of the first states in the nation to provide reimbursement for home telehealth technology through a Medicaid waiver for older adults ages 60 and older. On September 1, 2007, Pennsylvania's Office of Long-Term Living implemented a demonstration reimbursement policy to cover a range of services provided by home health, durable medical equipment providers, pharmacies, or hospitals through contracts with local county Area Agencies on Aging (AAAs). According to the Center for Health Care Strategies (Endquist et al), reimbursement not only covers remote patient monitoring technology, but also "smart home" technology by which a family member can access a website and determine a loved one's activity status, such as the time of awakening in the morning, the number of times the refrigerator opens, how many times the bathroom is used, when/if medications are taken, and whether an individual suffers a possible fall.

During 2007, the state of New Mexico implemented a policy allowing Medicaid to reimburse providers for telehealth services. According to the medical director of the Center for Telehealth at the University of New Mexico, the state's Medicaid program began one of the nation's most comprehensive reimbursement programs for telehealth services, thereby providing a model for the country. Eligible providers using telehealth are reimbursed at the same rate as a physical face-to-face encounter (Endquist et al).

In January of 2015, the Colorado State House Health, Insurance and Environment Committee unanimously approved a bill that would expand a current law supporting telemedicine only for those patients residing in counties with 150,000 or fewer residents. The telemedicine bill, which will now move to the state's House floor, was amended to refer to "telehealth," in order to reflect the broad array of services that can be delivered via telecommunications and other technologies. The bill would prevent health insurance plans from requiring in-person care to patients, when that care can be appropriately provided from a remote location. If passed, this bill would preclude health plans from requiring in-person care if consulting, monitoring, and other care could be administered as effectively at a distance, and would prevent plans from reimbursing providers who deliver telehealth on a different basis than for in-person care. Health plans could not charge different deductibles, co-payments or co-insurance amounts or set different annual or lifetime dollar maximums. Supporting testimony concluded that telehealth lowers costs and improves access to medical services and outcomes in urban and rural areas

Twenty states, including New Hampshire, Vermont, Maine, and the District of Columbia require that private insurers cover telehealth the same as they cover in-person services. Many other insurers cover at least some telehealth service—and many more have expressed interest in expanding their telehealth coverage (Dartmouth/Hitchcock). Of the eighteen states that cover

home telemedicine, only Alaska, Kentucky, and Maine reimburse for telerehabilitative services within a home health benefit, even though the same services are covered when provided in-person. Pennsylvania is the only state that will currently cover telemedicine in the home when provided by a caregiver (Thomas & Capistrant).

A 2014 study by the American Telemedicine Association measured components of state Medicaid policies that apply more stringent requirements for telemedicine as opposed to in-person services. States were evaluated based on requirements for written or verbal informed consent, or unspecified methods of informed consent before a telemedicine encounter can be performed. California is the only state that explicitly requires verbal informed consent, and of the 23 states with informed consent requirements, only twelve states have such requirements imposed by their state Medical Board.

Over the years, states have increasingly used managed care organizations (MCOs) to create payment and delivery models involving capitated payments to provide better access to care and follow-up for patients, and control costs. A wide variety of payment methods and other operational details among Medicaid managed care arrangements exists among a number of states. MCOs testing creative delivery models including medical homes and dual-eligible coordination have incorporated telemedicine as a feature of those models especially because it helps to reduce costs related to emergency room use and hospital admissions. Twenty states authorize telemedicine-provided services under Medicaid managed care plans.

Medicaid plans have several options to cover remote patient monitoring, usually under a federal waiver such as the Home and Community-based Services (HCBS) under Social Security Act section 1915(c). States may apply for this waiver to provide long-term care services in home and community settings rather than institutional settings. Kansas, Pennsylvania, and South Carolina are the only states that have used their waivers to provide telemedicine to beneficiaries in the home, specifically for the use of home remote patient monitoring (Thomas & Capistrand).

Emerging technologies

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

Given the high penetration and level of computing capacity available in even basic cell phones, it is possible that these technologies can make a significant difference to public health and health care delivery. The accessibility and data availability of mHealth methodologies could be utilized to change public health and health care on a large scale, for example, by employing mobile tools

to decrease the number of people who develop diabetes, prevent falls at home, and help people who need medication to take them as scheduled (NIH).

Other options include a low-cost text (SMS) message reminder system. A recent pilot study provided short text messages to two different patient populations. Messages were personalized from clinical staff on a weekly basis. Based on a post-test study, patients were satisfied with the number and frequency of messages (Upper Midwest Telehealth Resource Center).

3) An analysis of demographic trends by:

A) payor sources; and

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

Statewide and by county or other geographic setting.

Demographic trends

According to the Kaiser Commission, the United States will experience an age-related demographic shift in the coming decades as a result of the "Baby Boomers" reaching older adulthood, increased life expectancy, and advances in medicine and medical technology. The majority of Americans ages 65 and older will have long-term needs (70% of 'Baby Boomers' can expect to use some form of long-term care during their lives). The population most likely to need LTSS are the very old – individuals ages 85 and over – and that demographic is expected to increase by almost 70% in the next 20 years. (page 3 of The Kaiser Commission on Medicaid and the Uninsured Fact Sheet published September 2013). The Journal of American Medicine (JAMA) reports that seventy percent of older adults will need LTSS for an average length of three years. Currently, there are 12 million older adults receiving LTSS and 87% of these individuals receive it from unpaid family caregivers. The impact of the population's boom and bust raises many concerns about the future role and availability of family caregivers.

Indiana's demographic trends indicate a higher percentage of elderly population (those ages 85 and older) and a lower percentage middle-aged persons caused by out-of-state migration of younger cohorts, and age shifts with the baby boom generations' aging into old age followed by the baby-bust of those born after 1964, which may limit family support options within the next 15-25 years.

The Indiana CASOA study's other significant findings included the identification of a high level of dependency on informal caregivers and the high percentage (45%), of respondents who indicated they currently were caregivers. One of four respondents (25%) reported providing an average of twenty or more hours of care per week, and of all respondents, between 20% and 26% reported they felt physically, emotionally, or financially burdened by providing care for another person. These findings underscore Hoosier's traditional strong sense of family support and self-reliance, which is to be lauded and acknowledged, but as the study further indicated, family caregivers experience high levels of stress when providing care and often experience a negative impact on their health and well-being.

The AARP study found more than 90% of older people who receive care in the community rely on unpaid family care, either alone or in combination with paid help. The significance of this coupled with the demographic trends indicates a potential loss of this resource in future. Additionally, the impact on the current caregivers' future must be recognized. Providing care to a family member can result in the caregiver's loss of health, income, and burn-out, which may impact their ability to care for themselves as they age and begin to need assistance.

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Of course, age alone will not be the sole determinate of the need for LTSS in the future. Upcoming demands and needs will also be dependent on our current level of preventative care services and access to care.

By payer source:

JAMA reported in August 2013 that nationally, Medicaid is the primary payer for all long-term care services and supports and pays 40% of the total cost for care. Medicare post-acute care pays 21%; private pay covers 15%; private insurance pays 2%. The 22% balance is paid by "Other" and includes federal funds like SSBG and Older Americans Act, state, local, and various community resources.

In Indiana, the inclusive cost for all of Medicaid spending for long-term care from community and home settings to long-term care facilities totaled $2,148,318,000 for the first six months of fiscal year 2015. This amount came slightly under forecasted expenditures by four and half million dollars.

Can we determine number and age of all service recipients in community settings, in residential settings and in long term care settings by payer source?

Demand for services can be measured by waitlist for services; to what extent are the needs for specific services identified. Break down by AAAs (DA)

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

A 2005 study commissioned by the Family and Social Services Administration (FSSA) identified recommendations to strengthen the community-based long term services and supports by:

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

Longer term goals for serving more elder Hoosiers were:

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

At this time, Indiana has not developed a wait list policy different from the traditional "first-come-first" placements.

Detail the initial impact of Pilot program on offering more focus on case management's assessment of needs and <u>all</u> options for meeting those needs. Greater focus on needs for services determined by assessment and less focus funding source "bucket" per forma service planning.

 Impact from this has currently lead to more flexibility of provider agencies to offer smaller units of service to meet the client's actual need versus a minimum required number of hours for all clients regardless of need.

Review of Medicaid reimbursement for skilled nursing facility care, and a determination concerning whether reimbursement models should be modified to reflect current and future care models.

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

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

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

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

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

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

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

Future Care Models for Reimbursement Methodology

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

Capacity & Occupancy

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

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

Date	# of NFs	Certified Medicare Beds	Certified Medicaid Beds	Dually-Certified Beds (MA/MK)	Total # of Licensed Comprehensive Care Beds	Occupied Beds
1/28/2011	508	5,808	2,351	40,721	50,107	80%
5/20/2011	514	6,016	2,154	41,024	50,649	79%
9/21/2011	512	6,215	2,154	41,430	51,287	79%
1/13/2012	511	6,379	2,154	41,367	51,230	78%
5/11/2012	511	6,379	2,154	41,356	51,038	79%
12/21/2012	499	7,136	1,936	41,391	51,363	78%
4/11/2013	488	7,034	1,647	41,665	51,235	78%
6/11/2013	488	7,084	1,647	41,685	51,235	78%
9/9/2012	515	7,200	1,493	41,704	51,458	78%
12/11/2013	519	7,549	1,493	41,704	51,670	74%

2/3/2014	518	7,387	1,493	41,710	51,508	74%
2/28/2014	519	7,382	1,374	41,908	51,509	77%
4/1/2014	520	7,430	1,374	41,852	51,648	76%
5/5/2014	521	7,296	1,370	41,787	49,545	76%
6/3/2014	523	7,429	1,370	41,787	51,526	76%
7/2/2014	524	7,308	1,339	42,066	49,863	77%
8/1/2014	525	7,164	1,315	42,312	49,941	76%
9/4/2014	525	7,164	1,315	42,312	49,965	76%
10/10/2014	527	6,958	1,307	42,603	50,045	76%

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

Indiana's Nursing Facility Moratoria

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

In Indiana's State Government's July – December 2005 Performance Report, it was reported that FSSA "failed to assist seniors in maintaining their health and finding services that best fit their needs, often resulting in more seniors in nursing homes than is appropriate given their needs

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

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

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

Today's climate

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

Cost Impact of Excess Capacity

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

Impact of Excess Capacity on Quality of Care

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

The Future

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

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

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

Value-Based Purchasing

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

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

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

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

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

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

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

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

the 324 Indiana NSGO nursing facilities under the UPL program YTD were approximately $706 million (state and federal dollars).

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

Incentives for quality care and quality outcome:

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

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

> **Satisfaction Surveys** conducted in 2013 and 2014 being conducted in 2015 to measure residents' satisfaction; family satisfaction and employees' satisfaction.

Starting in February 2015 a new Clinical Experts Panel will be involved in updating the report card scoring formula, establishing new personnel metrics reviewing CMS clinical standards and examining the satisfaction data.

References

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Center for Connected Health Policy: The National Telehealth Policy Resource Center (2014). Retrieved March 2, 2015, from: http://cchpca.org/what-is-telehealth.

Colello, K. J., Mulvey, J., & Talaga, S.R. (2013). *Long-Term Services and Supports: Overview and Financing*. Congressional Research Service; 7-5700 www.crs.gov R42345. [citation format]

Darkins, A., Ryan, P. Kobb, R., Foster, L., Edmonson, E., Wakefield, & Lancaster, A.E. (2008). Care coordination/home telehealth: The systematic implementation of health informatics, home telehealth, and disease management to support the care of veteran patients with chronic conditions. *Telemedicine and e-Health*. 14(10): 1118-1126.

Endquist, G., Johnson, C., & Courtland Johnson, W. (2010). *Medicaid-funded long-term supports and services: Snapshots of innovation*. Center for Health Care Strategies, Inc.

Frisch. S. (2013). The United States will not have enough doctors. *BMJ*, 347:f6559.

Health Resources Services Administration (March 21, 2014). Retrieved March 2, 2015, from: http://www.healthit.gov/providers-professionals/faqs/what-telehealth-how-telehealth-different-telemedicine.

IOM (Institute of Medicine). 2012. *The role of telehealth in an evolving health care environment: Workshop summary*. Washington, DC: The National Academies Press.

Latoya, T., & Capistrant, L. (2014). State Telemedicine Gaps Analysis Coverage & Reimbursement. American Telemedicine Association: Connected to Care; 50 State Telemedicine Gaps Analysis Coverage & Reimbursement.

Lynch, K.E. (2012). Social Services Block Grant: Background and Funding. Congressional Research Service; Congressional Research Service 7-5700 www.crs.gov 94-953. [citation format]

Medicaid.gov.Telemedicine. Retrieved March 2, 2015 from: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html.

Telehealth and Remote Patient Monitoring for Long-Term and Post-Acute Care: A primer and provider selection guide (2013). LeadingAge Center for Aging Services Technologies, Washington, DC. (whitepaper)

O'Shaughnessy, C.V. (2010). Aging and Disability Resource Centers (ADRCs): Federal and State Efforts to Guide Consumers Through the Long-Term Services and Supports Maze. National Health Policy Forum, Background Paper No. 81.

Sikka, N., Paradise, S., Shu, M., (2014). Telehealth in Emergency Medicine: A primer. George Washington University School of Medicine. *American College of Emergency Physicians*.

Wennergren, J., Munshi, I., Fajardo, A. and George, V. (2014) Implementation of Clinical Video Telemedicine (CVT) within a VA Medical Center Is Cost Effective and Well Received by Veterans. *International Journal of Clinical Medicine*, 5:711-716.

What is Telemedicine? (n.d.). Retrieved February 28, 2015, from http://www.americantelemed.org/ab-telemedicine/what-is-telemedicine#.VP3NOfnF-hI.

The Aging and Disability Resource Center (ADRC) Demonstration Grant Initiative Interim Outcomes Report (2006). U.S. Department of Health and Human Services; The Lewin Group, November 2006.

Woodcock, C.H. (2011). Long-Term Services and Supports: Challenges and Opportunities for States in Difficult Budget Times; The Hilltop Institute, for the National Governors' Association.