



**IHCA  
INCAL**

INDIANA HEALTH CARE ASSOCIATION  
INDIANA CENTER FOR ASSISTED LIVING

One North Capitol Suite 100  
Indianapolis, IN 46204

TOLL FREE 800.466.IHCA  
PHONE 317.636.6406  
FAX 877.298.3749

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Family and Social Services Administration  
Division of Aging  
402 W. Washington Street, Room W454  
Indianapolis, IN 46204

Re: Indiana Health Care Association/Indiana Center for Assisted Living HEA 1493  
Comments

Dear Colleagues:

My name is Zach Cattell and I am the President of the Indiana Health Care Association/Indiana Center for Assisted Living ("IHCA/INCAL"). IHCA/INCAL is the state's largest trade association representing nursing facilities and assisted living communities, as well as the tens of thousands of employees who provide care to some of Indiana's most fragile citizens. Thank you for allowing me to provide these comments to the Division of Aging (the "Division") concerning the HCBS modernization project. These past two days of testimony have provided great insights into the challenges and opportunities of obtaining and providing the right type of care, in the setting of the consumer's choice, and in a cost-effective manner to the taxpayer.

This newest opportunity to improve on our Home and Community Based Services ("HCBS") delivery system, and the state's overall Long Term Services and Support ("LTSS") system, is upon us due to the passage of HEA 1493 during the 2017 session of the Indiana General Assembly (the "1493 Report"). As introduced, this legislation was the product of 25 years of dialogue between the Division, the Office of Medicaid Policy and Planning, provider associations, and others. The effort started when then FSSA Secretary John Wernert, M.D. challenged IHCA/INCAL to assist the agency with designing a long-term plan for long term care - and that is what we did.

It is critical to view the effort of drafting the 1493 Report in the context of the work done to get to this point. Though HEA 1493 did not pass as introduced and several critical components to right-sizing Indiana's LTSS capacity remain underfunded, the over-arching goals of HEA 1493 are sound- (1) Grow availability of HCBS first through surplus Medicaid funding; (2) Improve and right-size current nursing facility capacity; (3) Further incentivize quality improvement through pay for performance mechanisms; and (4) Ensure that frail and disabled consumers maintain a direct relationship with their providers. This plan was scored by Milliman to save the state \$196M over 8 years, all while serving 8,000

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more Hoosiers in our LTSS system by increasing HCBS Aged & Disabled Waiver ("A&D Waiver") spending by 57% over SFY 2015 spending.

Yet, the plan did not pass in its entirety. The issues and solutions are complex, expensive, and involve arcane terminology and processes. Also, more engagement from stakeholders and consumers was and is necessary, which is being rectified by the legislation itself through this 1493 Report process. Engagement of more stakeholders and consumers is crucial to achieving what we know is attainable for our fellow Hoosiers. A recent AARP report suggested that Indiana has the worst LTSS system in the nation. This is an unfortunate and misleading headline. I hope that within the overall negative message sent by that report to LTSS consumers, and to the tens of thousands of paid and unpaid caregivers who do their best in caring for LTSS consumers, that a positive can come from it - a focus on the delivery of care to those that need government assistance most, and how to meet those needs in a cost-effective manner to the taxpayer.

Within the five categories that are to be part of the 1493 Report, we share the following observations:

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

Increasing acuity of LTSS recipients is being observed by providers, but there are no consistent measures of need and use across Indiana's LTSS settings. Changes at the federal level for Medicare, via the IMPACT Act, are taking on the challenge of cross-setting acuity and resource measurement. Taking a step in this direction is needed to objectively understand acuity and resource use in Indiana with the LTSS and HCBS consumer community.

IHCA/INCAL members report that residents of nursing centers are much sicker than they were just 5 years ago, and this is evidenced by minimum data set and case mix index scores. We know that nursing facilities can handle this increased acuity and save the government money compared to hospital costs, yet we also know that nearly 20,000 consumers that meet nursing facility level of care are able to be cared for outside of the nursing facility through the A&D Waiver. A similar acuity phenomenon is occurring in Assisted Living and Home Health, yet we do not have an effective way to measure that need and resource use over time. Within the A&D Waiver, we are unaware of data from level of service evaluation tools that could be trended over time to examine changes in need across various authorized services.

Underlying the discussion of increasing need is the balance between the ability to provide certain services and care in various settings (scope), consumer desire of setting and independence (setting), and the ability of the government to pay for those services (payment). Discussions that are taking place now within the Assisted Living space have included concerns that Assisted Living communities should not become the intermediate care facility of years past, and certainly not a skilled nursing facility. However, when assessing a consumer for need and approving

services to meet those needs, an apples to apples comparison should be constantly available to measure the provision of services and cost, within HCBS services and between HCBS and institutional services. This data is sometimes provided during State Budget Committee meetings or meetings of the fiscal bodies of the Indiana General Assembly, but it is not readily available.

As an example, one member reported to us that several Assisted Living residents were assessed for the A&D Waiver and a higher service level need was identified. However, instead of recommending an increase in that service level, which would have been sufficient for the Assisted Living community to provide the services and within scope of practice, home health was instead referred into the community for the services. Home health is certainly a wonderful and needed service, but was it right for that point in time when the Assisted Living facility could have provided the same service at a lower rate?

The Milliman analysis for HEA 1493 provided a goal of diverting 40% of consumers who became newly eligible to receive nursing facility level services into HCBS settings - this is roughly 2,800 consumers per year and was noted as just a start. An over-arching theme to government payment for services is to do more with less, and that can often mean that higher levels of acuity and need are being seen in settings that have fewer resources to care for those needs. Maintaining a data system that can track provision of services and costs for those services is critical to ensuring that eligible consumers get what they need and in a safe and responsible manner.

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

Consumers and providers are members are frequently faced with lag times in two key areas - (1) Medicaid eligibility determinations and issuance of letters of approval; and (2) initial service level assessments and reassessments. Of the two, the first is more prevalent and may be more difficult to solve. We recommend that the Division of Family Resources be engaged to pinpoint key delays in the Medicaid eligibility process for Medicaid enrollees accessing LTSS. Many of the eligibility issues can and do originate with the need for additional information from the enrollee before an application for benefits can be processed, but also once a complete application is submitted the wait time for approval can be substantial. The second issue concerning timeliness of service level assessments and changes thereto can also be rectified through case manager support, training, and accountability processes.

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

Indiana's Area Agencies on Aging (AAAs) are a great resource for connecting consumers with available services in local communities. The direct experiences that our members have with the AAAs varies, but overall are positive. One consistent issue that we hear about both specifically and anecdotally is that case managers, those individuals that are tasked with guiding consumers through the process of obtaining and then using services, are overburdened. We attribute some of the issues with delays on service level assessments to caseloads, though we understand caseloads per case worker to be under 100 consumers per case manager.

If case managers are to grow in their roles as options counselors, more resources and training are necessary to provide consumer and providers a consistent and transparent system for evaluating options and placement in to services. At this time IHCA/INCAL does not have specific suggestions for alteration to the service level tools or specific models of options counseling, but our members desire to engage in a collaborative process with the AAA's and the DA to improve the existing system.

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

For the first time since 2008 a 5% reimbursement increase has been secured this year for Assisted Living providers who provide services to A&D Waiver recipients. IHCA/INCAL has previously provided written comment on reimbursement rate issues specific to Assisted Living services and encourage the Division to re-examine those comments. We believe that simplification of the reimbursement structure for Assisted Living, moving away from the three-tier system we have now to a single tier with add-ons for special services and doing so without the use of burdensome and costly cost reports, is important. Periodic increases to rates should at least be part of the Division and FSSA's overall budget request every two years during the writing of the states' biennial budget.

**5) Migration of individuals from the aged and disabled Medicaid waiver to amended Medicaid waivers, new Medicaid waivers, the state Medicaid plan, or other programs that offer home and community based services.**

Indiana's providers have been deeply involved in the HCBS transition planning process that various FSSA divisions have been leading for their respective program areas. It is within these recent experiences that we are concerned about the migration of consumers from program to program because what is currently contemplated under the A&D waiver transition will require consumers to move from a location or setting that they have chosen and resided in for a long time, in some cases many years. We believe that most of the issues identified in the remediation process can be resolved, but some cannot and those situations may be provider-controlled (physical plant upgrades that are too costly to make) or government-derived (interpretation of co-location and secured memory care). I

provide these examples to point to the importance of well-reasoned and reasonable requirements for providers to follow and timelines that are achievable.

The above issues are primarily with program design and communication. Regarding program design, which is essential to ensure proper transition between programs, the Division recently posted reports on its website that outline key considerations of program design and results from the National Core Indicators consumer survey from 2015-2016 ("NCI Survey"). IHCA/INCAL has not been able to fully digest all of the data in the NCI Survey, but there are clearly some good metrics within that survey to focus on for first areas of improvement.

In addition, the LewinGroup report dated December 21, 2015, *Considerations Associated with Selected Federal Authorities for Home and Community Based Services*, highlights very similar themes that IHCA/INCAL has promoted to the Division in the past, with one key exception. Managed LTSS is not a program design that our association supports at this time and cautions the agency from taking a short cut to rebalancing through full-risk based capitation for the frustration caused to consumers and providers alike. While lower cost is a shared goal, lower cost should not be delivered simply by inserting a fourth party between the state, consumers, and providers. This is not to say that managed care entities have nothing beneficial to offer in rebalancing, but we are unaware of significant gains in quality outcomes, consumer experience, or provider efficiencies due to MLTSS.

In conclusion, the IHCA/INCAL continues to stand ready and act to help the state design and implement an LTSS system with access to robust and high-quality HCBS and institutional services for those that need them most.

Sincerely,

Zach Cattell  
President