P.L. 145-2014

Family and Social Services Administration

October 2015

House Enrolled Act No. 1391—now P.L. 145-2014 since Governor Pence's signing of the bill—of the 2014 Indiana General Assembly required the Division of Aging (DA), the Indiana State Department of Health (ISDH), and the Office of Management and Budget (OMB) to 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 Indiana's policies and other states' approaches to serving individuals in home and community-based and institutional care settings more efficiently and cost-effectively through telemedicine and remote patient monitoring;
3) an analysis of demographic trends by payor sources, and demand and utilization of long-term care services options;
4) an analysis of program and policy options for long-term care services where demand exceeds current capacity for providing the services;
5) a review of Medicaid reimbursement for skilled nursing facility care, and determinations concerning the reimbursement methodology, incentives quality care and outcomes; and
6) an analysis of Indiana's past policies and other states' approaches to managing construction of additional skilled nursing facilities, including the costs/benefits to Indiana's budget and impacts on the Medicaid program, as well as the impact of additional skilled nursing facilities on availability and cost of capital for renovation and new construction of other senior housing options.

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2) an analysis of

A) past policies implemented in Indiana; and

B) other states' approaches;

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

3) An analysis of demographic trends by:

A) payor sources; and

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

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

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

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

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

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

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

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

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Executive Summary

The scope of Long-Term Services and Supports (LTSS) for older adults and persons—including children—with disabilities is often referred to as the continuum of long-term care. Service sites can occur in one's home, a community setting, or a long-term care facility. It is important to note, however, that this continuum does not always follow a linear progression. People may enter and exit service options many times – when and where depends on a number of variables: the availability of family and other informal support systems, disease processes and chronic conditions, rehabilitation needs, and housing options.

It is no longer necessary to view nursing home placement exclusively as the "end" of the care continuum. Though medically fragile people may be best cared for in a skilled nursing facility, the delivery of care can now occur in a variety of community, home, and institutional settings, with the appropriate services and supports.

Services in Indiana are most often accessed through the aging network via the state's sixteen Area Agencies on Aging (AAAs). Using a combination of federal, state, and some local funding program sources, each of which has its own unique requirements, AAAs work hard to knit together a safety net of support for vulnerable Hoosiers.

Federal support comes in the form of Medicaid, Older Americans Act, Social Services Block Grant, and the Money Follows the Person Demonstration Grant. State dollars are spent on CHOICE (Community and Home Options to Institutional Care for the Elderly and Disabled). Waiting lists for these services are based on a traditional "first-come first-served" basis.

Many services for older adults and persons with disabilities focus on physical needs, but the systemic needs of an increasingly aging population also warrant a focus on elder justice issues that protect its most frail and vulnerable citizens. A number of services and programs exist in Indiana to protect the rights, property, and physical well-being of its most vulnerable populations in the community and in facilities, but availability of these services may be limited due to inadequate funding.

LTSS Costs

Though many people mistakenly continue to believe that Medicare pays for long-term care, it does not. This confusion most likely stems from misinterpretation of the coverage provided by Medicare's "post-acute" benefits. *Medicaid* is the primary payer for LTSS. Private health insurance may also provide some coverage for certain services, but only in specific circumstances. People also pay out-of-pocket for services.

More than three million people in the United States relied on Medicaid for HCBS in 2010, an increase of more than 50% since the year 2000. Community-based services totaled $219.9 billion in 2012. During the same time, Medicaid paid for 61% ($134.1 billion) of all national LTSS spending.

Indiana's Medicaid expenditures for community-based services (1915(c) Waivers and Other HCBS) totaled nearly $950 million in 2013 for all FSSA divisions. The cost for Medicaid spending for all of Indiana's long-term care, including institutional and HCBS expenditures totaled an estimated $2,985,826,538 dollars for FY2013, representing a nearly eleven percent increase (10.74%) in expenditures from the FY2012 total of $2,665,060,979.

Demographics

Trends suggest considerable growth in the number of Americans who will need LTSS in the coming decades. Life expectancy remains relatively high, baby boomers continue to age into older adulthood, and advances in medical technology allow more persons with chronic illnesses and disabling conditions to live longer and independently in the community.

Indiana's most populated areas will see increases of more than 80% in people ages 65 and older in the next twenty years. By 2030, growth in that group will begin to stabilize after the last of the boomers turns 65. As boomers continue to age during the following twenty years, the state is going to experience unprecedented increases in the 85+ age group. Those over age 85, the "oldest-old," are four times more likely to be frail and require LTSS, than persons ages 65 to 84. Seven out of ten older adults needing LTSS will do so for an average of three years.

Unmet Needs

In 2013, the National Research Center conducted a self-assessment survey of Indiana's older adults. Hoosiers are concerned with many of the same issues as other Americans: housing, transportation, caregiving, and a general lack of knowledge of how to get help when needed.

Indiana's AAAs also recently conducted surveys and public hearings within their regions and found that local responses mirrored concerns throughout the state. Available transportation for accessing community services, and caregiver support were found to be very significant needs. And "not knowing who to call" for information and assistance, as well as a general lack of awareness of the existence of Indiana's aging network continue to make that list.

Many older adults and others with disabilities experience serious problems because of poor housing quality or inadequate home design. Add in the lack of affordable housing, and the impact on their ability to meet other basic needs skyrockets, often forcing choices between paying rent, utilities, food, or medical care. A household that spends 30% or more of its income on housing is considered "housing cost burdened." For 2008, 35% of Hoosier householders (owners and renters) ages 65 and older experienced housing cost burden beyond 30% of income, making aging in place not easily attainable.

Finding affordable senior housing may be one of the biggest challenges facing older adults and their family members. The U.S. Department of Housing and Urban Development (HUD) creates affordable housing programs for older adults and persons with disabilities. However, the demand

for federally subsidized rental housing is far greater than the supply. Only one in four low-income renter households that qualify for federal housing assistance receives it, and typically only after a lengthy wait.

Many older Hoosiers plan to age in place in communities where daily activities require some form of transportation but a large number of them will find their ability to drive safely diminish over time. Affordable alternatives to driving must be in place in order for older adults and persons with disabilities to maintain their independence. Indiana communities have taken advantage of rural transportation grants and community transportation services, but countless older adults will continue to rely on family members and friends for getting to the grocery or to medical appointments.

Nationally, 12 million older adults currently receive LTSS, and 87% of those receive much of that care from unpaid family or "informal" caregivers. Many older Hoosiers also depend upon informal caregivers. Nearly half of respondents to the aforementioned survey indicated they currently are caregivers, and twenty-five percent of them provide an average of twenty or more hours of care per week.

Hoosiers traditionally have a strong sense of self-reliance, but family caregivers often experience high stress levels. With the impending increase in persons ages 85 and older, and the shift that will occur as boomers age with fewer children to care for them (boomers have not had as many children as earlier generations), family support options will likely be limited over the next two decades. If fewer family members are available to provide everyday assistance to the growing numbers of frail older people, those older adults will likely need institutional care.

Accessing LTSS

People seem to encounter difficulty and frustration at every turn when trying to find LTSS information and services. Many people, even those with the financial resources to pay for their care, do not know where to get help or how to access services, if they are even aware the services exist. Information becomes an important commodity as consumers struggle to make informed decisions, often when they are at a crisis point such as being discharged from a hospital and having to transition to home or a care facility.

Nearly nine of out of ten older Hoosier adults wish to age in place, yet acknowledge a lack of awareness of services and access to LTSS, To enable aging in place, access to HCBS information is critical. Increasing knowledge of options and linking information is key for an aging and disabled population needing a continuum of LTSS.

A 2013 study that annually evaluates the nation's LTSS found that Indiana ranked among the five highest in the nation for its early development of its Aged and Disability Resource Centers (ADRCs). The ADRCs are a vital part of the information system that aids an individual's decision-making. Each of Indiana's AAAs was designated as an ADRC with the goal of

operating as a visible and trusted resource within its own multi-county geographic area. To be most effective, ADRCs must function beyond their AAA identity to become a part of a statewide network of organizations and systems that provide access to LTSS across all populations and payers.

There is a growing need for LTSS as our population ages, and there are not sufficient resources to fund ADRCs to handle the demand. Consumers must be met where they are, with information and support so they can make knowledgeable choices in order to purchase or obtain the right care at the right time in the least restrictive setting. In September 2014, FSSA's Division of Aging was awarded a federal planning grant 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).

Indiana has used its one-year grant period to prepare a three-year plan for implementing a NWD system by involving key stakeholders—consumer groups, industry associations, and state agencies—in an analysis of the strengths and weakness of the current system, and what a No Wrong Door system should look like. The past year has culminated in submittal of a draft NWD strategy that includes plans ranging across the creation of a standardized web portal for consumers to implementation of an integrated case management system to intensifying public outreach.

Rebalancing LTSS

Rebalancing Medicaid long-term care expenditures describes a state's efforts to *reduce* expenditures on long-term care in institutional settings, and *increase* expenditures on LTSS in home and community-based settings. Over the last several decades, states have been working to rebalance their LTSS systems by devoting a greater proportion of Medicaid spending to HCBS instead of institutional care.

In 2013, Indiana ranked 47th in the nation in its percentage of Medicaid LTSS dollars spent on HCBS. For the same year, Indiana's nursing facility expenditures per state resident were the tenth *highest*, rising from 12th in the nation in 2012. FSSA is working with stakeholders to create a strategic plan to rebalance Medicaid spending over the next 5-8 years.

Nationally, spending on nursing facilities across all payers totaled nearly $156 billion in 2013. Indiana's Medicaid expenditures for nursing facility care in FY2013 totaled $1,695,492,875. Medicaid nursing facility rates are determined pursuant to the rate setting methodology as defined in Indiana Code, and are comprised of several different rate components and rate add-ons.

As of August 20, 2015, the Office of Medicaid Policy and Planning (OMPP) published a notice of proposed changes to the reimbursement methodology for nursing facilities (NFs). At that time,

the OMPP proposed to continue the three percent (3%) reduction that was set to expire on June 30, 2015, for rates paid to nursing facilities under the Medicaid state plan and state regulations. However, this three percent (3%) reduction will remain in effect through June 30, 2017. Beginning July 1, 2017, the OMPP proposes to remove the three percent (3%) rate reduction.

Managing Nursing Facility Supply and Demand

As of 2005, Indiana had almost 50% more nursing facility beds than the national average. Supply exceeded demand, resulting in a higher bed day cost. Beginning December 5, 2005, a temporary (90-day) moratorium was instituted for new Medicaid certifications on nursing home beds. A nursing facility reimbursement rate containment proposal was also approved to reduce the rate of payment to nursing facilities. The estimated savings to the state in SFY06 was nearly $13 million ($12,900,000).

In 2011, legislative action established a moratorium on the certification of new Medicaid beds with exceptions for replacement beds, small house facilities, and continuing care retirement communities. During the 2013 legislature, the state Senate passed a bill that would put a five-year moratorium on new nursing home construction. The House passed the legislation, noting empty beds across the state, but the bill died in March of 2014. In the 2015 session, a comprehensive moratorium for the next three years was passed. Exceptions exist in this moratorium for construction of replacement facilities, small house facilities and continuing care retirement communities.

Other states are also grappling with issues relating to balancing supply and demand in their systems of LTSS. Certificate of Need (CON) programs are aimed at restraining health care facility costs and allowing coordinated planning of new services and construction. Laws authorizing such programs are one mechanism by which state governments seek to reduce overall health and medical costs. As of 2014, about 36 states retained some type of CON program, law, or agency.

Indiana's nursing facility moratorium currently in place may free up funds for existing facilities to upgrade and improve their existing facilities or replace older structures. Additionally, during the moratorium, resources may be available for constructing alternative residential or care facilities that allow more flexible housing options as residents age.

The impact of excess nursing facility bed capacity results in an increase in direct costs per resident. 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—$7.5M of which are state dollars—because the fixed costs per each resident increase over the same time.

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.

Telehealth/Telemedicine

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

House Bill No. 1451, introduced during the 2015 legislative session, concerned coverage for telemedicine services. The bill defined telemedicine services as health care services delivered by the use of interactive audio, video, or other electronic media, but it excluded certain types of health care delivery services. The new bill also contained language regarding insurance coverage for telemedicine.

Telehealth Initiatives

Hospitalizations of nursing facility residents are frequent, and often result in complications, morbidity, and Medicare expenditures that amount to more than a billion dollars annually. A controlled study recently undertaken of nursing facilities in Massachusetts provided the first indications that switching from on-call to telemedicine physician coverage during "off" hours could reduce hospitalizations, and generate cost savings to Medicare in excess of the facility's investment in the service.

Indiana's Franciscan Visiting Nurse Services (FVNS) launched its telehealth program in 2009 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 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.

In a recent pilot at four sites in Indiana and Tennessee, a newly formed collaboration between a behavioral health services provider, mental health application-designer, and telecommunications giant Verizon, was able to reduce visits to emergency rooms by 39%, and in-patient days by 53% among a targeted population of high-utilizing Medicaid patients with behavioral issues.

Emerging Technologies

Telehealth and telemedicine are gaining more and more attention as states look for ways to reduce health care delivery problems, contain costs, improve care coordination, and ease

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

More vendors are focusing on home-based healthcare solutions that give consumers more control over their own care. In addition to being more convenient for patients, these tools and products can reduce costs and provide physicians with patient information more quickly and efficiently. Health and wellness programs, including diet, exercise routines, and consultations with life and wellness coaches, are being implemented to improve post-discharge care. Keeping patients healthy after receiving procedures helps reduce complications and avoid costly readmissions.

The Future of LTSS

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

There will continue to be a strong need for high-quality skilled nursing homes even though many nursing facilities have watched their census fall simultaneously with an increase in the level of care needs of their residents during a time of transmuting Medicaid and Medicare funding. The number of people needing LTSS will increase more than 20% by the year 2025. Once that "silver tsunami" hits, Indiana will surely need high-quality facilities for the portion of that population that needs skilled, long-term nursing care.

It is projected that the number of primary care physicians will fall by 91,000 over the next ten 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.

The Basics

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

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

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

In 1981, the federal government began granting Medicaid waivers to states for the provision of Home and Community-Based Services (HCBS) to persons who would otherwise be institutionalized if these services were not provided. These waivers were authorized under Section 2176 of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (PL 97-35), and the original legislative intent of the HCBS waiver program was to slow the growth of Medicaid spending.

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.

1981 – The Omnibus Budget Reconciliation Act (OBRA) of 1981 allowed states waivers for home and community-based services as an alternative to nursing facility care.

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.

Over twenty years later in 2003, the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) launched an Aging and Disability Resource Center

(ADRC) initiative. This was part of a nationwide effort to restructure access to services and supports for older adults and individuals with physical disabilities to complement other long-term care system activities designed to provide a single point of entry for information and assistance in connecting to community-based long-term care.

Long-Term Services and Supports (LTSS) Overview

The scope of LTSS for older adults and persons—including children—with disabilities is often referred to as the continuum of long-term care, and service sites may occur in one's home, a community setting, or a long-term care facility. It is important to note, however, that this continuum does not always follow a linear progression. People may enter and exit service options many times – when and where depends on a number of variables: the availability of family and other informal support systems, disease processes and chronic conditions, rehabilitation needs, and housing options.

But it is no longer necessary to view nursing home placement exclusively as the "end" of the care continuum. Though medically fragile people may be best cared for in a skilled nursing facility, the delivery of care can now occur in a variety of community, home, and institutional settings, with the appropriate services and supports.

LTSS Models

LTSS include a variety of health and health-related assistance needed by persons who lack the capacity to care for themselves due to physical, cognitive, or mental disabilities or conditions. Persons needing LTSS include young and older persons alike with physical disabilities, behavioral health diagnoses, and/or other chronic or developmental disabling conditions. LTSS include such tasks as human support by way of supervision, cueing, and/or standby assistance, assistive technologies, workplace supports, and care and service coordination for people who live in their own homes, community residential settings, or institutional settings. In fact, the two main models of LTSS are Home and Community-Based Services (HCBS) and facility-based or institutional care.

Delivered in one's home and/or in community settings, HCBS provides individualized services ranging from personal assistance with bathing to the skilled care required when administering injections, wound care, and other medical services, while facility-based LTSS care is provided in and structured around institutions such as comprehensive care facilities.

Home health care provides a wide range of services in one's home. It is usually less expensive, more convenient, and when used appropriately, can be as effective as the types of care one receives in a hospital or skilled nursing facility. Examples of personal care or *non-medical* care services provided in one's home run the gamut from companionship to assistance with bathing, grooming, dressing, and incontinence care, to medication reminders, light housekeeping, meal preparation, and respite for family caregivers and scores of other services in between, while *skilled* home health services include wound care for pressure ulcers or a surgical wound, patient and caregiver education, intravenous or nutrition therapy, injections, and monitoring serious illness and unstable health status.

Nursing facilities (NFs) serve a very important role in the continuum of care within the LTSS system, and all Indiana NFs must be licensed by the Indiana State Department of Health (ISDH). In order to provide services to Medicaid and/or Medicare recipients, NFs must comply with all state and federal regulations, which control nearly every aspect of NF operations and care provided to residents.

Any NF's main goal is to provide services and support to each resident physically, socially, mentally, and psychologically. Services are provided 24/7 by registered or licensed practical nurses, and certified nursing assistants, and the range of care has grown tremendously to accommodate increasing resident acuity, including diabetes, stroke, wound management, cardiac, orthopedic, dialysis, dental, podiatric, and palliative. Nursing staff also provide administration of medication and medical care under a physician's supervision, and assist with residents' personal care and activities of daily living (ADLs). Therapy for physical, occupational, and speech are also offered.

Some facilities are purposely designed to care for specific populations, such as residents with Alzheimer's and those needing specialized pulmonary care such as ventilators, tracheotomies, CPAPs/BiPAPs, nebulizer treatments, suctioning, Chronic Obstructive Pulmonary Disease (COPD) treatments, pneumonia, and chronic emphysema. One area in which Indiana is unable to meet needs is in offering specialized care settings for individuals with either traumatic or anoxic brain injuries. In order to provide such a diverse and acute level of care specifically for each resident, NFs will continue to be a key component in the continuum of care for LTSS.

Longer-term rehabilitative and skilled care services are provided through a network of licensed health providers while residential options are available through assisted living settings, licensed residential care and nursing facilities, and combinations of continuing care communities. All these services, whether provided in home and community-based settings or institutional settings, contribute to the definition of LTSS, and each service is critical to the continuum of care for a very diverse aging and disabled population's changing needs.

Over the last twenty years, there has been a national shift toward HCBS due in large part to peoples' preference to receiving services at home and in their own communities, plus states' obligations under the Supreme Court's *Olmstead* decision, which found that the unjustified institutionalization of persons with disabilities violates the Americans with Disabilities Act.

Indiana's LTSS – Funding Sources and Services

Services for older adults and those with physical disabilities in Indiana are often accessed through the aging network via the state's sixteen Area Agencies on Aging (AAAs), which are the critical initial access points for outreach, information, and assistance services throughout the state (see Appendix A for Indiana's AAA map). The AAAs raise funds in their local communities through organized efforts such as the local United Way and other regional

fundraising projects, but their assistance and brokering of services is greatly enhanced by financial support through federal sources such as Medicaid waivers, Social Services Block Grants (SSBG), and demonstration grants, and the state-funded CHOICE program and Older Americans Act funds. However, the number and range of funding sources for LTSS constitutes a patchwork of services comprised of differing age, disability, and income requirements.

Home and Community-Based Services in Indiana

Older Americans Act (OAA)

The OAA provides Area Agencies on Aging (AAA) funding for community-based services for clients regardless of income levels, but it does require service prioritization for low-income, minority, and rural elderly. Titles under the OAA include requirements for community outreach, information and assessment provisions, legal assistance, congregate and homebound meals, family caregiver programming, health and wellness programs, and long term care ombudsman services. AAAs determine the community services to be funded to meet these requirements.

CHOICE

Indiana implemented the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program in 1992 to offer an alternative to institutional care for individuals with two Activity of Daily Living (ADLs) deficits to provide services to support individuals in their homes to delay the need for facility-based care. CHOICE services are administered locally by the AAAs, and funds can provide services of personal care, home health care, respite for caregivers, transportation, and other necessary services to avoid institutionalization.

Aged & Disabled (A&D) Waiver

A broad array of services are accessed through 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. Waivers generally focus on people with more complex needs for care, since all long-term care or A&D waiver consumers must 1) meet nursing facility Level of Care (LOC), defined as the inability to perform at least three ADLs such as eating, bathing, and dressing due to physical health conditions, and 2) be financially eligible for Medicaid.

The A&D waiver provides an alternative to nursing facility admission for older adults and persons of all ages with a physical disability. This waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility *if the waiver or other supports were not available*.

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. 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.

Social Services Block Grant

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 (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, including self-sufficiency promotion, abuse prevention, and supporting community-based care for older adults and the disabled. Indiana uses SSBG funding for a variety of programming for many populations and services. A portion of these funds is granted to the AAAs for a wide range of ancillary HCBS for those individuals meeting both income guidelines and service needs who do not necessarily have deficits in ADLs, but do experience other risks such as abuse or neglect, including self-neglect.

Money Follows the Person (MFP) Demonstration Grant

The MFP demonstration grant was awarded to Indiana in 2007. This demonstration is federally funded and created by section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171), and supports the state's efforts to "rebalance" its long-term support systems. Indiana's MFP program is designed specifically as a transition program that assists individuals living in a qualified institution to move safely back into the community, and ensure a safe adjustment to community living. The MFP program provides these services to individuals who are aged, physically disabled, and/or intellectually disabled residing in nursing facilities or intermediate care facilities for individuals with intellectual disabilities. The program also provides services to youth ages six through seventeen who reside in psychiatric residential treatment facilities.

The MFP is a transitional funding source only, and can fund a participant for just 365 days post-discharge. At the end of the participation period, an individual will continue to receive services and supports funded by the partnering funding source as long as they meet LOC requirements.

The demonstration grant ends in 2020. Indiana is now working on a sustainability plan to continue identifying and transitioning individuals from institutional settings back into the community even after MFP ends.

Financial Management and Protective Services

Many services for older adults and persons with disabilities focus on physical needs, and rightfully so. Nevertheless, the systemic needs of an increasingly aging population also must

include a focus by the state on elder justice issues to protect its most frail and vulnerable citizens. Adult Protective Services and available Guardianship and Long-Term Care Ombudsman efforts to protect the rights, property, and physical well-being of vulnerable at-risk populations in the community and in facilities must be enhanced and broadened.

Indiana has a significant population of aging and disabled citizens residing in nursing facilities, group homes, adult family care, state hospitals, and in the community who require protection from abuse, neglect, and exploitation, and assistance with tasks associated with running a household such as managing personal finances and paying bills. Please note that the following protective services are not universally available or may be limited in availability due to program funding restrictions, and availability of resources and funding priorities.

Adult Protective Services

Indiana's Adult Protective Services (APS) program was established to investigate reports and provide intervention and protection to vulnerable adults who are victims of abuse, neglect, or exploitation. APS field investigators operate out of the offices of county prosecutors throughout the state. If the APS Unit has reason to believe that an individual is an endangered adult, they investigate the complaint or involve law enforcement or other agencies to investigate and make a determination as to whether the individual reported is indeed, an endangered adult. To be eligible for service under this program, an individual must be an Indiana resident, eighteen (18) years of age or older, physically or mentally incapacitated, and reported as abused, neglected, or exploited.

Abuse means any touching (battery) of a person in a rude and insolent manner. Neglect is the intentional withholding of an essential care or service; abandonment of an individual is also considered neglect. Exploitation is the intentional misuse of a person's property, person, or services for financial gain.

Adult Guardianship

Courts appoint guardians to assist and protect people with cognitive disabilities who are unable to manage their own personal or financial affairs. Referred to as "incapacitated persons" in state statute, these individuals are often vulnerable to financial exploitation, medical neglect, physical abuse, emotional abuse, and other kinds of harm. Having a court-appointed guardian can dramatically reduce the likelihood of such threats through the prudent management of finances, timely health care decision-making, appropriate determination of living arrangements, and assistance in other numerous important ways that protect both the person and their assets.

In 2013, Indiana's General Assembly provided funding to establish the Adult Guardianship Office under the Indiana Supreme Court's Division of State Court Administration. This newly established office serves as a resource for courts and the general public on all issues related to adult guardianship and administers grant funding to increase the number of volunteer-based guardianship programs throughout the state.

Long Term Care Ombudsman

The Indiana Long Term Care Ombudsman is a federally- and state-funded program that provides advocacy and related services for consumers of congregate long-term care services, regardless of age or payor source. Congregate settings include nursing facilities, residential care facilities, assisted living facilities, adult foster care homes, and county-operated residential care facilities.

Representative Payee

Overseen by the Social Security Administration (SSA), a representative payee is a person, agency, organization, or institution selected to manage funds for persons who are determined unable to do it or to direct others to manage money for them. The SSA must evaluate medical and other types of evidence about an individual's inability to manage funds before appointing a representative payee. A variety of entities can serve as one's representative payee: someone concerned with the individual's welfare such as a parent, spouse, close relative, guardian, or friend, an institution such as a nursing facility or health care provider, a public or non-profit agency, social services agency, or financial organization, providers or administrative officers in homeless shelters, or a community-based non-profit agency approved by SSA.

Personal Affairs Management

Personal affairs managers provide support and oversight for maintaining an individual's health and safety and to protect their financial resources. These services, delivered in someone's home or other community locations, are designed to protect vulnerable adults at risk of self-neglect or exploitation by others because of age-related or disability-related cognitive impairments, mental illness, and/or developmental disabilities. Services may include psychosocial assessment and development of an individualized service plan and counseling of the individual and family members by a Masters-level professional, assistance with correspondence, paying bills and balancing checkbooks, budget planning and/or debt management, assistance with applications for relevant sources of financial aid or other community resources, intervention and advocacy with creditors, and even escort transportation to medical appointments.

Indiana's Capacity to Access Services

At this time, Indiana has not developed a waitlist policy different from the traditional "first-come first-served" placements. Further, the DA has managed to keep the A&D waiver "open" throughout the past two fiscal years, which in turn, has driven down wait lists for the CHOICE program. Indiana knows it must be ready to meet an emerging number of needs as its population ages so we continue to look at service demand, demographics, and other states' and national information. As a measure of unmet needs, waitlists must be monitored on a regular basis.

Who (or What) Pays for LTSS?

Medicaid and Medicare are the major government health care programs that account for about two-thirds of total national spending. Medicaid is the nation's main publicly financed health

insurance program, covering the acute and LTSS needs of millions of low-income Americans of all ages. Out-of-pocket spending is the biggest source of private spending for LTSS and is particularly large for institutional care. Private insurance pays for only a small share of total spending on LTSS, although the number of people with private long-term care (LTC) insurance is growing slowly. However, Medicaid will continue to be the *primary* payer for a range of institutional and community-based LTSS for persons needing assistance with daily self-care tasks. Private LTC insurance and Medicaid generally provide coverage only for institutional care for an extended period (typically three to five years in the case of private LTC insurance and indefinitely in the case of Medicaid), and coverage is *not* dependent upon an acute health care episode.

It is worth mentioning that Medicare and private health insurance cover LTSS *only* as part of a post-acute care benefit that covers rehabilitative care—short stays in skilled nursing facilities and home health visits—for people needing skilled care. However, the criteria for Medicare coverage is rapidly changing, with new bundling of services and payments under Accountable Care Organizations and the increasing enrollments of older adults in Medicare Managed Care through the Medicare Advantage Plans. The standard of Medicare coverage of up to 100 days of skilled nursing facility (SNF) care per episode of illness after a medically necessary inpatient hospital stay of at least three days has evolved over time with revisions of eligibility to control cost. For traditional Medicare beneficiaries who qualify for a covered stay, Medicare currently pays 100 percent of the payment rate only for the first twenty (20) days of care. Beginning with day 21, beneficiaries are responsible for copayments. For 2014, the copayment was $152 per day.

As previously discussed, sources of payment for LTSS include various federal and state programs for older adults. The wide range of HCBS and corresponding potential payment sources offered in Indiana are included in Appendix B. Private charitable donations such as the United Way can be used as sporadic funding sources, but those payments cannot be considered a sustainable source of financial support.

Private health insurance, Medicare, Medicaid, Prior Authorization (certain covered services that must be approved by the physician in advance in order to document the medical necessity for those services), and private LTC insurance all may cover stays in nursing homes as well as home health agency visits, but in different circumstances and only for certain, varying lengths of time. These multiple funding streams make it difficult to disentangle what – or who – pays for which services.

What *are* the Costs?

According to the National Health Policy Forum, more than three million people in the United States relied on Medicaid for HCBS in 2010, an increase of more than 50% since the year 2000. Community-based services totaled $219.9 billion in 2012, and Medicaid was the primary source of payment for those services, followed by out-of-pocket payments by individuals and their

families. During the same time, Medicaid paid for 61% ($134.1 billion) of all national LTSS spending.

Even though the federal government shares Medicaid costs with the states, the burden on states is substantial and most likely will only increase as the population ages. Indiana's Medicaid expenditures for community-based services (1915(c) Waivers and Other HCBS) totaled nearly $950 million in 2013. Indiana provided approximately one-third of this funding to enable provision of programs and services administered by the Family and Social Services Administration (FSSA).

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

The cost for Medicaid spending for all of Indiana's long-term care, including total institutional and total HCBS expenditures totaled an estimated $2,985,826,538 dollars for FY2013, representing a nearly eleven percent increase (10.74%) in expenditures from the FY2012 total of $2,665,060,979.

The Division of Aging has been successful in keeping the primary waiver for those meeting nursing facility level of care open for the last two years. The waiver now serves 46% more people than it did just three years ago. This is reflected in the growth in waiver spending as well. The Division administers other HCBS funding sources; these appropriations have remained flat. See Appendices C, D, and E for graphs representing spending for waiver and non-waiver programs, institutional care, and combined HCBS and institutional care for the A&D waiver over the last several years.

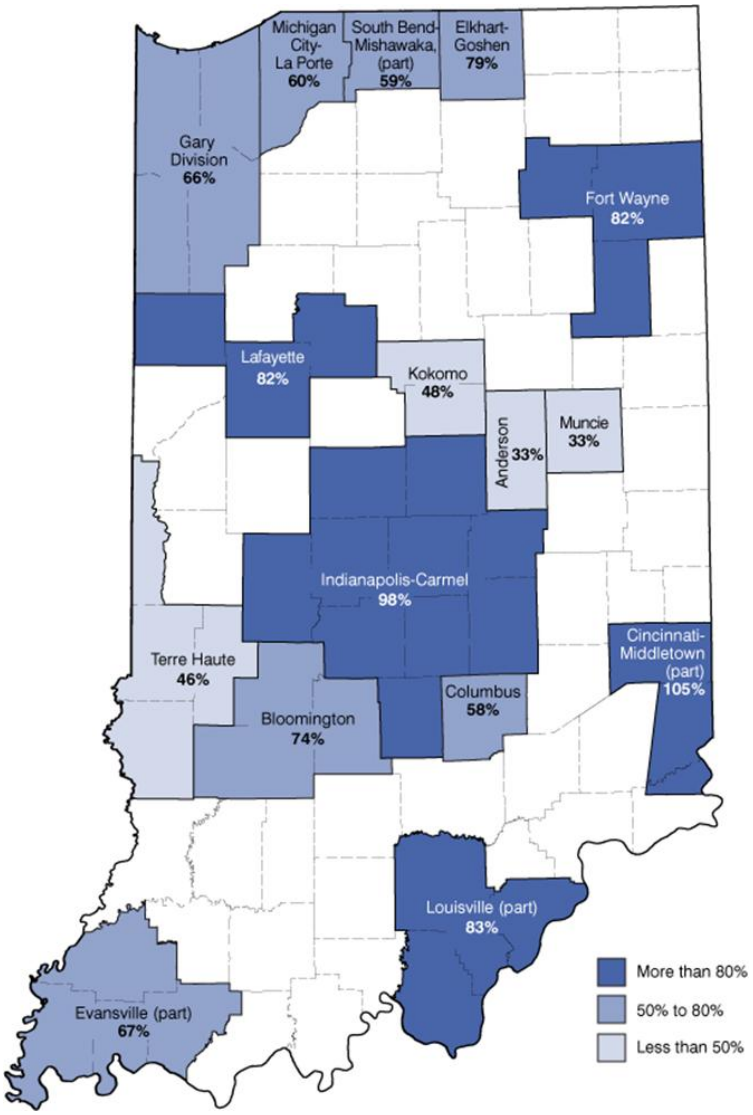
Indiana's Demographic Trends and LTSS

Demographic Characteristics of Older Adult Hoosiers

According to the American Community Survey, adults ages 65 and older made up 13 percent of the Indiana's population statewide in Census 2010, and that number is projected to grow to 20 percent of the population by 2030. To gain a full perspective of how older Hoosiers are faring, see other relevant data demonstrating their demographic characteristics as compared with the state's total population in Appendix F.

Indiana's Population Projections

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



Source: Indiana Business Research Center

The map represents the percent change in population of those ages 65 and older from 2010 to 2030. Five of Indiana's metropolitan (metro) areas will see increases of more than 80 percent in the population ages 65 and older in the next 20 years. In fact, spurred by a relatively strong net in-migration of older adults, the senior population in the Indiana portion of the Cincinnati-Middletown metro will more than double.

The fast-growing Indianapolis-Carmel metro—that accounts for more than one-quarter of the state's total population—will see its senior population nearly double over the same period. Meanwhile, only four metros will experience growth in seniors less than 50 percent, ranging from 32.5 percent in Anderson to 48 percent in Kokomo. It is worth noting that three of those will experience declines in total population and the fourth (Terre Haute) has total population growth of just a few hundred residents.

The entire baby boomer cohort will be of traditional retirement age by 2030. After that point, growth in the 65+ category is expected to level off somewhat. However, between 2030 and 2050, large increases are anticipated in the 85+ age group as those boomers continue to age.

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

Indiana's LTSS Program Funding Eligibility and Service Delivery

Between traditional Older Americans Act services, CHOICE and SSBG funds, and the Medicaid waivers for persons determined eligible both financially and by level of inability to perform ADLs, services were provided to nearly 100,000 older adults and persons with disabilities in Indiana during 2014. Following are each of Indiana's LTSS funding sources and its eligibility criteria.

Older Americans Act (Title III) – Eligibility is based upon being age 60 or over with priority areas of service delivery geared to those who are members of a racial minority, have income below poverty level, or live in rural areas.

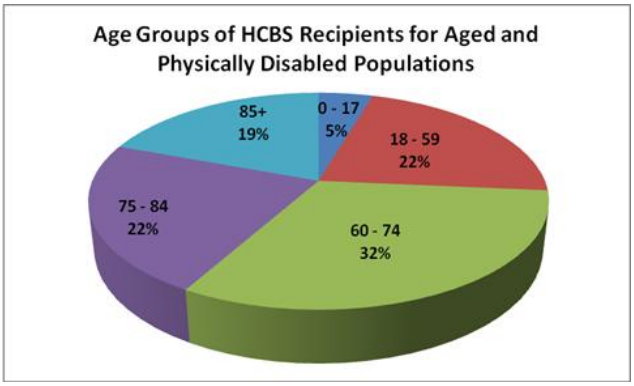
Aged & Disabled (A&D) Medicaid Waiver – Serves ages infants to older adults based upon Nursing Facility Level of Care (must have three deficits in ADLs due to a medical condition or an ongoing skilled medical need), and be eligible for Medicaid. The Special Income Limit (300% of SSI) and Spousal Impoverishment Protection are applied in Medicaid eligibility determinations for waiver recipients.

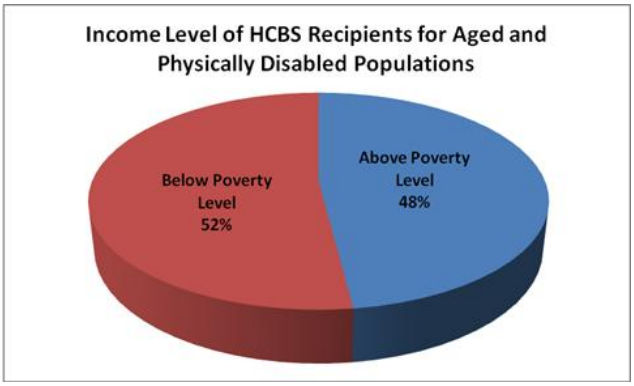
Traumatic Brain Injury – Serves persons ages 22 or older at time of a brain injury, and requires eligibility for Medicaid. The Special Income limit (300% of SSI) and Spousal Impoverishment Protection are applied in Medicaid eligibility determinations for waiver recipients.

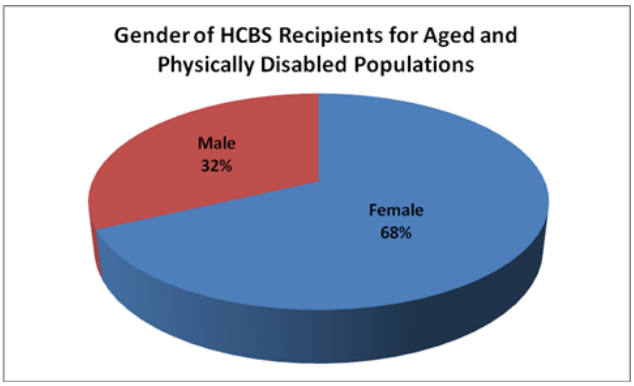
Social Services Block Grant – Serves all ages for those with incomes of less than 300% of poverty

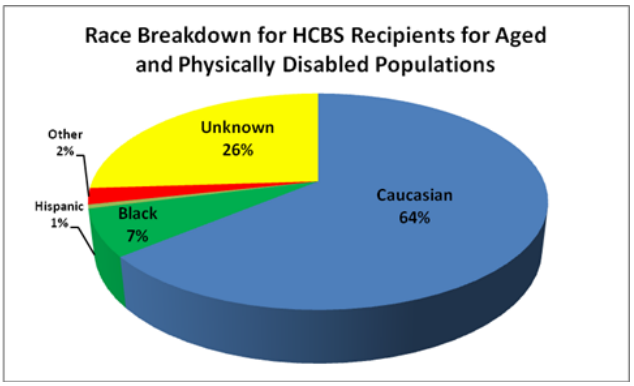
CHOICE – Serves disabled individuals, infants to older adults, based upon two (2) deficits in ADLs

The charts below represent a breakdown by area for March 2015 of various populations that are required to be served via program eligibility, through Division of Aging funding. Please see Appendix G for a fuller picture of these numbers.









Demand for Services…or Unmet Needs

Indiana's *Community Assessment Survey for Older Adults*

In 2013, the National Research Center conducted and evaluated a statistically valid sample of older adults' self-assessments across Indiana and compared our state's results with national study findings. The *Community Assessment Survey for Older Adults* (CASOA) study gauged current availability and the means for accessing information so an aging population can make plans and decisions for themselves when reviewing current options and preparing for a wide range of service needs. The CASOA findings for Indiana were consistent with other states' concerns about transportation, housing, and a general lack of knowledge of how to get help when needed. Although needs were spread across the board, older Hoosiers reporting the largest percent of unresolved needs were more likely to be between the ages of 60 to 74, non-white or non-Hispanic, have a reported lower income, or own their homes.

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

- long-term care;
- daytime care options for older adults;

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

AAAs' Needs Assessments

The AAAs have taken the CASOA data specific to their counties and used it to update their own needs assessments. They also hosted multiple public hearings and surveys with their local residents in preparation for their 2016-2017 Area Plans required by the state, and the federal Administration on Community Living.

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

An emerging and escalating unmet need also identified in the AAAs' community assessments is support and assistance for caregivers of frail elderly. Another unmet need is an often long waiting period between service application and eventual receipt of services, which could indicate not only a lack of resources but inefficiencies within the application process. Nationally, more than 400,000 people were on a waiting list for HCBS waiver programs during 2014.

All these studies continue to identify primary needs that hamper one's ability to age in place and remain in a community setting, such as housing and transportation along with concerns regarding caregiving responsibilities.

Housing

Housing plays a unique role in everyone's lives, but particularly so for older adults and persons with disabilities. It serves as shelter and provides a sense of comfort and security. It has much to do with quality of life, and it can influence a person's physical independence and ability to participate in community life. A lack of *affordable* housing not only affects people's ability to acquire and maintain adequate shelter, but it also can limit their ability to meet other basic needs. Budgetary constraints often forces individuals to make choices between paying for rent, utilities,

food, and/or medical care, which often result in poor health outcomes through food insecurity, exposure to extreme temperatures, housing instability, and doing without with regard to medical care and medications. Many older adults can also experience serious problems because of poor housing quality, inadequate home design, or challenges in protecting their financial interest in the home, such as predatory lending practices.

According to AARP's Public Policy Institute, a household—homeowner or renter— that spends 30% or more of its income on housing is considered "housing cost burdened." High levels of housing cost burden indicate that housing markets are failing to provide millions of older adults with options that meet their needs at reasonable costs. Individual housing choices that were affordable years ago may no longer meet changing needs as people age, and housing costs may no longer fit within a household's budget when financial situations worsen. Finally, rising property taxes, utilities and maintenance costs, and falling incomes, not to mention declines in health status, can make aging in place an unreachable goal for many. The U.S. Census Bureau's American Community Survey estimated that, for 2008, 35% of Hoosier householders (owners and renters) ages 65 and older experienced housing cost burden beyond 30% of income.

Finding affordable senior housing may be one of the biggest challenges facing older adults and their family members. The largest provider of affordable housing in the country is the U.S. Department of Housing and Urban Development (HUD), which creates affordable housing for citizens across the country by funding programs for rent assistance, home ownership, and assistive services for older adults and persons with disabilities. HUD oversees a number of affordable rental programs:

1. Public housing is rental housing for low-income families, the elderly and those with disabilities.
2. Multi-family subsidized housing is privately-owned affordable HUD-subsidized housing.
3. Section 202 Supportive Housing for the Elderly is designed specifically for older adults and persons with disabilities to live as independently as possible but who may need *some* assistance with ADLs. Note that this type of housing does not provide housekeeping services, nor do most of them offer transportation.
4. The Housing Choice Voucher Program (formerly Section 8) provides rent vouchers for housing in the private market to low-income individuals, families, older adults, and persons with disabilities.

But the demand for federally subsidized rental housing is far greater than the supply. Only one in four low-income renter households that qualify for federal housing assistance is receiving it, and typically only after a lengthy wait.

Other residential options for disabled or older adults choosing to remain within the community, that are generally paid for by private funding include:

- Personal homes or apartments;

- Shared housing with family;
- Shared housing informally with others (non-family); or
- Senior apartments often referred to as congregate living.

The following housing options are paid for through the use of Medicare, Medicaid, long-term care insurance, or individuals paying privately:

- Continuing care communities, which support aging in place by allowing a person to move among and between independent and assisted living to ISDH-licensed residential and/or comprehensive care (a nursing facility);
- Rehabilitative facilities licensed by ISDH, which are often considered short-term and funded by Medicare based upon age and short-term rehab potential;
- Comprehensive care facilities licensed by ISDH, for which short-term stays are funded by Medicare, based upon age, diagnosis, and rehabilitation potential. Otherwise, they are paid for privately or funded by Medicaid as assets are diminished.

Waiver-provided care in community settings may allow an individual without a residence to avoid entering an institution, or allow persons to transition from a facility back into the community even though their personal housing options may be limited. These supported services can be provided through:

- Residential care facilities, including assisted living, county homes, and group homes, which are licensed by the Indiana State Department of Health;
- Adult Family Care, which are family homes that provide a home setting for up to four unrelated adults; and
- Newer options that enable persons to remain in a home setting include Structured Family Care, which provides a live-in caregiver for waiver participants, or provides for the participant to live with the caregiver on a full-time basis.

Transportation

Many older Hoosiers plan to age in place in their neighborhoods and communities where daily activities require some form of transportation. Inevitably, many of those persons will find their own ability to safely drive a vehicle diminish over time. Older adults need affordable alternatives to driving in order to maintain their independence as long as possible. Pedestrian-friendly streets and recreational trails built with older adults and persons with disabilities in mind will help all Hoosiers get around safely and remain active, regardless of where they live. But only adequate public transportation services can assure that older adults are able to travel as often or as far as they would like, without worrying about inconveniencing others. Without access to affordable travel options, older adults face isolation, a reduced quality of life, and possible economic hardship.

Section 5310 of the Federal Transit Act authorizes capital assistance to states for transportation programs that serve older adults and people with disabilities. States distribute Section 5310 funds to local operators in both rural and small urban settings that are either nonprofit organizations or the lead agencies in coordinated transportation programs. The program provides vehicles and related equipment to private non-profit organizations and eligible public bodies involved in transporting elderly and disabled customers. Indiana annually receives about $2.5 million in federal funds to distribute on an 80 percent and 20 percent local matching basis ($2.8 million in 2014). Eligible equipment includes passenger vehicles, accessibility equipment and communication systems.

Indiana's Section 5310 program is designed to serve areas where accessible public transit for these individuals is unavailable, inadequate, or inappropriate in rural and small urban areas. Each of Indiana's counties has agencies that currently operate Section 5310 vehicles. Eligibility requirements and fares vary by agency.

However, a 2004 study found that seniors ages 65 and older who no longer drive make 15 percent fewer trips to the doctor, 59 percent fewer trips to shop or eat out, and 65 percent fewer trips to visit friends and family, than drivers of the same age. Many Indiana communities have taken advantage of rural transportation grants and community transportation services, but a large number of older adults rely on family members and older friends to transport them.

Family Caregivers

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

According to AARP, the United States' caregiver support ratio is expected to take a nose-dive as baby boomers transition from caring for others to moving into old age themselves. A period of transition will occur during the 2010s and 2020s, as younger boomers age out of their peak caregiving years and the oldest boomers age into the 80-plus high-risk years. When those boomers move on from their caregiving years, the age cohort of younger persons ages 45–64 is projected to increase by only one percent between 2010 and 2030. During the same period, the 80-plus population is expected *to increase by almost 80 percent.*

Indiana's own demographics indicate that the high number of those ages 85 and older, a lower percentage of middle-aged persons caused by out-of-state migration of younger cohorts, and age shifts with the baby boom generations' aging into old age followed by the "baby-bust" (the

sudden decline of the birth rate from the early 1960s to the early 1980s) will most likely limit Hoosier family support options within the next 15-25 years.

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

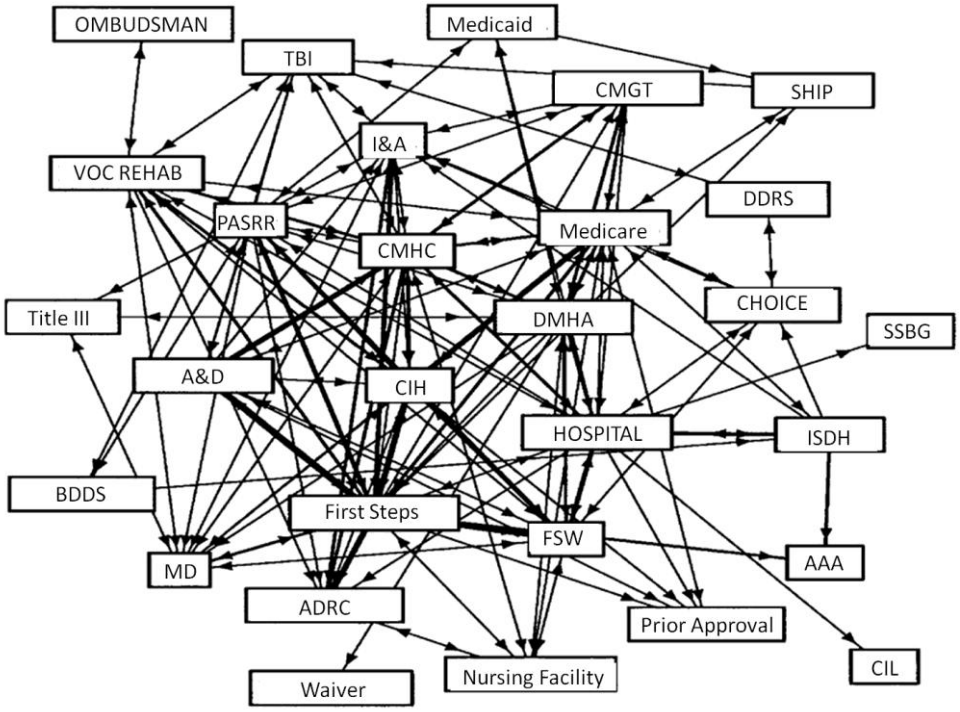
We must also include the unmet needs of younger consumers—those that are not aged—but children with LTSS needs who are served by many of the same funding streams. Caregiver "burnout" is a substantial concern for families raising children who have medically complex and/or developmental issues. It is noteworthy that the financial stress of caregiving is also found at this end of the age spectrum, often due to young parents' lack of significant work periods/history to provide a foundational safety net. A considerable reduction in work hours for at least one parent to stay at home to care for a child is also often reported by many families, which can have a far-reaching impact for that family's financial security going forward. This issue of family caregivers will only continue as these children and their parents both age, resulting in increased financial stress as the demands for services also increase.

These findings underscore Hoosiers' traditional strong sense of family support and self-reliance—in 2013, over 800,000 people provided nearly 800 million unpaid or informal hours of care to family members—but as the study further indicated, family caregivers experience high levels of stress when providing care and often experience a negative impact on their health and well-being. And if fewer family members are available to provide everyday assistance to the growing numbers of frail older people, more people are likely to need institutional care at great personal cost, as well as increased costs of health care to federal and state programs. Greater reliance on fewer family caregivers to provide HCBS could also add to costs borne by family members and close friends—in the form of increasing emotional and physical strain, competing demands of work and caregiving, and financial hardships.

LTSS Program and Policy Options

According to a 2010 report by the National Health Policy Forum, many describe the process of accessing LTSS akin to wandering through a maze. The graphic below demonstrates very well the tangle of confusion, difficulty, and frustration people encounter while trying to find their way through the web of services. Many of them, including those who have financial resources to pay for their care, do not know where to get help or how to access preferred services, if they are even aware the services exist. For persons knowledgeable about caring for older adults and younger people with disabilities, the national LTSS system is 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 institutional settings. However, the program eligibility criteria are complex, and services are limited to only those meeting strict income and asset tests along with documented level of care requirements.

Since many consumers have difficulty navigating the complexity of the LTSS system, more work must be done to increase the knowledge and planning capabilities for care alternatives, available programs, and benefits. Information becomes very important as consumers make informed decisions—often when they are at a crisis point such as being discharged from a hospital and must transition to home or a care facility.

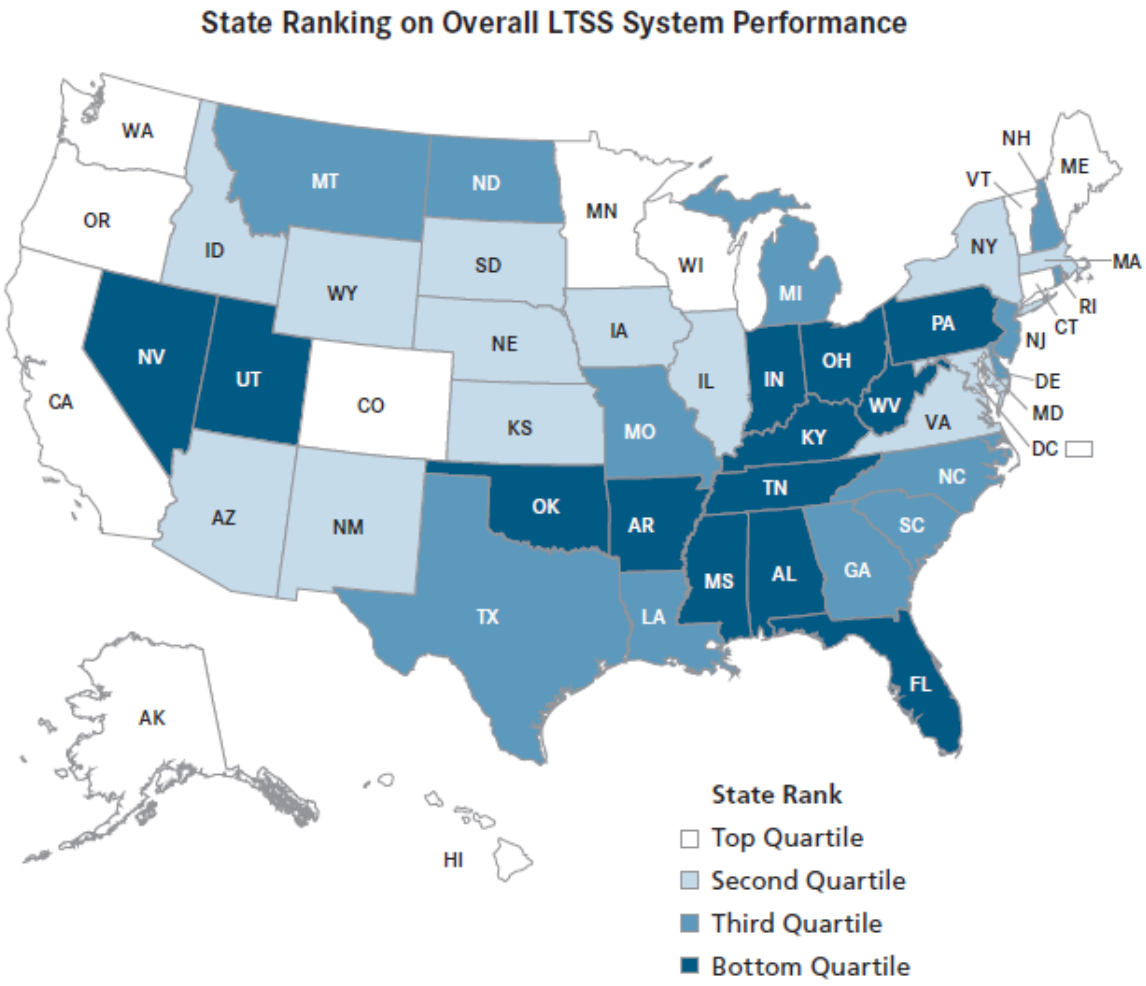
Another important area of focus are the persons currently living in nursing or rehabilitation facilities who want to go back home with supportive care; they face significant challenges navigating access to community services. The Money Follows the Person (MFP) program exists to help these individuals navigate the steps necessary to make a transition back to the community by assisting in selecting a new home setting and by arranging various home and community-based services to be available at time of facility discharge. But enhanced federal funding for the MFP program ends in 2020.

In evaluating the nation's LTSS, a recent report by AARP, the Commonwealth Fund, and the Scan Foundation, *Raising Expectations: A State Scorecard on Long-Term Services and Supports*

for Older Adults, People with Physical Disabilities, and Family Caregivers, 2014, was reviewed in which the following framework for assessing system performance was established. The study identified the following five key characteristics of a high-performing LTSS system:

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

Please note that this second edition of the Scorecard—an earlier version was released in 2011—seeks only to provide states with performance standards against which they can compare their data with other states' information in order to aid in measuring progress toward the goal of meeting the needs of older adults, persons with disabilities, and family caregivers. The map on the following page depicts state rankings on overall LTSS performance. It is important to note this map represents only a snapshot in time. States, including Indiana, may have made improvements in their LTSS systems that are not reflected in the most current (2009 to 2013) data available.



The analysis of the 2013 data used in the Scorecard indicates that Indiana lags behind other states in the development of a wide range of LTSS. The table in Appendix H, State Ranking on LTSS System Performance by Dimension, demonstrates the finding that Indiana consistently scored in the lowest quartile with an overall ranking of 47th among all states and District of Columbia. It is notable that overall rankings for our state ranged from a "high" of 33rd for Effective Transitions [among Settings], to a "low" of 51st for Support for Family Caregivers.

One area referenced on the Scorecard in which Indiana does have limited success is within the Accessibility and Affordability dimension, which provides an evaluation of how affordable services are for people of moderate and higher incomes, how effective the safety net is for those who cannot afford services, and how easily consumers of all incomes can find the LTSS they need. Indiana ranked among the five highest in the nation for its early development of its Aged and Disability Resource Centers (ADRCs). However, according to a recent CMS report, Indiana is 41st in the nation in spending on Medicaid case management services, at only $.75 per resident as compared with the national average of case management cost of $7.84 (Appendix I). A functional ADRC network depends upon case management and Options Counseling services for

those persons with extensive needs, in order to provide planning and discussion around selecting optimal applicable LTSS.

As the state moves into newer efforts to streamline access to information and services the ADRC network must continue to evolve and develop consistency and uniformity across the state. ADRC network development is a critical initiative for the Division of Aging. Development efforts include the creation of a statewide identity or branding of the network, investment in technology and resource database development, and improved consistency in operation to insure that the consumer experience is similar across the network.

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

Lack of Service Knowledge and Access

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

A vital information system to aid an individual's decision-making are the ADRCs. Each of Indiana's sixteen AAAs was awarded the designation as an ADRC in the past with the goal of operating as a visible and trusted resource within its own multi-county geographic area as a part of Indiana's ADRC network. The Administration for Community Living (ACL), the newly formed umbrella agency which now includes AOA, and Centers for Independent Living (CILs) along with CMS, has defined five key functions ADRCS must perform: information and referral/awareness (I&R/A), options counseling, streamlined eligibility determination for public programs and streamlined access to services, person-centered transition support, and quality assurance and continuous improvement.

To be most effective, ADRCs must function beyond their AAA identity to become a part of a statewide network of organizations and systems that provide access to LTSS across all populations and payers. Members of all statewide networks have to connect with each other, and the way to do that is through building community partnerships and moving from a focus on eligibility and offering an individual a set menu of services, toward a more proactive, consumer-

focused approach of identifying individual needs through in-depth assessment. However, not all Hoosier ADRCs have been considered functioning fully enough to meet the broad-based role as a recognized source for information and referral to a wide spectrum of services and supports for all ages, all payers, and all programs.

Service delivery to an increasing population of aging and disabled individuals must be driven by service availability, eligibility criteria, assessed needs, and focusing on enhancing one's current abilities rather than developing dependencies on programs and services prematurely. This model is currently being tested in HEA 1391's CHOICE pilot projects located in four areas of the state.

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

The statewide goal is to move all ADRCs forward to greater visibility and effectiveness for all residents of all ages in Indiana. Indiana's ADRC aging network must: 1) expand its visibility and accessibility to allow for the broadest network of available information on the range of services regardless of payer sources, 2) allow an individual or family member to interact directly with the network for self-referral to do their own planning and determination of care needs and options, and 3) alert consumers to wider ranges of services beyond the current traditional model of services.

To encourage further development of the ADRC network, the Division of Aging recently awarded one-time grant funds to address two targeted areas: building community partnerships and/or building a local resource database for the state's future network development. The DA believes these grants are an opportunity for improving the overall functioning and effectiveness of our ADRC network.

Managed Long Term Service and Supports

MLTSS refers to an arrangement between state Medicaid programs and contractors through which the contractors receive capitated payments for LTSS and are accountable for the delivery of services and supports that meet quality and other standards set in the contracts. MLTSS programs are very diverse. They include programs that make capitated payments to contractors primarily for LTSS, and for all or most Medicaid services, and fully integrated Medicare-Medicaid programs that include all Medicaid and Medicare services.

By January 2014, it was projected by Truven that more than half of the states would be exploring managing their long-term services and supports through a capitated managed care program rather than the traditional fee-for-service model. In 2004, eight states had implemented Medicaid

managed long-term services and supports (MLTSS) programs. Six states had more than doubled the size of their programs by June of 2012, and an additional eight states had implemented programs. The recent growth and future plans reflect an accelerating trend among states toward managed care purchasing strategies for LTSS. Initially hampered by a very limited supply of organizations that had both the experience and ability to accept risk for LTSS, the development of the MLTSS market was initially slow; however, the supply of organizations that developed this product line has increased greatly since that time.

One example of a managed care model for home and community-based care available in limited communities in Indiana is the PACE Program.

Program of All-Inclusive Care for the Elderly (PACE) Program – Managed Care LTSS

Another HCBS option is the PACE program, a Managed Care LTSS (MLTSS), which provides coordinated person-centered care to older adults with chronic care needs while maintaining their independence at home for as long as possible. The program serves individuals ages 55 years and older who live in a PACE service area, require Nursing Facility LOC, and are able to live safely in the community at the time of enrollment. In addition to assisting individuals with social, emotional, and practical challenges older adults often face, PACE delivers all necessary medical and supportive services, including primary medical and nursing care, occupational, physical, and speech therapies, Durable Medical Equipment, laboratory and diagnostic services, prescription medications, home care, medically necessary transportation, and nutrition counseling and meals.

PACE supports caregivers with training, support groups, and respite care, and the program's interdisciplinary team of professionals offers guidance and support for family caregivers. If a PACE enrollee does require hospitalization or nursing facility care, the program pays for it and continues to coordinate the individual's care through its partner facilities and organizations.

Participation in PACE is voluntary, and available to eligible individuals across the financial spectrum, utilizing Medicare, Medicaid, or paying privately. At this time, the program serves over 34,000 individuals by 114 PACE organizations operating in 32 states nationally. Indiana currently has one PACE organization located on the south side of Indianapolis.

Indiana's Future LTSS

For Indiana to manage increasing numbers of older adults and disabled persons, its care system must further expand to identify and quantify unmet LTSS needs to aid efforts in long-term planning. Across the United States and certainly in Indiana, older adults, people with disabilities and family caregivers are struggling to find and afford the services and supports they need to maintain their independence and quality of life. The system of LTSS must transform, and soon. The population is growing older, more people are developing disabilities at younger ages, and family caregivers are walking a high-wire tightrope in trying to balance family and work responsibilities. LTSS issues touch all segments of society: individuals of all ages and incomes, state and federal policymakers, as well as providers of services.

No Wrong Door System

Indiana recognizes that with its rapidly expanding older population and the persons with wide-ranging mental, physical and developmental disabilities who are aging, it is necessary that an improved system of access to information, assessment of needs, and improved entry to services must be in place, including better coordination of all the many points of entry for consumers and families. Therefore, a critical step Indiana is taking to address LTSS for all generations is the No Wrong Door initiative.

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

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

Division leaders within FSSA are collaborating in the development of NWD to ensure all populations and all payers can more easily access the long-term services and supports they need. NWD touches all demographics from children to older adults and those with physical disabilities as well as mental and developmental issues, regardless of financial status. A NWD system is one that:

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

Indiana has used its one-year grant period to prepare a three-year plan for implementing a No Wrong Door system by involving key stakeholders in an analysis of the strengths and weakness

of the current system, and what a No Wrong Door system should look like, in addition to other significant considerations. Key stakeholders include FSSA divisions, the AAAs and ADRCs, community healthcare systems, hospital trade associations and hospital discharge planners, nursing and assisted living facilities, Community Mental Health Centers, Centers for Independent Living, faith-based organizations, organizations serving families with children who have special health care needs and/or disabilities, Indiana's nursing facility associations, Indiana Health Care Association, LeadingAge Indiana, Hoosier Owners and Providers for the Elderly (HOPE), and Veterans Administration Healthcare Systems, among others.

Indiana's path to a NWD system will be incremental and occur over a series of phases. Specifically, Indiana's NWD plan includes the following:

- the creation of a standardized web portal for consumers to search for provider services based on geographical location (among other criteria);
- generation of a self-assessment tool that allows consumers to complete a questionnaire that assists with identification and clarification of needs, and all available services and supports to address those needs;
- implementation of an integrated case management system (CaMSS) to support delivery of timely, flexible, and cost-effective services, as well as improve reporting, standardize processes, and better coordinate care;
- intensifying public outreach;
- improving person-centered counseling; and
- establishing a NWD Governance and Administration cabinet-level body across multiple state agencies that sets a process in place that ensures meaningful input from key stakeholders into ongoing development and implementation.

FSSA believes NWD is a chance for Indiana to look across the entire system and determine how we can adjust to meet our consumers' needs, placing them at the center of the very systems that serve them. We are also aware that the necessary tools and trainings are not currently in place to prepare the individuals and organizations that manage those doors to provide appropriate assessment and supported decision-making to consumers and their families.

Rebalancing LTSS

According to an August 2015 report by FSSA, rebalancing Medicaid long-term care expenditures is the concept used to describe a state's efforts to reduce expenditures on long-term care in institutional settings and increase expenditures on long-term services and supports in home and community-based settings. Over the last several decades, states have been working to rebalance their LTSS systems by devoting a greater proportion of Medicaid spending to HCBS instead of institutional care.

Rebalancing efforts are driven by 1) consumer preferences for HCBS, 2) the fact that these services are often less expensive than comparable institutional care, and 3) states have community integration obligations under the Americans with Disabilities Act and the *Olmstead* decision.

In 2013, Indiana ranked 47th in the nation in its percentage of Medicaid LTSS dollars spent on HCBS. For the same year, Indiana's nursing facility expenditures per state resident were the tenth *highest* in the nation, rising from 12th in the nation in 2012 (Appendix J). Aggregate nursing facility expenditures in Indiana are on the rise, largely due to the increased numbers of Non-State Government Owned (NSGO) nursing facilities receiving enhanced supplemental payments under the Upper Payment Limit (UPL) program. Approximately 50% of total nursing facility expenditures come in the form of supplemental payments. Rebalancing LTSS in the Hoosier state will be more complicated because of these factors.

Indiana's long-term care system has experienced significant changes over the last ten to fifteen years, resulting in a very complicated structure. In order to create a more predictable system with outcomes that provide service and supports in the least restrictive setting compatible with appropriate care and resources, FSSA is designing a five to eight-year plan that will provide recommendations by Fall 2015. The goal for this plan is to establish a more balanced system that moves Indiana from its current position that favors institutional care, to one that is more aligned with the Centers for Medicare and Medicaid Services' (CMS) goal: an equitable 50/50.

Review of Medicaid Reimbursement for Skilled Nursing Facility Care

Nationally, spending on nursing facilities across all payers totaled nearly $156 billion in 2013. The majority of this spending was financed by Medicaid, as most families cannot afford the high cost out-of-pocket, and Medicare benefits for these services are very limited.

Indiana's Medicaid expenditures for nursing facility care in fiscal year 2013 (the most recent year for which we have official data) totaled $1,695,492,875. 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. Components include:

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

Capital rates reimburse 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 rates reimburse 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.

As of August 20, 2015, the Office of Medicaid Policy and Planning (OMPP) published a notice of proposed changes to the reimbursement methodology for nursing facilities (NFs). At that time, the OMPP proposed to continue the three percent (3%) reduction currently set to expire on June 30, 2015, for rates paid to nursing facilities, under the Medicaid state plan and state regulations, at 405 IAC 1-14.6, as amended by LSA Document #13-422, posted at 20131204-IR-405130422FRA. This three percent (3%) reduction will remain in effect through June 30, 2017. Beginning July 1, 2017, the OMPP proposes to remove the three percent (3%) rate reduction.

The change in reimbursement is necessary in order to remain within the available Medicaid appropriation. It is estimated that the fiscal impact of continuing the three percent (3%) reduction will be an annual savings of state and federal expenditures of 1) approximately $13.9 million for FFY 2015 (federal share of $9.2 million and state share of $4.7 million), and 2) $55.6 million for FFY 2016 (federal share of $37.0 million and state share of $18.6 million), as compared with state and federal expenditures without the three percent (3%) reduction (see Appendix K).

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

Value Based Purchasing

Indiana nursing facilities are eligible for a quality add-on payment of up to $14.30 per Medicaid resident day. This add-on is funded through a Quality Assessment Fee (QAF) on all nursing facility beds in Indiana. Facilities receive the add-on payment through achievement in a quality scoring formula that is built around their ISDH report card score, nursing hours per patient day, and staff retention and turnover rates.

These payments and the formula were developed as part of Indiana's Value Based Purchasing (VBP) initiative. This has been a collaborative, multi-phase effort that began in 2008 (although implementation of Indiana's QAF in 2003 was retroactively identified as Phase 1). The formula was arrived at in the third phase of the VBP planning process.

In 2015, the DA embarked upon a fourth phase of VBP for the purpose of updating the current formula. We anticipate the committee participating in this update will be making recommendations in early 2016 so new rules around VBP can be promulgated to be effective in 2017. The agency anticipates a continued focus on quality improvement efforts beyond this date, in collaboration with ISDH, the nursing facility industry, and other stakeholders, including academic partners.

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

Nursing facility reimbursement is also augmented for many facilities in Indiana as a result of their participation in the CMS Upper Payment Limit program. The UPL program is authorized in state statute and operated according to the state Medicaid Plan. Indiana's UPL program provides supplemental payments to non-state government owned or operated (NSGO) nursing facilities. A NSGO nursing facility is one that has entered into agreements with a county-owned hospital system.

These entities enter into a payment agreement with the FSSA/OMPP. As part of these agreements, each NSGO entity funds the state's portion of the payment through an Intergovernmental Transfer (IGT). After matching with federal dollars, the state then makes the supplemental payments to the NSGO entities. Essentially, these payments consist of the difference between the Medicaid rate and the Medicare rate, based on acuity levels of residents within the NSGO facilities.

In SFY 2014, payments to the 339 Indiana NSGO facilities under the UPL program totaled $717.8 million dollars. Because the program is funded through the IGT and the matching federal dollars, the State is able to operate this program at no cost, outside of administrative expenses.

Managing Construction of Additional Skilled Nursing Facilities in Indiana

Past Policies

In Indiana's State Government's July – December 2005 Performance Report, it was reported that 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."

At that time, 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.

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).

In 2011, 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 began prior to June 30, 2011, expired June 30, 2014. The moratorium was codified in IC 16-29-6 and applied only to facilities for which construction began after July 1, 2011. There were exceptions for replacement beds, small house facilities and continuing care retirement communities.

During the 2013 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 had 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. The House passed the legislation, noting empty beds across the state, but the bill died in March of 2014.

Current moratorium

As Indiana's long-term care facility occupancy dropped to 76% during 2014, adding an estimated cost increase of approximately $25 million dollars shared by the federal and state Medicaid program, SB 460 in the 2014 legislative session proposed a three-year moratorium on the construction of new facilities to allow demand to catch up with supply, and took effect in May 2015. The three-year moratorium on building new nursing homes does not apply to counties with an occupancy rate higher than 90 percent, and it will allow facilities to be built if they are

replacing older nursing homes. Assisted living and independent living facilities are not affected by the law.

Other States' Strategies

Certificate of Need (CON) programs are aimed at restraining health care facility costs and allowing coordinated planning of new services and construction. Laws authorizing such programs are one mechanism by which state governments seek to reduce overall health and medical costs. Many CON laws initially were put into effect across the nation as part of the federal "Health Planning Resources Development Act" of 1974. Despite numerous changes in the past 30 years, about 36 states retain some type of CON program, law or agency as of 2014.

The 1974 federal Act required all 50 states to have a mechanism in place involving the submission of proposals and obtaining approval from a state health planning agency before beginning any major capital projects such as building expansions or ordering new high-tech devices. Many states implemented CON programs in part because of the incentive of receiving CON federal funds.

The federal mandate was repealed in 1987, along with its federal funding. In the decade that followed, 14 states discontinued their CON programs. However, 36 states currently maintain some form of construction management program, and even the 14 that repealed their state CON laws still retain some mechanisms intended to regulate costs and duplication of services.

Florida 14-Year Moratorium Lifted

In the spring of 2015, and in anticipation of a swelling elderly population and a possible boost to the state's economy, Florida ended a 14-year moratorium and approved permits to build 22 new skilled nursing facilities across the state. The permits also allow for a number of expansion projects at 11 facilities. The approved projects represent $400 million in construction across 25 counties and the addition of 2,600 beds.

The moratorium was imposed in 2001 by the Florida Legislature to mitigate the impact from the state's escalating Medicaid spending, as well as what was seen as an effort to encourage more community-based facilities. The state's new Medicaid-managed care program was a catalyst for lifting the ban.

Rhode Island's NF Reimbursement Rates and Providers' Bed Tax

Rhode Island wants to reduce nursing home reimbursement rates by 3% and raise providers' bed tax ceiling by 0.5%. The plan also includes an offer for SNFs to earn lost funding back if they make substantial efficiency and quality improvements. These changes would slash the state's Medicaid spend by $180 million in fiscal 2016—nearly half of which would come from these and other aggressive spending measures. It is estimated that nursing home rate cuts would save the state about $18 million a year, and an additional $6 million in nursing home cuts would result from value-based purchasing initiatives. Overall, lost revenue for nursing home care provided by

the state's 84 Medicare-certified nursing centers would total approximately $24 million, according to the Rhode Island Health Care Association.

Other savings would come from stepped-up Medicaid fraud prevention efforts, cuts to programs that provide coordinated care management of people with severe mental illness, and home health stabilization for people with complex behavioral or medical conditions. Nursing homes also would lose their adjustment for inflation, which is set to take effect in October.

Minnesota Nursing Facility Moratorium and Rebalancing

Currently, Minnesota has a moratorium on the licensure and Medicaid certification of new nursing home beds and construction projects that exceed $1.4 million. However, there are certain exceptions to the moratorium including for facilities built to address an extreme hardship situation in a particular area, to license or certify beds in a new facility constructed to replace a facility, or to license or certify beds that are moved from one location to another within the state. In addition, the state may grant construction project exceptions to the nursing facility moratorium if legislation authorizes and funds those projects.

In fiscal year 2013, the Minnesota Commissioner of Health was given the authority to approve moratorium exception projects for which the full annualized state share of MA costs does not exceed $1 million. The legislature has also, at times, authorized statutory exceptions to the moratorium. There is an incentive for nursing facilities to create single-bed rooms as a result of bed closures. Facilities that create single-bed rooms as a result of bed closures receive an increase in their operating payment rate. Nursing facilities are prohibited from discharging residents for purposes of establishing single-bed rooms. Planned closure rate adjustments provide incentive payments for the planned closure of nursing home beds in an area of the state in which excess bed capacity exists or where a rebalancing of long-term care services is desired. This incentive was discontinued in 2011 and restored in 2013.

Impact of Additional SNFs on Renovation and New Construction

The nursing facility moratorium currently in place may free up funds for existing facilities to upgrade and improve their existing facilities or replace older structures. The cost of construction is highly dependent on the age of the facility and the extent of needed remodeling. Additionally, during the moratorium, construction resources may be available for constructing alternative residential or care facilities such as assisted living or continuing care retirement communities that allow more flexible housing options as residents age.

However, funding for construction is generally driven by private banking risk analysis and cost-benefit ratio. Capital funding sources are likely to value new construction over rehabbing older facilities, in which risk is higher and return on investment is less. The impact on other construction options such as congregate housing, assisted living, and residential care facilities should not be adversely affected by a moratorium as those alternatives from nursing facility

placement will continue to grow, supported by the construction industry and driven by a private-pay market.

Cost Impact of Excess Capacity

The impact of excess nursing facility bed capacity results in an increase in direct costs per resident. 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 $7.5 million in state dollars 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 of Nursing Facilities in Indiana

With the increase in home care, nursing facilities are seeing a more frail resident population. Some facilities may have fewer residents, but many of those residents have higher acuity. Additionally, short-term rehabilitation residents are occupying higher percentages of nursing facility beds. Lower occupancy rates have also 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.

Financial concerns, hospital discharge patterns, and the location of homes throughout the state also are factors. Low occupancy rates produce challenges for a 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 in order to attract residents.

Nationally, many nursing facilities have watched their census fall simultaneously with an increase in the level of care needs and fragility of their residents during a time of redirected Medicaid and Medicare funding. The need for high-quality skilled nursing homes will continue to grow as 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.

Telehealth/Telemedicine

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

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

Recent Indiana Policies

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

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

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

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

Past Policies

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

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

Efficient and Cost-Effective Telehealth in HCBS/Institutional Settings

Veterans Administration

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

Over 14,000 veterans have enrolled in the telehealth program since its inception, making 23,267 visits just during 2013. The VAMC calculates that nearly 500,000 miles related to travel were

avoided (by calculating the number of miles avoided in travel from home to a local satellite site as compared with traveling from home to the Indianapolis VA). By VAMC's calculations, its telehealth program has saved $331,132 in travel costs alone since 2011. In addition, the program has been well received by veterans, with an overall satisfaction score of 96%.

Nursing Facility Resident Hospitalizations

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

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

Chronic Disease Management - Franciscan Nurse Visiting Services

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

Indiana's Franciscan Visiting Nurse Services' (FVNS) launched its telehealth program in 2009 , and redesigned and implemented the current program in 2012 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.

SmartPhone Behavioral Health Program Cuts ER Use in Indiana and Tennessee

In a recent pilot at four sites in Indiana and Tennessee, a newly formed collaboration between a behavioral health services provider, mental health application-designer, and telecommunications giant Verizon, was able to reduce visits to emergency rooms by 39%, and in-patient days by 53% among a targeted population of high-utilizing Medicaid patients with behavioral issues. The partners wanted to determine whether technology plus a health and wellness coach (and a little cash used on such items as bathroom grab bars, nicotine therapy, or even a pulse oximeter) could change healthcare utilization patterns.

Other States' Approaches to Telehealth/Telemedicine

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

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

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

Emerging Telehealth Technologies

More vendors are focusing on home-based healthcare solutions that give consumers more control over their own care. In addition to being more convenient for patients, these tools and products can reduce costs and provide physicians with patient information more quickly and efficiently. Health and wellness programs, including diet, exercise routines, and consultations with life and wellness coaches, are being implemented to improve post-discharge care. Keeping patients healthy after receiving procedures helps reduce complications and avoid costly readmissions.

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.

Smartphones, laptops, and tablets are also being used in hospitals to allow doctors to sync to the facility's network and outside hospitals to enable patients to monitor vital signs and transmit this information to their physicians. Medical networks are upgrading privacy and security measures as this telehealth technology grows. With a huge number of Baby Boomers preparing to retire, and preferring to stay at home rather than spend time in hospitals, mobile technologies are bringing healthcare to these patients.

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.

The Future of Telehealth in Indiana

It is projected 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 due to recent changes enacted by the Affordable Care Act. With a projected 32 million additional Americans entering the health system and the baby boom generation coming of age and using Medicare services, many practitioners are realizing that telemedicine may help address the problems of providing timely access to healthcare for this the population.

Glossary

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

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

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

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

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

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

Aged and Disability Resource Centers (ADRCs)

Assisted Living (AL) is a residential option that provides personal care assistance, housekeeping, attendant care and companion services, medication management (to the extent

permitted under State law), and therapeutic social and recreational programming. Services are provided in a private apartment, which provides a homelike environment in an ISDH-licensed residential care facility Services include 24-hour on-site response staff. This program offers a way to promotes maximum independence, while providing supervision, safety, and security.

Attendant Care (ATTC) services primarily involve hands-on, non-skilled 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 monitor all other services required in the individual's care plan. Case Management is required in conjunction with the provision of many home and community-based services.

CHOICE (Community and Home Options to Institutional Care for the Elderly and Disabled) program funds began in 1984, and the program continues to focus on the role of community-based services as a means to avoid premature institutionalization.

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

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

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

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

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

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

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

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

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

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

Home and Community-Based Services (HCBS) include a wide range of services and options as defined in 455 IAC 2 that allow care to be offered to persons in either their own home or various community settings. Eligibility for HCBS varies by payment source. Medicaid waivers have the strictest guidelines as they require the participant to meet Nursing Facility Level of Care

(NFLOC) and Medicaid guidelines. Other funding sources may use the number of deficits in Activities of Daily Living (ADLs) to determine eligibility.

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

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

Home-Delivered Meals are nutritionally balanced meals that help prevent institutionalization because the absence of nutrition in individuals with frail and disabling conditions presents a severe risk to health. Up to two meals per day can be reimbursed under the waiver.

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

Information Assistance (I&A) is a service that, 1) provides individuals with information on services available within the communities, 2) links individuals to the services and opportunities that are available within the communities, and 3) to the maximum extent practicable, establishes adequate follow\-up procedures.

Legal Assistance assists older adults with understanding and maintaining their rights, exercising their choices, helping them benefit from available services and resolve disputes. The program also promotes the need for lifetime planning through the understanding and the use of advance directives.

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

Nursing Facility Level of Care (NFLOC) is the level of physical and other needs that indicate a person is appropriate for care within a skilled nursing facility.

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

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

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

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

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

Options Counseling is an interactive process by which consumers receive guidance in their decisions to make informed choices about long-term supports. Directed by the individual, the process may include others the person chooses or those legally authorized to represent the individual.

Options Counseling includes the following steps: 1) A personal interview to discover strengths, values, and preferences of the individual and the utilization of screenings for public programs, 2) a facilitated decision support process that explores resources and service options, and supports the individual in weighing pros and cons, 3) developing action steps toward a goal or a long-term support plan and assistance in applying for and accessing support options when requested, and 4) quality assurance and follow-up to ensure supports and decisions are working for the individual. Options Counseling is for persons of all income levels but is targeted for persons with the most immediate concerns, such as those at greatest risk for institutionalization.

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

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

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

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

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

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

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

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

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

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

Traumatic Brain Injury (TBI) Waiver provides home and community-based services to individuals who, but for the provision of such services, would require institutional care. A TBI is trauma that has occurred as a closed or open head injury and may produce an altered state of consciousness, and result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability, not including birth trauma related injury. Any closed head injury occurring before age twenty-two (22) or any open or closed-head injury occurring after age 22. The service includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

Upper Payment Limit (UPL) & Intergovernmental Transfer (IGT) Programs are facilitated through CMS, and augment reimbursement for many nursing facilities. Indiana's UPL program provides supplemental payments to non-state government owned or operated (NGSO) nursing facilities, which are those that have entered into agreements with a county-owned hospital system.

Value-Based Purchasing (VBP) refers to a set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures. VBP strategies are being used in an effort to drive improvements in quality and to slow the growth in health care spending.

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 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.

Appendices

Appendix A – Map of Indiana's Area Agencies on Aging

INDIANA ASSOCIATION OF AREA AGENCIES ON AGING

AREA 1
Northwest Indiana Community Action Corporation
5240 Fountain Drive
Crown Point, IN 46307
219.794.1829 OR 800.826.7871
TTY: 888.814.7597
FAX: 219.794.1860
www.nwi-ca.com

AREA 2
REAL Services, Inc.
1151 S. Michigan Street
South Bend, IN 46601-3427
574.284.2644 OR 800.552.7928
FAX: 574.284.2642
www.realservicesinc.org

AREA 3
Aging and In-Home Services of Northeast Indiana, Inc.
2927 Lake Avenue
Fort Wayne, IN 46805-5414
260.745.1200 OR 800.552.3662
FAX: 260.422.4916
www.agingihs.org

AREA 4
Area IV Agency on Aging & Community Action Programs, Inc.
660 N. 36th Street
Lafayette, IN 47903-4727
765.447.7683 OR 800.382.7556
TDD: 765.447.3307
FAX: 765.447.6862
www.areaivagency.org

AREA 5
Area Five Agency on Aging & Community Services, Inc.
1801 Smith Street, Suite 300
Logansport, IN 46947-1577
574.722.4451 OR 800.654.9421
FAX: 574.722.3447
www.areafive.com

AREA 6
LifeStream Services, Inc.
1701 Pilgrim Boulevard
Yorktown, IN 47396-0308
765.759.1121 OR 800.589.1121
TDD: 800.801.6606
FAX: 765.759.0060
www.lifestreaminc.org

AREA 7
Area 7 Agency on Aging and Disabled West Central Indiana
Economic Development District, Inc.
1718 Wabash Avenue
Terre Haute, IN 47807
812.238.1561 OR 800.489.1561
TDD: 800.489.1561
FAX: 812.238.1564
www.westcentralin.com

AREA 8
CICOA Aging and In-Home Solutions
4755 Kingsway Drive, Suite 200
Indianapolis, IN 46205-1560
317.254.5465 OR 800.432.2422
TDD: 317.254.5497
FAX: 317.254.5494
www.cicoa.org

AREA 9
Area 9 In-Home & Community Service Agency
520 South 9th Street
Richmond, IN 47374
765.966.1795 OR 800.458.9345
FAX: 765.962.1190
www.iue.edu/area9

AREA 10
Area 10 Agency on Aging
631 W. Edgewood Drive
Ellettsville, IN 47429
812.876.3383 OR 800.844.1010
FAX: 812.876.9922
www.area10agency.org

AREA 11
Thrive Alliance
1531 13th Street, Suite G900
Columbus, IN 47201
812.372.6918 OR 866.644.6407
FAX: 812.372.7864
www.thrive-alliance.org

AREA 12
LifeTime Resources, Inc.
13091 Benedict Drive
Dillsboro, IN 47018
812.432.6200 OR 800.742.5001
FAX: 812.432.3822
www.lifetime-resources.org

AREA 13
Generations
Vincennes University
Statewide Services
1019 N. 4th Street
Vincennes, IN 47591
812.888.5880 OR 800.742.9002
FAX: 812.888.4566
www.generationsnetwork.org

AREA 14
LifeSpan Resources, Inc.
33 State Street Third Floor
New Albany, IN 47151-0995
812.948.8330 OR 888.948.8330
TTY: 812.542.6895
FAX: 812.948.0147
www.lsr14.org

AREA 15
Hoosier Uplands / Area 15 Agency on Aging and Disability Services
521 West Main Street
Mitchell, IN 47446
812.849.4457 OR 800.333.2451
TDD: 800.743.3333
FAX: 812.849.4467
www.hoosieruplands.org

AREA 16
SWIRCA & More
16 W. Virginia Street
Evansville, IN 47737-3938
812.464.7800 OR 800.253.2188
FAX: 812.464.7843
www.swirca.org

Appendix B – HCBS and Corresponding Potential Payment Sources Offered in Indiana

Home & Community Based Services (HCBS)	Medicaid Waiver	Medicaid	Medicare	CHOICE	SSBG	Title III - OAA	State Funds	Private-Pay Funds*	Other Federal Funds
Information & Assistance						X			
Case Management	X			X	X	X		X	
Personal /Attendant Care	X			X	X	X		X	
Homemaker	X			X	X	X		X	
Personal Emergency Response	X			X	X	X		X	
Handyman/chore				X	X	X		X	
Home Health Care		X	X					X	
Respite-Aide	X			X	X	X		X	
Respite-skilled	X	X						X	
Home delivered meals	X			X	X	X		X	
Congregate meals						X			
Transportation	X	X		X	X	X		X	X
Senior Centers						X			
Adult Day Services	X			X				X	
Adult Family Care	X								X
Assisted Living	X							X	X
Structured Family Care	X								
Home Modifications	X							X	
Vehicle Modifications	X	X						X	
Community Transitions	X								X
Health Care Coordination-RN	X								X
Nutritional Supplements	X								
Legal Assistance						X		X	
Ombudsman						X	X		X
Guardianship							X		
PACE		X	X						

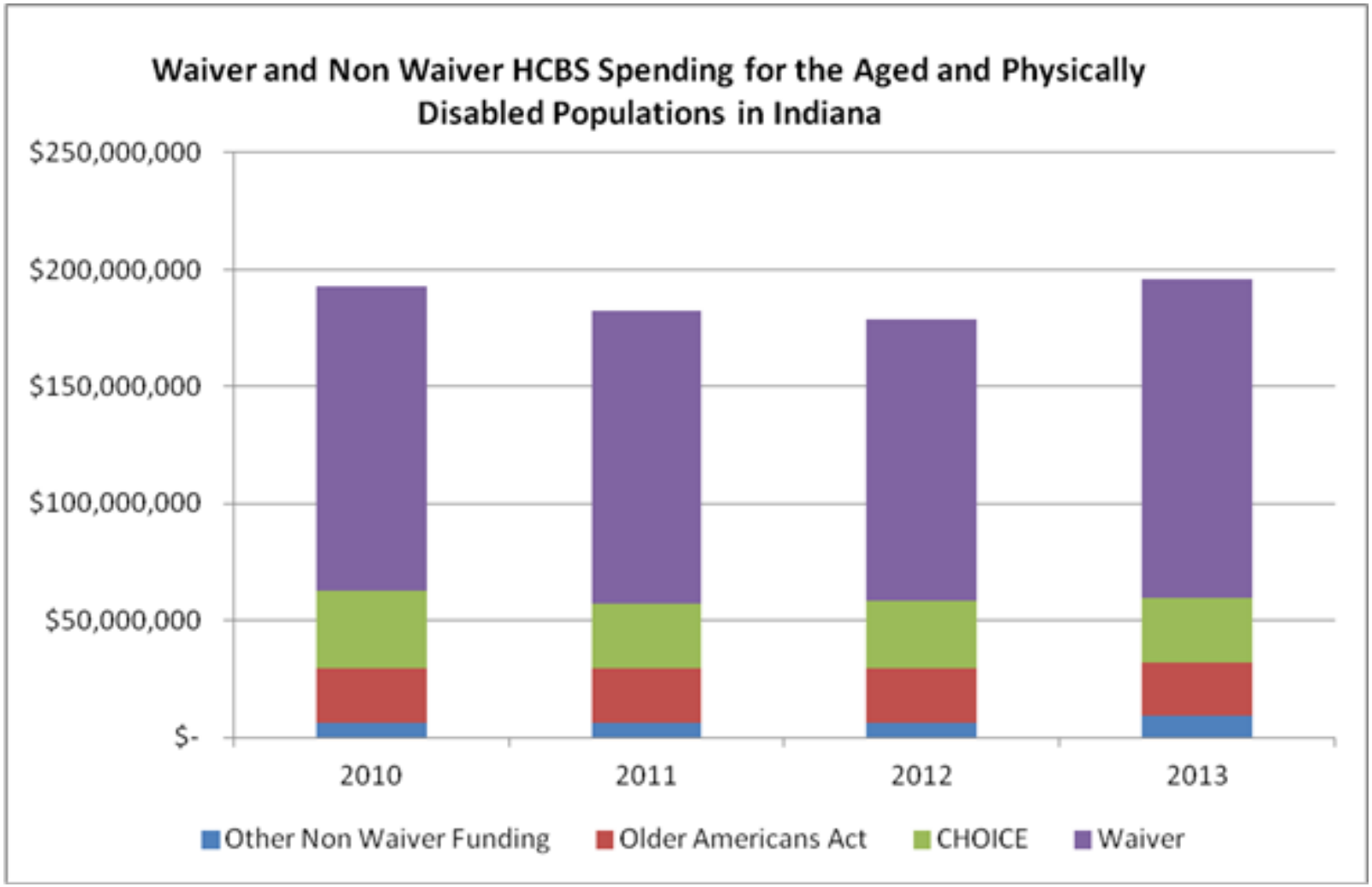
Adult Protective Services					X		X			
Personal Affairs Management						X				
Specialized Medical Equipment	X	X	X					X	X	
Pest Control	X			X	X	X		X		

KEY:

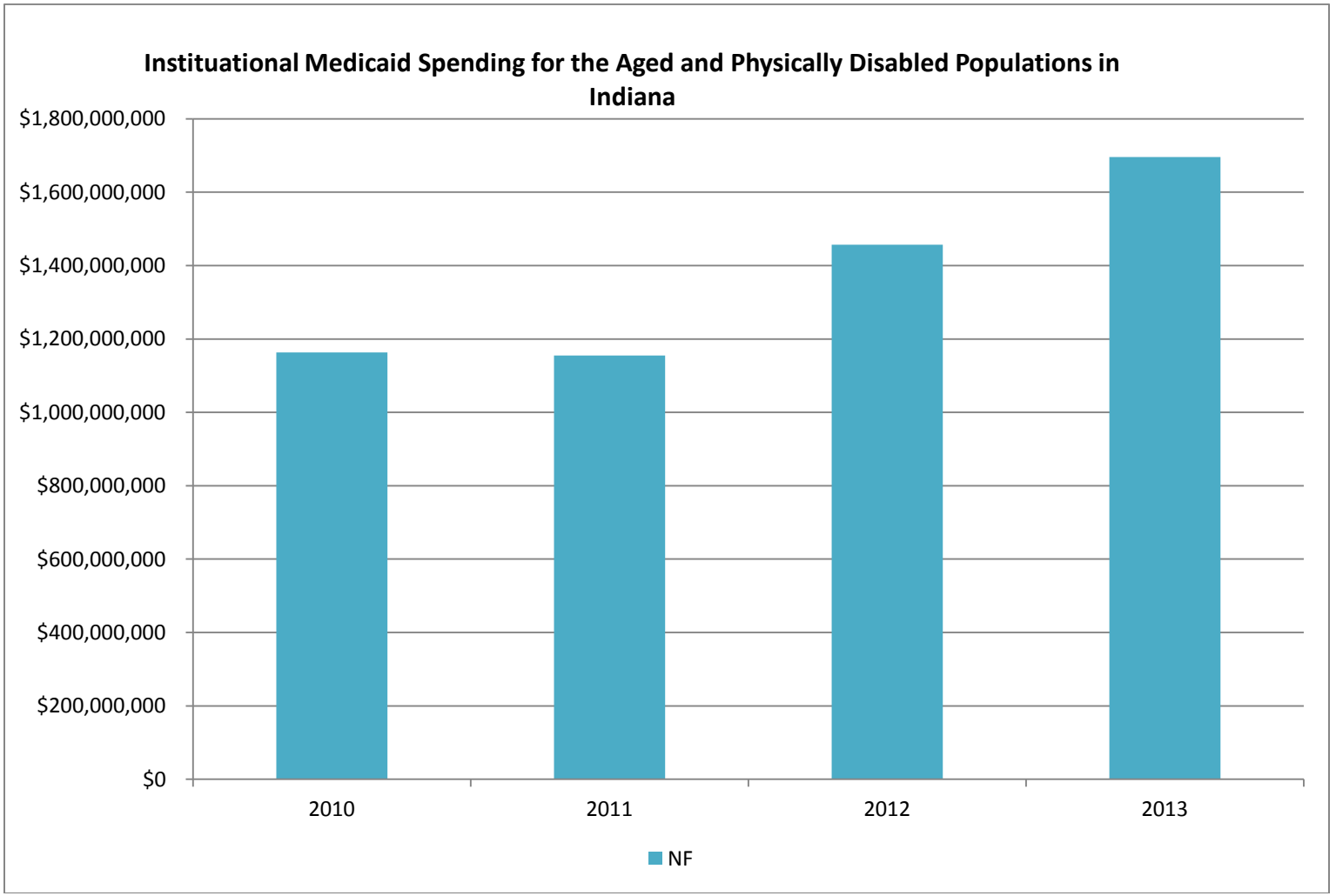
ACCESS & CARE COORDINATION
IN-HOME SERVICE DELIVERY
COMMUNITY BASED SERVICES
ALTERNATIVE RESIDENTIAL
OTHER SERVICES

* Can include self-pay, use of privately donated funds from fundraising efforts, or local funds such as United Way.

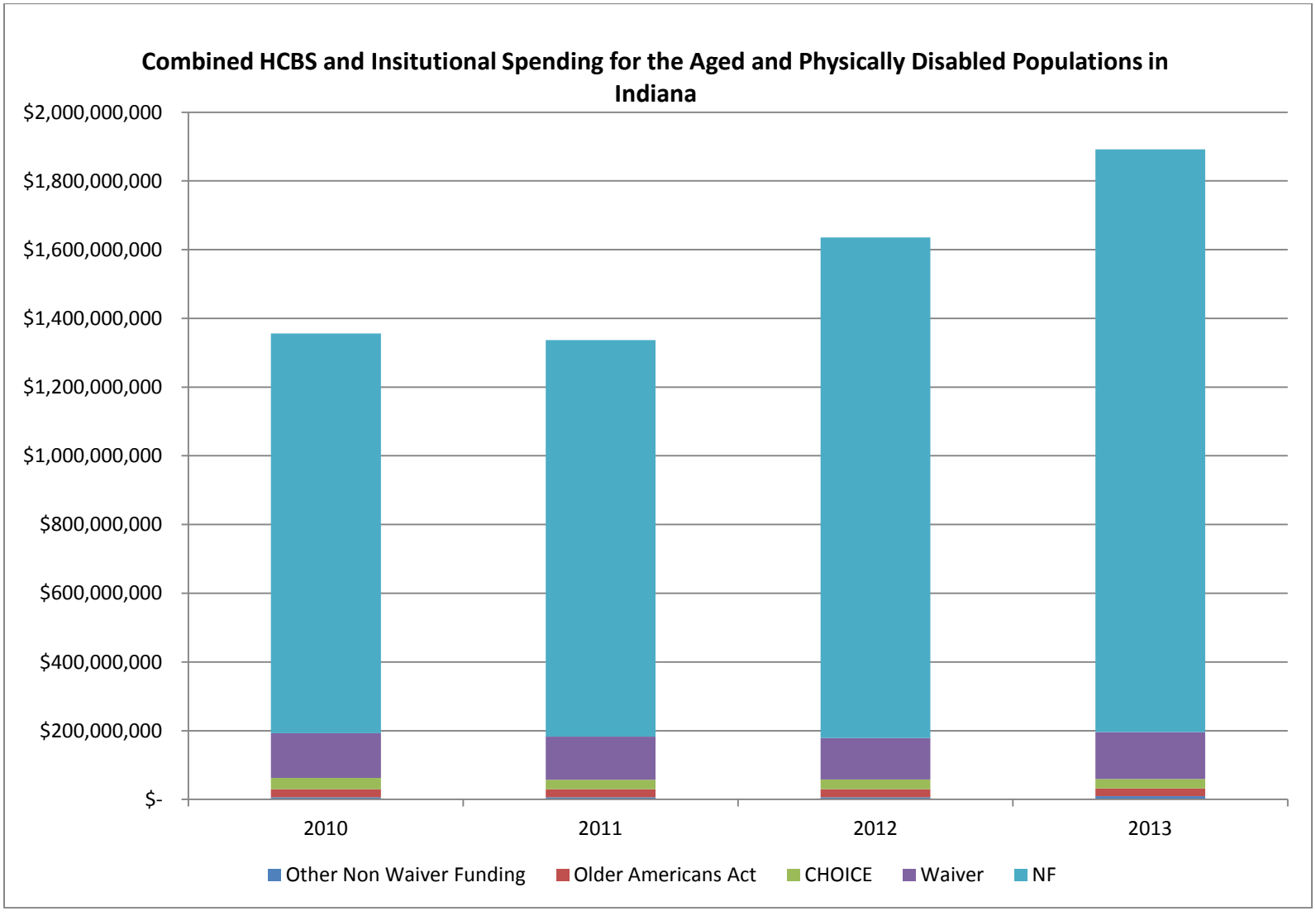
Appendix C – Waiver and Non-Waiver HCBS Spending for A&D Population 2010 - 2013



Appendix D – Institutional Medicaid Spending for the A&D Population



Appendix E – Combined HCBS and Institutional Spending for the A&D Populations



Appendix F – American Community Survey 2009-2013 Estimates – Indiana

Population 65 Years of Age and Older in Indiana		
	Total population of Indiana	**Hoosiers 65 years and over**
Total population	**6,514,861**	**866,730**
SEX AND AGE		
Male	49.2%	42.8%
Female	50.8%	57.2%
Median age (years)	37.1	73.9
RACE/ HISPANIC OR LATINO ORIGIN		
One race	97.9%	99.4%
White	84.6%	92.3%
Black or African American	9.1%	5.8%
American Indian and Alaska Native	0.2%	0.2%
Asian	1.7%	0.7%

Native Hawaiian/Other Pacific Islander	0.0%	0.0%
Some other race	2.3%	0.4%
Two or more races	2.1%	0.6%
Hispanic or Latino origin (of any race)	6.2%	1.6%
White alone, not Hispanic or Latino	81.1%	91.2%
RELATIONSHIP		
Population in households	6,327,145	826,980
Householder or spouse	58.8%	92.3%
Parent	0.8%	3.8%
Other relatives	35.0%	2.5%
Nonrelatives	5.4%	1.4%
Unmarried partner	2.4%	0.6%
HOUSEHOLDS BY TYPE		
Households	2,481,793	547,094
Family households	66.7%	53.5%

Married-couple family	50.0%	44.2%
Female householder, no husband present, family	12.3%	7.3%
Nonfamily households	33.3%	46.5%
Householder living alone	27.7%	44.6%
MARITAL STATUS		
Population 15 years and over	5,192,108	866,730
Now married, except separated	50.4%	55.5%
Widowed	6.1%	28.6%
Divorced	12.4%	11.6%
Separated	1.5%	0.6%
Never married	29.7%	3.7%
EDUCATIONAL ATTAINMENT		
Population 25 years and over	4,258,878	866,730
Less than high school graduate	12.8%	20.0%
High school graduate, GED, or alternative	35.2%	43.9%
Some college or associate's degree	28.8%	20.0%

Bachelor's degree or higher	23.2%	16.1%
RESPONSIBILITY FOR GRANDCHILDREN UNDER 18 YEARS		
Population 30 years and over	3,842,620	866,730
Living with grandchild(ren)	3.3%	3.3%
Responsible for grandchild(ren)	1.7%	1.1%
VETERAN STATUS		
Civilian population 18 years and over	4,913,683	866,730
Civilian veteran	9.3%	22.3%
DISABILITY STATUS		
Civilian non-institutionalized population	6,414,808	830,879
With any disability	13.0%	37.4%
No disability	87.0%	62.6%
RESIDENCE 1 YEAR AGO		
Population 1 year and over	6,434,804	866,730

Same house	84.9%	94.2%
Different house in the United States	14.8%	5.6%
Same county	9.2%	3.6%
Different county	5.6%	2.0%
Same state	3.5%	1.3%
Different state	2.0%	0.7%
Abroad	0.4%	0.2%
PLACE OF BIRTH		
Total population	6,514,861	866,730
Foreign born	308,060	28,085
Not a U.S. citizen	65.1%	24.2%
LANGUAGE SPOKEN AT HOME AND ABILITY TO SPEAK ENGLISH		
Population 5 years and over	6,087,409	866,730
English only	91.8%	95.9%
Language other than English	8.2%	4.1%
Speak English less than "very well"	3.3%	1.8%

EMPLOYMENT STATUS		
Civilian population 16 years and over	5,095,287	866,730
In labor force	64.4%	16.0%
Employed	58.2%	15.1%
Unemployed	6.2%	0.9%
Percent of civilian labor force	9.6%	5.5%
Not in labor force	35.6%	84.0%
INCOME IN THE PAST 12 MONTHS (IN 2013 INFLATION-ADJUSTED DOLLARS)		
Households	2,481,793	547,094
With earnings	78.1%	33.7%
Mean earnings (dollars)	64,262	37,202
With Social Security income	29.5%	93.9%
Mean Social Security income (dollars)	17,833	19,454
With Supplemental Security Income	4.5%	4.6%
Mean Supplemental Security Income	9,533	9,790

(dollars)		
With cash public assistance income	2.4%	1.3%
Mean cash public assistance income (dollars)	3,236	3,071
With retirement income	18.6%	52.8%
Mean retirement income (dollars)	17,420	16,742
With Food Stamp/SNAP benefits	12.1%	6.4%
POVERTY STATUS IN THE PAST 12 MONTHS		
Population for whom poverty status is determined	6,317,159	830,879
Below 100 percent of the poverty level	15.4%	7.3%
100 to 149 percent of the poverty level	9.6%	10.6%
At or above 150 percent of the poverty level	75.0%	82.0%
2009-2013 American Community Survey 5-Year Estimates; retrieved 6/12/15 at: http://factfinder.census.gov/facts/tableservices/jsf/pages/productview.xhtml?src=CF		

Appendix G - Percentage of Total Numbers Served by Program Area - March 2015

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

Demographic percentages by program funding sources, March 2015, INsite.

Appendix H – State Ranking on LTSS System Performance by Dimension

INTRODUCTION

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.

Appendix I – Truven Data on Case Management Services Expenditures

TRUVEN HEALTH ANALYTICS

Case Management

State	FY 2013 Expenditures Per State Resident	Rank 2013	Rank 2012	FY 2008 Expenditures	FY 2009 Expenditures	Percent Change 08-09	FY 2010 Expenditures	Percent Change 09-10	FY 2011 Expenditures	Percent Change 10-11	FY 2012 Expenditures	Percent Change 11-12	**FY 2013 Expenditures**	Percent Change 12-13
Minnesota	$37.24	1	1	$149,485,228	$158,502,334	6.0	$202,026,086	27.5	$200,380,348	-0.8	$199,908,880	-0.2	**$201,921,472**	1.0
Maine	$31.83	2	2	$81,774,122	$84,554,398	3.4	$59,663,646	-29.4	$55,073,276	-7.7	$40,408,589	-26.6	**$42,294,394**	4.7
Montana	$26.41	3	3	$19,410,969	$20,282,802	4.5	$19,593,395	-3.4	$20,575,674	5.0	$27,278,859	32.6	**$26,797,651**	-1.8
Tennessee	$18.79	4	6	$137,562,154	$213,495,800	55.2	$91,100,746	-57.3	$118,058,383	29.6	$107,415,447	-9.0	**$122,056,922**	13.6
Oregon	$16.53	5	4	$84,257,012	$65,889,077	-21.8	$68,755,006	4.3	$64,388,114	-6.4	$88,981,659	38.2	**$64,943,614**	-27.0
Virginia	$16.22	6	8	$58,486,997	$119,120,617	103.7	$126,650,283	6.3	$133,486,535	5.4	$130,156,003	-2.5	**$134,162,766**	3.1
Oklahoma	$15.00	7	16	$47,195,581	$52,775,846	11.8	$71,287,648	35.1	$51,440,930	-27.8	$44,900,325	-12.7	**$57,785,991**	28.7
Nebraska	$14.97	8	10	$25,438,888	$27,579,460	8.4	$25,998,472	-5.7	$23,374,431	-10.1	$26,548,782	13.6	**$27,971,305**	5.4
New York	$14.84	9	5	$539,912,059	$572,818,607	6.1	$639,155,598	11.6	$566,843,739	-11.3	$388,037,326	-31.5	**$292,302,802**	-24.7
Iowa	$14.83	10	14	$35,577,437	$36,839,532	3.5	$36,767,562	-0.2	$39,802,373	8.3	$40,248,782	1.1	**$45,849,443**	13.9
Nevada	$14.53	11	9	$29,461,691	$34,786,548	18.1	$45,906,914	32.0	$67,959,423	48.0	$39,457,742	-41.9	**$40,552,655**	2.8
New Hampshire	$13.47	12	43	$56,499	$68,117	20.6	$83,081	22.0	$83,805	0.9	$59,637	-28.8	**$17,821,911**	29784.0
California	$13.44	13	11	$393,673,375	$584,390,671	48.4	$541,625,119	-7.3	$614,747,922	13.5	$517,097,518	-15.9	**$516,390,476**	-0.1
Connecticut	$12.79	14	25	$30,578,494	$47,131,062	54.1	$32,533,645	-31.0	$23,858,001	-26.7	$28,021,285	17.5	**$46,024,199**	64.2
Alabama	$12.70	15	13	$42,714,706	$55,256,547	29.4	$52,473,942	-5.0	$59,102,773	12.6	$64,416,708	9.0	**$61,401,992**	-4.7
North Dakota	$11.65	16	12	$4,115,103	$10,099,232	145.4	$9,327,997	-7.6	$8,983,076	-3.7	$9,234,837	2.8	**$8,431,978**	-8.7
Missouri	$11.39	17	19	$54,238,695	$65,837,200	21.4	$57,843,595	-12.1	$57,173,963	-1.2	$62,087,845	8.6	**$68,846,474**	10.9
Idaho	$11.32	18	17	$13,699,897	$13,991,013	2.1	$13,789,193	-1.4	$16,033,610	16.3	$17,345,502	8.2	**$18,258,453**	5.3
Mississippi	$9.88	19	7	$48,846,671	$50,574,712	3.5	$49,977,957	-1.2	$53,859,253	7.8	$48,583,503	-9.8	**$29,553,047**	-39.2
Wisconsin	$9.28	20	21	$41,465,220	$67,057,251	61.7	$39,519,254	-41.1	$74,407,805	88.3	$53,717,470	-27.8	**$53,290,852**	-0.8
Kansas	$7.82	21	18	$26,699,757	$28,263,716	5.9	$27,440,398	-2.9	$29,170,538	6.3	$30,198,789	3.5	**$22,649,128**	-25.0
Rhode Island	$7.73	22	26	$11,468,438	$9,902,732	-13.7	$9,736,442	-1.7	$11,481,880	17.9	$7,641,505	-33.4	**$8,146,940**	6.6
Florida	$7.30	23	28	$79,329,283	$108,456,254	36.7	$117,930,591	8.7	$104,000,083	-11.8	$104,316,282	0.3	**$143,006,271**	37.1
Ohio	$6.45	24	27	$15,293,771	$38,297,376	150.4	$40,760,843	6.4	$48,233,615	18.3	$68,409,408	41.8	**$74,639,845**	9.1
Kentucky	$5.79	25	20	$42,124,435	$46,291,280	9.9	$62,048,150	34.0	$53,422,431	-13.9	$44,267,277	-17.1	**$25,458,674**	-42.5
Georgia	$4.97	26	23	$103,251,982	$90,558,936	-12.3	$92,722,664	2.4	$94,872,811	2.3	$82,089,619	-13.5	**$49,705,314**	-39.4
South Carolina	$4.18	27	24	$42,335,113	$43,845,536	3.6	$33,705,305	-23.1	$35,258,708	4.6	$37,663,607	6.8	**$19,954,852**	-47.0
Wyoming	$4.10	28	41	$2,189,331	$2,358,541	7.7	$1,672,347	-29.1	$1,737,360	3.9	$258,321	-85.1	**$2,390,033**	825.2
Colorado	$3.89	29	30	$23,047,933	$18,272,365	-20.7	$21,400,093	17.1	$21,568,643	0.8	$20,526,333	-4.8	**$20,505,502**	-0.1
North Carolina	$3.42	30	22	$108,061,563	$117,948,827	9.1	$176,634,824	49.8	$102,723,039	-41.8	$87,650,679	-14.7	**$33,713,741**	-61.5
Louisiana	$3.36	31	29	$18,211,709	$19,944,022	9.5	$19,590,178	-1.8	$21,315,070	8.8	$23,023,536	8.0	**$15,568,083**	-32.4
Pennsylvania	$3.35	32	32	$71,967,959	$23,524,451	-67.3	$28,728,103	22.1	$38,697,697	34.7	$42,743,579	10.5	**$42,795,261**	0.1
Texas	$3.25	33	31	$228,407,184	$55,811,911	-75.6	$74,981,189	34.3	$106,096,566	41.5	$88,783,901	-16.3	**$86,164,977**	-2.9
New Jersey	$2.66	34	34	$16,839,305	$18,483,867	9.8	$20,159,945	9.1	$23,611,240	17.1	$23,910,348	1.3	**$23,666,911**	-1.0
Illinois	$2.65	35	33	$32,659,779	$39,665,469	21.5	$30,010,842	-24.3	$34,140,710	13.8	$35,974,314	5.4	**$34,166,398**	-5.0
Michigan	$2.26	36	35	$18,517,590	$22,697,188	22.6	$20,168,923	-11.1	$18,243,148	-9.5	$19,986,435	9.6	**$22,340,515**	11.8
West Virginia	$1.42	37	36	$5,903,559	$4,194,816	-28.9	$3,800,983	-9.4	$3,508,384	-7.7	$3,033,489	-13.5	**$2,636,422**	-13.1
Maryland	$1.36	38	37	$343,469	$366,648	6.7	$9,473,469	2483.8	$7,993,241	-15.6	$8,235,204	3.0	**$8,082,428**	-1.9
Arkansas	$1.16	39	39	$3,056,746	$3,287,295	7.5	$2,491,152	-24.2	$2,545,130	2.2	$2,522,319	-0.9	**$3,445,998**	36.6
Hawaii	$1.02	40	38	$782,255	$416,609	-46.7	$1,046,870	151.3	$1,303,463	24.5	$1,198,487	-8.1	**$1,432,114**	19.5
Indiana	$0.75	41	40	$9,920,946	$7,668,926	-22.7	$7,343,992	-4.2	$7,100,068	-3.3	$4,622,780	-34.9	**$4,955,062**	7.2
Vermont	$0.14	42	42	$0	$0	0.0	$29,872	100.0	$34,125	14.2	$45,103	32.2	**$89,171**	97.7
New Mexico	$0.02	43	44	$203,927	$94,848	-53.5	$65,564	-30.9	$58,758	-10.4	$35,906	-38.9	**$37,948**	5.7
Utah	$0.00	44	45	$1,722,881	$1,759,090	2.1	$1,255,492	-28.6	$1,298	-99.9	$3,488	168.7	**$6,980**	100.1
Washington	$0.00	45	46	$16,804,315	$0	-100.0	$0	0.0	$2,095	100.0	$283	-86.5	**$131**	-53.7
Alaska	$0.00			$0	$0	0.0	$0	0.0	$0	0.0	$0	0.0	**$0**	0.0
Arizona	$0.00			$0	$0	0.0	$0	0.0	$0	0.0	$0	0.0	**$0**	0.0
Dist. of Columbia	$0.00			$0	$0	0.0	$0	0.0	$0	0.0	$0	0.0	**$0**	0.0
Delaware	$0.00			$0	$0	0.0	$0	0.0	$0	0.0	$0	0.0	**$0**	0.0
South Dakota	$0.00			$0	$0	0.0	$0	0.0	$0	0.0	$0	0.0	**$0**	0.0
Massachusetts	-$8.84	51	15	$125,191,843	$218,799,671	74.8	$336,255,957	53.7	-$23,660,981	-107.0	$79,284,932	-435.1	**-$59,294,353**	-174.8
United States	$7.84			$2,842,285,871	$3,201,961,200	12.7	$3,323,533,327	3.8	$2,993,092,554	-9.9	$2,750,332,623	-8.1	**$2,462,922,743**	-10.5

Notes:

Data do not include services provided through managed care organizations.

Data are presented based on state reporting. No further explanation of trends is available for the purposes of this report.

Appendix J – Truven Data on Nursing Facility Medicaid Expenditures

TRUVEN HEALTH ANALYTICS

Nursing Facilities

Table E

State	FY 2013 Expenditures Per State Resident	Rank 2013	Rank 2012	FY 2008 Expenditures	FY 2009 Expenditures	Percent Change 08-09	FY 2010 Expenditures	Percent Change 09-10	FY 2011 Expenditures	Percent Change 10-11	FY 2012 Expenditures	Percent Change 11-12	FY 2013 Expenditures	Percent Change 12-13
New York	$354.57	1	1	$7,306,714,259	$7,758,357,529	6.2	$7,093,727,477	-8.6	$7,835,791,706	10.5	$6,956,815,223	-11.2	**$6,983,453,624**	0.4
Dist. of Columbia	$349.35	2	3	$181,248,320	$197,295,629	8.9	$204,874,253	3.8	$263,583,187	28.7	$216,525,388	-17.9	**$226,766,565**	4.7
Connecticut	$347.52	3	2	$1,242,115,976	$1,239,830,985	-0.2	$1,254,145,490	1.2	$1,217,700,131	-2.9	$1,257,493,079	3.3	**$1,250,852,152**	-0.5
Rhode Island	$313.54	4	4	$297,862,677	$293,189,722	-1.6	$304,373,238	3.8	$308,336,219	1.3	$323,345,787	4.9	**$330,268,108**	2.1
Pennsylvania	$300.37	5	7	$3,946,467,696	$3,685,498,884	-6.6	$3,598,171,010	-2.4	$3,774,755,299	4.9	$3,578,102,387	-5.2	**$3,839,084,653**	7.3
Delaware	$298.79	6	43	$176,289,498	$185,844,847	5.4	$185,834,973	0.0	$167,980,215	-9.6	$100,854,551	-40.0	**$276,450,873**	174.1
North Dakota	$293.10	7	5	$166,988,061	$172,083,717	3.1	$187,496,497	9.0	$196,323,201	4.7	$202,359,085	3.1	**$212,165,701**	4.8
West Virginia	$290.93	8	6	$442,903,243	$459,245,338	3.8	$480,001,815	4.5	$505,480,923	5.3	$534,038,607	5.6	**$539,260,544**	1.0
Mississippi	$263.56	9	9	$712,853,480	$727,351,102	2.0	$747,895,706	2.8	$750,603,273	0.4	$756,786,480	0.8	**$788,640,228**	4.2
Indiana	$258.04	10	12	$1,207,634,537	$1,189,057,416	-1.5	$1,163,250,684	-2.2	$1,154,645,676	-0.7	$1,457,213,591	26.2	**$1,695,492,875**	16.4
Massachusetts	$229.56	11	8	$1,670,187,564	$1,843,580,460	10.4	$1,939,964,656	5.2	$1,624,848,773	-16.2	$1,680,781,140	3.4	**$1,540,099,007**	-8.4
New Hampshire	$226.95	12	10	$303,216,132	$314,619,705	3.8	$309,381,926	-1.7	$313,339,583	1.3	$324,511,092	3.6	**$300,173,161**	-7.5
Arkansas	$216.78	13	11	$562,495,199	$572,633,770	1.8	$615,035,471	7.4	$627,215,924	2.0	$664,352,720	5.9	**$641,411,420**	-3.5
Ohio	$211.76	14	13	$2,560,188,710	$2,566,326,290	0.2	$2,714,864,696	5.8	$2,625,006,277	-3.3	$2,454,341,021	-6.5	**$2,450,452,939**	-0.2
New Jersey	$205.20	15	14	$1,910,408,539	$1,993,193,271	4.3	$1,913,718,015	-4.0	$1,892,884,455	-1.1	$1,823,551,529	-3.7	**$1,828,596,548**	0.3
Louisiana	$199.64	16	20	$719,869,207	$745,220,932	3.5	$776,918,106	4.3	$834,318,908	7.4	$861,215,506	3.2	**$924,200,498**	7.3
Hawaii	$199.34	17	15	$221,688,660	$104,540,851	-52.8	$2,162,887	-97.9	$230,353,612	10550.3	$281,934,273	22.4	**$280,867,064**	-0.4
Maryland	$190.96	18	16	$1,007,471,304	$1,066,496,276	5.9	$1,068,709,975	0.2	$1,080,290,376	1.1	$1,145,380,412	6.0	**$1,134,084,218**	-1.0
Kentucky	$189.19	19	17	$816,489,032	$833,041,443	2.0	$836,559,443	0.4	$857,251,589	2.5	$842,711,716	-1.7	**$832,398,912**	-1.2
Wisconsin	$187.35	20	27	$800,910,678	$1,168,989,173	46.0	$941,114,759	-19.5	$918,630,051	-2.4	$938,038,333	2.1	**$1,075,959,616**	14.7
Alabama	$186.77	21	18	$835,392,040	$938,110,423	12.3	$875,270,827	-6.7	$901,897,515	3.0	$920,037,327	2.0	**$902,867,111**	-1.9
Vermont	$186.12	22	21	$115,353,766	$116,585,573	1.1	$115,208,106	-1.2	$113,273,247	-1.7	$117,665,805	3.9	**$116,670,437**	-0.8
Iowa	$185.17	23	19	$471,047,086	$467,789,597	-0.7	$494,249,893	5.7	$537,178,895	8.7	$579,049,213	7.8	**$572,608,338**	-1.1
Maine	$179.22	24	26	$251,231,442	$254,549,153	1.3	$258,270,066	1.5	$223,800,411	-13.3	$225,757,804	0.9	**$238,126,635**	5.5
Nebraska	$178.84	25	24	$332,017,360	$317,724,608	-4.3	$320,878,579	1.0	$307,008,539	-4.3	$326,999,066	6.5	**$334,247,659**	2.2
Michigan	$178.75	26	25	$1,487,455,111	$1,551,504,718	4.3	$1,680,461,198	8.3	$1,725,811,579	2.6	$1,726,097,013	0.1	**$1,769,348,886**	2.5
Wyoming	$174.92	27	23	$69,720,452	$72,830,830	4.5	$74,265,694	2.0	$85,081,157	14.6	$100,954,262	18.7	**$102,017,436**	1.1
Alaska	$170.54	28	22	$73,558,912	$118,708,635	61.4	$117,631,024	-0.9	$123,236,772	4.8	$129,111,061	4.8	**$125,729,566**	-2.6
Missouri	$162.62	29	30	$848,689,837	$869,145,172	2.4	$907,754,984	4.4	$886,108,769	-2.4	$938,706,634	5.9	**$983,050,012**	4.7
Montana	$158.43	30	29	$152,760,292	$158,222,614	3.6	$155,944,522	-1.4	$163,691,536	5.0	$162,086,707	-1.0	**$160,780,101**	-0.8
South Dakota	$157.27	31	28	$138,111,126	$142,270,612	3.0	$144,038,021	1.2	$136,498,248	-5.2	$135,051,804	-1.1	**$132,970,013**	-1.5
Idaho	$146.13	32	35	$156,283,685	$159,282,628	1.9	$127,429,597	-20.0	$201,345,023	58.0	$214,012,949	6.3	**$235,677,751**	10.1
Oklahoma	$145.80	33	37	$528,366,521	$529,503,379	0.2	$508,370,052	-4.0	$494,455,738	-2.7	$498,177,896	0.8	**$561,789,425**	12.8
Florida	$144.88	34	34	$2,414,746,244	$2,423,463,477	0.4	$2,800,172,069	15.5	$2,885,014,465	3.0	$2,810,830,349	-2.6	**$2,839,666,292**	1.0
Minnesota	$144.19	35	32	$859,873,961	$871,036,606	1.3	$849,706,275	-2.4	$820,136,574	-3.5	$816,475,470	-0.4	**$781,797,797**	-4.2
Tennessee	$140.15	36	33	$1,040,896,033	$1,084,015,868	4.1	$1,180,859,656	8.9	$1,014,365,719	-14.1	$855,101,277	-5.8	**$910,608,998**	-4.7
Illinois	$138.33	37	36	$1,460,256,010	$1,613,063,632	10.5	$1,569,510,732	-2.7	$1,442,237,824	-8.1	$1,700,028,540	17.9	**$1,783,153,384**	4.9
Georgia	$136.00	38	39	$1,311,548,580	$990,197,359	-24.5	$1,294,870,614	30.8	$1,124,442,246	-13.2	$1,220,227,072	8.5	**$1,339,272,448**	9.8
Kansas	$122.27	39	31	$360,845,205	$372,488,745	3.2	$380,058,177	2.0	$422,717,190	11.2	$441,217,098	4.4	**$354,069,422**	-19.8
Colorado	$120.99	40	40	$501,243,727	$554,129,974	10.6	$578,087,099	4.3	$580,362,399	0.4	$626,956,716	8.0	**$637,871,480**	1.7
North Carolina	$117.81	41	38	$1,114,886,086	$1,292,999,791	16.0	$1,225,762,028	-5.2	$1,213,528,238	-1.0	$1,223,410,897	0.8	**$1,155,379,762**	-5.6
California	$116.81	42	42	$4,325,458,814	$4,497,510,500	4.0	$4,282,590,640	-4.8	$4,430,348,849	3.5	$4,269,301,245	-3.6	**$4,489,340,591**	5.2
South Carolina	$111.39	43	41	$503,057,848	$513,252,844	2.0	$570,714,864	11.2	$531,769,520	-6.8	$553,342,116	4.1	**$531,556,194**	-3.9
Virginia	$102.21	44	44	$744,461,171	$768,388,778	3.2	$801,339,217	4.3	$838,014,392	4.6	$824,653,549	-1.6	**$845,906,299**	2.5
Texas	$89.26	45	45	$1,947,506,929	$2,151,900,944	10.5	$2,307,487,821	7.2	$2,274,057,786	-1.4	$2,402,323,476	5.6	**$2,366,025,337**	-1.5
Washington	$88.03	46	46	$575,576,583	$580,933,247	0.9	$580,197,583	-0.1	$607,723,671	4.7	$619,206,117	1.9	**$613,871,834**	-0.9
Oregon	$84.64	47	47	$319,638,841	$311,380,778	-2.6	$358,553,554	15.1	$337,036,881	-6.0	$331,399,408	-1.7	**$332,476,533**	0.3
Nevada	$68.45	48	49	$168,576,194	$162,315,188	-3.8	$171,068,541	5.4	$170,995,236	0.0	$191,097,176	11.8	**$191,056,479**	0.0
Arizona	$66.45	49	48	$424,022,382	$447,162,227	5.5	$443,685,422	-0.8	$438,093,179	-1.3	$497,505,102	13.6	**$440,895,633**	-11.4
Utah	$58.96	50	50	$162,268,625	$149,547,198	-7.8	$158,416,991	5.9	$162,420,042	2.5	$174,239,834	7.3	**$171,152,571**	-1.8
New Mexico	$1.55	51	51	$173,981,173	$130,733,763	-24.9	$219,640,851	68.0	$3,529,642	-98.4	$2,708,830	-23.3	**$3,243,202**	19.7
United States	$169.28			$50,117,184,956	$51,727,146,201	3.2	$51,890,685,774	0.3	$52,373,520,660	0.9	$52,134,087,533	-0.5	**$53,173,184,332**	2.0

Notes:

Alaska's reported 2008 NF expenditures decreased significantly from 2007 to 2008, and then increased in 2009. The $42 million decrease is similar to the increase in reported ICF/ID spending, so it is possible NF expenditures were reported under ICF/ID.

Hawaii provided an estimate for calendar year 2012. This estimate was used for both FY 2012 and FY 2013.

Minnesota 2013 data are estimated expenditures for calendar year 2013.

Data for several states include expenditures for Medicaid Upper Payment Limit programs or provider taxes.

Data do not include expenditures for managed care programs in the following states (years of missing data in parentheses): California (2008 - 2012); Hawaii (2009, 2010); Massachusetts (2008); New Mexico (2011 - 2013); Washington (2008 - 2011).

Data are presented based on state reporting. No further explanation of trends is available for the purposes of this report.

Appendix K -- Fiscal Impact Calculation of Increase/Decrease in Estimated Medicaid Payments

State of Indiana, Family and Social Services Administration
Fiscal Impact Calculation (Values in $ Millions)
Proposed Effective Date: July 1, 2015
Total Increase / (Decrease) in Estimated Medicaid Payments

Nursing Facility: 3% Rate Reduction/Fee-for-Service Program

State Fiscal Year						
	From:	**7/1/2015**			**7/1/2016**	
	To:	**6/30/2016**			**6/30/2017**	
		SFY 2016	SFY 2016		SFY 2017	SFY 2017
		12 Months	Total		12 Months	Total
Total Decrease		$ (54.7)	$ (54.7)		$ (57.6)	$ (57.6)
Federal Share		$ (36.4)	$ (36.4)		$ (38.3)	$ (38.3)
State Share		$ (18.3)	$ (18.3)		$ (19.3)	$ (19.3)
Federal Fiscal Year						
	From:	**7/1/2015**	**HCFA 179**		**10/1/2015**	**HCFA 179**
	To:	**9/30/2015**	**Reporting**		**9/30/2016**	**Reporting**
		FFY 2015	(Thousands)		FFY 2016	(Thousands)
		3 Months			12 Months	
Total Decrease		$ (13.9)			$ (55.6)	
Federal Share		$ (9.2)	$ (9,239)		$ (37.0)	$ (36,956)
State Share		$ (4.7)			$ (18.6)	
Applicable FMAP		66.52%			66.52%	
State Share		33.48%			33.48%	
Notes						

1. The FFY 2015 base FMAP for Indiana is 66.52% (79 FR 3385), and is used to estimate the FMAP for both FFY FMAP for FFYs 2016 and 2017.
2. Fiscal estimates provided by Milliman.

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