



# SILVER BIRCH

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RE: Written testimony on HB 1493, HCBS Modernization  
Commentary on Home and Community-Based Services

Thank you for the opportunity to provide written testimony concerning HCBS modernization and expansion called for by HB 1493.

Silver Birch Living, LLC is a provider of purpose-built HCBS assisted living. Silver Birch of Hammond is operating and similar communities are under construction in Michigan City, Muncie and Kokomo with additional communities in their pre-development phase. As DA moves forward with its 1493 report and modernizing Indiana's HCBS system, we request that DA continue consultation with interested providers and trade associations.

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

Effectiveness and Efficiency of the Assisted Living Service

A key reason that Silver Birch is focused on the assisted living element of the HCBS network is that assisted living ("AL") is a highly effective and efficient use of resources to support aged and disabled persons in a home-like environment. Assisted living provides the integrated web of services listed below, which frequently results in improved health and wellness outcomes:

- reliable 24-hour support for both scheduled and unscheduled needs;
- reliable support for a regular regime of medications;
- reliable and quality meals;
- reliable and regular housekeeping and laundry assistance;
- emergency response systems;
- a readily accessible environment for persons with mobility limitations;
- wellness programs for diet, exercise, mobility and disease prevention; and
- opportunities for active and regular social engagement.



A&D waiver participants that don't use assisted living generally need to manage two, three or more waiver providers, creating inefficiencies in arranging and managing resources. Hoosiers participating in A&D waiver services other than assisted living receive an average of 2.44 HCBS services plus case management services. That calculation is derived from data that FSSA provided to CMS in the 2017 amendment to the HCBS waiver (specifically Appendix J-2 for Waiver Year 4 ended June 30, 2017).

- Appendix J-2 states that for the Waiver Year ended July 1, 2017, the A&D program's 21,153 Unduplicated Waiver Participants totaled 67,726 waiver "Users", meaning that waiver users on average utilize 3.2 waiver services.
- 98% of waiver participants utilize case management (which is not a hands-on, direct service). After eliminating case management, then the 21,153 Unduplicated Waiver Participants represented 46,979 Waiver Users.
- During the Waiver Year ended June 30, 2017, AL was used by 3,260 A&D waiver participants, which was 15% of unduplicated waiver participants. Assisted living users are not permitted to access other A&D waiver services.
- After eliminating the assisted living waiver users, there were 17,893 A&D unduplicated waiver users utilizing 43,719 A&D waiver services other than case management, which is an average of 2.44 waiver services for each non-AL participant. Of these users:
  - More than 10,700 (or 60% of non-AL waiver recipients) received waiver-funded attendant care;
  - More than 10,100 (or 56%) received waiver-funded personal emergency response systems;
  - More than 9,000 (or 50%) received waiver-funded home delivered meals;
  - More than 5,600 (or 31%) received waiver-funded homemaker assistance;
  - More than 3,350 (or 19%) received waiver-funded respite care; and
  - Another 800 received funding for environmental modification to their homes.

Assisted living bundles all six of these waiver services with one vendor, providing a highly efficient use of resources. In addition, AL provides the regular medication management, assistance with 24-hour unscheduled needs and the opportunity for a rich social environment.

Without assisted living, each of the two, three or more waiver providers for a single waiver participant must be certified, managed, coordinated, monitored, evaluated and reimbursed. This is not the most appropriate use of limited resources at the AAA, DA or FSSA. By bundling all of these services with one provider, assisted living creates a more streamlined system for implementation and supervision for the consumer, the AAA and for FSSA.

#### Efficient use of Limited Labor Force in Assisted Living

In considering the most appropriate use of resources, the Division and the General Assembly should also anticipate the availability of a qualified workforce. Indiana faces a well-recognized shortage of qualified health workers at even entry level positions with the fewest certification requirements.



HCBS services such as attendant care, home-delivered meals and homemaker assistance provide only partial coverage of 24-hour needs while the individuals proving those services spend significant time each week travelling between clients. In a system with increasing numbers of elderly persons each year and a shortage of health care workers, it is imperative to emphasize options that can utilize health care workers more efficiently. Assisted living settings utilize valuable health care workers more efficiently by eliminating travel time, while providing consistent and reliable coverage of unscheduled needs.

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

*Need Transparency with inter-RAI assessment.* A necessary improvement to the functional assessment process is greater transparency on the scoring of the inter-RAI tool. Hoosier citizens and providers do not know what level of functional ADL needs results in functional eligibility. It is widely known that either nursing facility level of care or three ADLs are needed, but what level of ADL need crosses the threshold? Most AAA case managers seem to be trained to say, “the computer tells us if you are eligible”. Is this what is intended in a person-centered network?

By allowing consumers and providers to understand the threshold needs for each ADL category, then consumers, their families and providers can more readily self-assess and determine appropriateness for AL waiver services.

*Functional Assessment Process.* The Division of Aging’s “No Wrong Door Plan” draft dated August 2016 was based on nearly two years of communication with various stakeholder groups. Its findings included this statement from its page 7:

“Consumers reported multiple barriers in the effective and timely assessment of long-term services and supports. These barriers include the need to provide the same information repeatedly to multiple divisions, the receipt of inconsistent information from multiple points in the process, lengthy delays in Medicaid processing..... In addition, the forms and business processes uses are very complex and inefficient.”

The functional eligibility assessment process for the A&D waiver is cumbersome, inconsistent, difficult to manage and frustrating. We urge DA to dramatically simplify the functional eligibility process to make it more comparable to the process used for more expensive skilled care.

Currently, to access HCBS, an aged or disabled person must be evaluated and approved by three separate entities, a process which we have come to call the 74-year old’s Triathlon for A&D Eligibility:

1. AAA roles of:
  - a. Initial phone screening,



- b. followed by scheduling an in-person screening using the inter-RAI tool;
- c. followed by the AAA case manager preparing a plan of care;
2. A physician's assessment evidenced by filing a Form 450-B; and
3. Division of Aging's double checking the AAA plan of care and form 450-B and frequently requesting additional information.

These processes duplicate one another. The 450-B may have made sense 10 years ago before the inter-RAI, but now duplicates it. It is not entirely clear that physicians or nurse practitioners truly understand the scope of services provided by assisted living or other HCBS, or that assisted living is considered "in-home care". The 450-B requires the physician/ nurse practitioner to certify that "in-home care is safe and feasible" which duplicates the finding of the inter-RAI. Most important, collecting Form 450-B is perhaps the most consistent and significant delay in HCBS eligibility determination. At our Silver Birch of Hammond community, 62 physician offices have been sent a Form 450-B, and only 26 have returned them.

***We recommend that DA eliminate the need for a 450-B in a level of care determination.*** If regulations need to be changed, then as an interim measure, DA should at least accept a 450-B that is dated 15 or 21 days prior to the AAA LOC determination, Currently, a 450-B that is dated one day prior to the AAA LOC determination will be rejected for non-conformity with DA procedures. Until the 450-B is eliminated, at least the consumer and family can try to chase his/her physician for it while waiting for the AAA face-to-face screening date to arrive.

Similarly, while DA is the one party that has never met the consumer in person, DA holds the authority to approve or deny services based on a desk review of paperwork submitted by others. Then DA is further delayed if it issues a Request for (additional) Information from the AAA.

In a theoretically frictionless system, this entire process could be completed smoothly. The reality is that these duplicate processes requires nearly perfect compliance and coordination among all parties to be completed in 30-45 days. Delays and re-starts cause many consumers to become discouraged and drop out of the process, or in some cases, their health condition worsens to the point of hospitalization or institutionalization in a SNF, as they are not receiving appropriate care.

***We urge DA/FSSA to permit HCBS functional assessments and plans of care to be performed by any licensed doctor, registered nurse or nurse practitioner.*** This shift would eliminate long delays in access to the system and would also allow consumers seeking HCBS to have access to LTSS similar to those accessing skilled care communities.

To utilize skilled care, Indiana consumers can access multiple paths for a functional assessment, not limited solely to AAAs. SNF consumers are not required to receive options counseling. Their plans of care aren't completed by AAA case managers. Furthermore, the State does condition access to SNF care based on a prior review, modification and approval of SNF plans of care.

The current HCBS functional assessment system is very process-centered rather than person-centered. Consumers must call when the AAA is open for business. Phone screenings are not



completed right away, but are scheduled for future dates. Consumers make another appointment for face-to-face evaluation when the AAA case managers are available, often 12-17 days in the future. Many consumers seeking these services can be forgetful and are challenged with keeping appointments or following up with paperwork. Some are homeless or can't afford more cell phone minutes, so are difficult to reach via telephone.

Consumers must wait for AAA case managers to prepare their plans of care and then wait for Division of Aging to review. Consumers and their families have no idea of the overall process and no window into its progress, other than calling a case manager, who may change during the process.

Relying solely on AAAs for functional assessment and plan of care will always be a weak and fragile system:

- Case managers are not health professionals; many are quite early in their careers and there is frequent turnover.
- On-demand training tools for case managers are very limited and very basic.
- Within a single AAA, we have experienced a substantial range of subject matter knowledge, promptness in preparing case notes/ plans of care and use of judgement in subjective decisions.
- Some case managers have incomplete case notes and plans of care, thus their POC is sent back by DA with requests for additional information. For the Silver Birch of Hammond community, DA seems to be requesting additional information from Area 1 AAA for roughly 15-20% of Plans of Care submissions.
- Case workers generally are out in the field and separated from direct supervision most of the time.
- The AAAs do not have adequate incentives to follow through with difficult cases. If there are delays in response to phone messages to a consumer or repeated calls to get a 450-B from a physician, AAAs have incentive to close out the file and terminate contact.

The current AAA-centered functional assessment system generates process-oriented outcomes. While system improvements should not be built based on anecdotes, our experiences reveal the significant weaknesses in the current system. In the past week alone, we are aware of these AAA determinations:

- AAA case manager conducted its face-to-face assessment of consumer currently receiving SNF care. AAA assessment using inter-RAI tool concluded that the consumer failed to meet the level of care criteria. Suggested the resident appeal.
- A different consumer currently receiving SNF care contacted AAA for assistance. AAA initial phone screening indicated that AAA not schedule the face-to-face assessment until AAA received written documentation from the SNF medical director or director of nursing stating that the resident would be discharged within 30 days. This places HCBS eligibility in the hands of the SNF. Furthermore, once the consumer is discharged, where is that



individual going to move? Consider that the entire HCBS functional process requires face-to-face assessment, writing up the plan of care, collecting the 450-B, submitting to DA, responding to DA requests for additional information. How frequently is that completed within 30 days, particularly when the AAA requires 12-17 days to schedule the face-to-face assessment?

The requirement that HCBS functional assessments and plans of care be performed by the local AAA is a policy of “Only One Door Permitted”, or more accurately, a policy of “Must Pass Through These Three Doors in This Sequence [Unless Sent Back for More Information in Which Case Pass Through Five or Six Doors in a Revised Sequence]”.

We recognize the federal HCBS regulations on conflict-free case management and the preference for options counseling. But the current system prioritizes these abstract objectives ahead of real people getting streamlined access to needed services and benefits.

DA’s August 2016 No Wrong Door Plan concluded that Indiana’s functional eligibility process for accessing HCBS was a major barrier for consumers. The No Wrong Door Plan included access/assessment as one of its five “vision” goals over the next 3-5 years: *“that Indiana consumers experience streamlined access to needed services and benefits”*. Our anecdotal evidence indicates that as of one year later, much remains unchanged.

To achieve the 3-5-year vision of the No Wrong Door Plan, the process needs to open more doors for functional assessment and plans of care. Relying solely on AAAs for functional assessment and plan of care will always be a weak and fragile system. We urge DA/FSSA to permit HCBS functional assessments and plans of care to be performed by any licensed doctor, registered nurses or nurse practitioners. Similar to SNFs, plans of care should be able to be completed after a resident moves into an AL community. This shift would eliminate long delays in the access to the system and would also allow consumers seeking HCBS to have access similar to LTSS similar to what skilled care communities. If AAA assessment is required by federal CMS regulations, perhaps these health professionals can become certified to complete assessments and plans of care by completing the same training that is required for case managers to conduct the same work.

In sum, to achieve the goals that FSSA has set forth, we ask the agency to adopt the following changes:

- Provide greater transparency into the thresholds within each ADL category required to substantiate a level of care determination;
- Eliminate the requirement of the 450-B to access HCBS;
- Allow a broader range of individuals, including licensed healthcare practitioners, to complete the inter-RAI and prepare a plan of care; and
- Allow the plan of care to be completed after the resident moves into an AL community.



*Single Level of Service for Assisted Living and perhaps TBI.* Currently, both assisted living and TBI have three levels of service and reimbursement rates. Too much energy is expended by providers and case managers in appealing level of service determinations. In addition, examining statewide decisions on AL Level 1, 2 and 3 indicate significant differences across AAAs in their level of service determinations. To eliminate this element of subjectivity and complexity, Silver Birch Living advocates for a single Level of Service for living, with a supplemental payment for wandering behavior.

*Frequency of Case Manager Plan of Care updates:* Indiana's current HCBS requires case manager plan of care updates every 90 days or upon change of condition. Given the shortage of case managers and delays in scheduling new consumers, it certainly would be reasonable to change the reassessment to every 185 or 370 days. Anecdotally, it is reported that plan of care reassessments at 90 days are rather cursory and meaningful POC reviews occur only upon change of status.

*Clustering Case Managers for AL Providers.* DA should encourage AAAs to have a single case manager assigned to each AL provider. This will create efficiencies in transportation and communication for the case managers.

*DFR Financial Screening.* Many aged and disabled persons have financial profiles that differ from the families and children that also use Medicaid benefits. Aged and disabled applicants are more likely to have pensions, retirement accounts, and trusts that hold assets. These can be confusing arrangements for persons that are unfamiliar with them. Furthermore, A&D waiver applicants have a different income limits than other Medicaid applicants, and this sometimes gets confused by DFR reviewers. We recommend that DFR establish a specialist unit that reviews all A&D eligibility applications, so that the staff reviewing aged and disabled applications can have targeted training and accumulated focused expertise in the special situations that accompany the aged and disabled population.

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

To expand options for individuals to receive services and supports appropriate to meet an individual's their needs, we suggest that FSSA/DA transition the A&D waiver to a 1915(i) waiver. This would permit adjusting the level of care determination so the state CHOICE program could be absorbed within the 1915(i) waiver, while generating a substantial federal match and also expanding the service offerings to include services such as assisted living.

To assess the options to meet individual's needs in a cost-effective and high-quality manner that focuses on health and social outcomes, Silver Birch supports measuring quality indicators. An



emphasis on specific health and social outcomes would be consistent with an industry-wide trend over many years for greater evidence-based methods of care.

FSSA/DA should identify which social and health outcomes are deemed as important. For an aged and disabled population, there are several quality indicators that other jurisdictions have identified, including incidence of falls, percentage of population receiving annual flu shots and similar indices. Silver Birch supports quality indicators, but we do not support collecting data for its own sake. Indicators need to remain focused on material outcomes that can be compared across different HCBS services and institutional LTC services. Each incremental data element carries its own cost of collection and evaluation so it should be clearly worthwhile before mandating its collection.

Managed care has some advocates that advance it as a solution for better outcomes at lower cost. However, it is quite unclear whether managed care programs for mid-acuity Aged & Disabled populations provide any benefits. Managed care programs generate their savings by managing extremely high acuity populations and tend to offer very minimal, if any, value added for individuals with the more middle acuities that can be addressed outside of skilled nursing facilities. The Kaiser Commission on Medicaid and the Uninsured indicates that managed care programs for the aged and disabled “are not a simple process” and “strong state oversight is essential”. The Kaiser Commission also notes that managed care also requires additional overhead costs such as each insurer building a new provider network, negotiating provider rates and separate billing mechanics by each provider for each insurer. Kaiser indicates that input from consumers and providers is also essential, as managed care creates a conflict between “care coordination” and consumer preferences.

Research by Marguerite Burns of Harvard Medical School and Sharon Long of University of Minnesota indicate no clear cost savings from Medicaid managed care with the Aged and Disabled population. The Burns and Long paper states:

The few published studies that have examined mandatory Medicaid managed care and health care spending for adults with disabilities have generated conflicting results. Historical evidence of cost savings from Medicaid managed care derives from research on relatively healthy children and parents. However, even in this population, savings are not inevitable. This mixed evidence is unsurprising because the direction of the impact of Medicaid managed care on expenditures probably depends on the beneficiaries’ baseline characteristics and the fee-for-service Medicaid program in the state.

We urge more caution in the anticipation of cost savings for states that move this complex Medicaid population from fee-for-service to managed care.

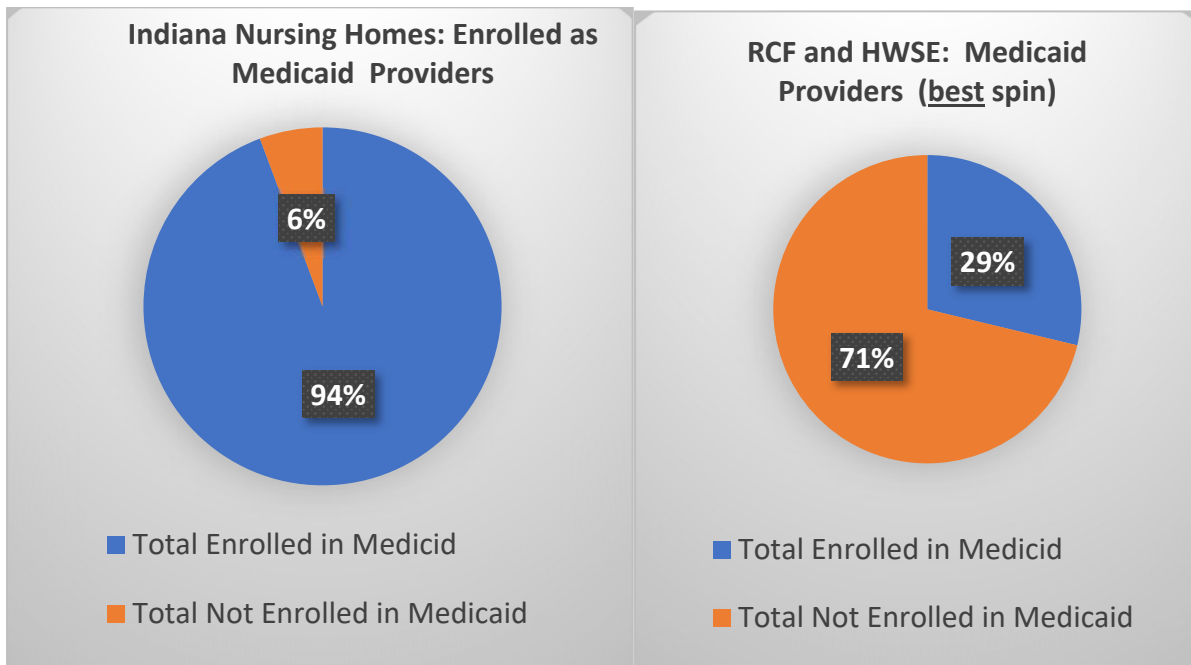




**(4) Evaluation of the adequacy of reimbursement rates to attract and retain a sufficient number of providers, including a plan to regularly and periodically increase reimbursement rates to address increased costs of providing services.**

FSSA/DA must assess rate adequacy for all of its HCBS programs. Our response focuses primarily on assisted living, but the principles apply to most HCBS service categories.

In assessing rate adequacy, it is informative to compare the percentage of skilled nursing and assisted providers that accept Medicaid. As shown in the graph below, only 29% of existing assisted living providers accept Medicaid; 94% of skilled nursing providers do.



The percentage of AL providers that accept Medicaid may further shrink as a result of the implementation of CMS' settings rule.

While reimbursement rates may not fully explain the difference in provider penetration, they are a significant factor. Three sources tracking the costs to Indiana consumers for private pay assisted living during 2014 to 2016 indicate that private pay rates are 24-40% greater than the \$2,851<sup>1</sup> per

<sup>1</sup> Per the draft waiver amendment posted by FSSA on its web site on February 22, 2017, the average reimbursement rate paid to assisted living Medicaid waiver provider during the waiver year ended June 30, 2016 was \$71.39 per day. Assuming a month of 30.4 days, the average Medicaid reimbursement is \$2,170 per month. To provide a comparable analysis the



month total payment that assisted living Medicaid waiver providers received during WY 2016 and 2017. The three sources indicate average private pay assisted living rates in Indiana are:

1. \$3,528 per month in Indiana for one-bedroom private pay assisted living according to the 2016 edition of the Genworth Annual Cost of Care Survey which is 23.7% greater than the average rate paid to Indiana provider of assisted living Medicaid waiver services during FY 2016;
2. \$3,825 per month reported as the 2014 average costs of assisted living in Indiana by the “A Place for Mom” website which is 34% greater than the average rate paid to Indiana provider of assisted living Medicaid waiver services; and
3. \$3,995 per month as the average of 35 assisted living properties in six Indiana metro markets as reported in market studies by Valerie S. Kretchmer & Associates completed in 2015 and 2016. This is 40% greater than the average rate paid to Indiana providers of assisted living Medicaid waiver services.

Even when one factors in the 5% rate increase effective July 1, 2017, 2014-2016 private pay assisted living rates surpass the Medicaid rate by 19%-35%. Clearly, Indiana’s HCBS rates for assisted living have not kept pace with their market rate analogs, resulting in many fewer assisted living providers accepting Medicaid vis-à-vis their skilled nursing peers.

In part, this is attributable to the recent stagnation in rate adjustments. During the period 2003 to 2008, Indiana’s Medicaid program consistently processed adjustments in the rates paid to all providers under its Aged and Disabled waiver program, including adjustments effective April 2003, July 2005, July 2006 and July 2008. Following the financial crisis and recession of 2008/2009, Indiana postponed rate increases due to expectations of fiscal pressures. During the nine (9) year period from July 2008 to July 2017, the reimbursement rate to assisted living providers increased only once, a 2% rate increase effective January 1, 2014. This 2% rate increase over nine (9) years was substantially less than the inflationary increases of other relevant indices, including:

- A 13.6% increase in the Consumer Price Index for the Midwest, the CPU-U Midwest for January 2009 to January 2017. (Source: Bureau of Labor Statistics).
- A 14.2% increase in the average monthly wages for persons employed in the assisted living, nursing home and continuing care retirement community sector for the period 4Q 2007 to 4Q 2015. (Source: U.S. Census Bureau, NAICS code 623 for nursing care, residential facilities and CCRCs in the State of Indiana).
- A 15.4% increase in the maximum Federal SSI payment amount for an individual, from \$637 per month in 2008 to \$735 per month in 2017, (Source: Social Security Administration).

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resident paid portion should be added, which for 2016 was the monthly SSI maximum of \$733 per month, minus Indiana’s \$52 per month personal allowance, or a total of \$681 per month. The sum of \$2,170 paid by Medicaid and \$681 paid by the resident for room and board totals \$2,851 per month for assisted living Medicaid waiver providers



- A 18.4% increase for in the average monthly charges in Indiana for private pay assisted living in a one bedroom assisted living, during the period 2008 to 2016, from \$2,979 to \$3,525 per month. (Source: Genworth Annual Cost of Care Survey of that incorporates more than 6,200 completed surveys in 440 regions of the nation, including thirteen metro areas of Indiana.)

To address this problem, FSSA should implement an annual process for adjusting rates. With regard to rate adjustment, CMS recognizes several methodologies for doing so. Among those, CMS has identified tying increases in rates to changing cost indices as an appropriate methodology. This would be akin to the annual change in SSI and Social Security indexes based on publicly available CPI changes.

Cost indices are readily available and would not require additional time or expense to collect and utilize. Three of the largest expenses that an assisted living community incurs are labor, food, and utilities. These expense categories represent approximately 75% of the operating budget for assisted living communities.

***We recommend rate increases tied to the weighted change in these major costs, based on benchmarking to related, publicly available indices.*** As an example, labor costs comprise approximately 60% of our communities' expense. Through its Qualify Workforce Indicator Data, the Census Bureau publishes a wage price index for CCRC and assisted living employees in Indiana. This data set could be used for benchmarking labor cost changes, or FSSA could utilize the data that Myers & Stauffer already collects on skilled nursing facilities to create a wage index. Similar data for food and utility cost changes can be obtained from the Census Bureau.

For assisted living HCBS services, an index for annual rate increases for could be based on a simple weighted average such as this one:

<u>Cost Category</u>	<u>Weight</u>	<u>Data Source</u>
Labor	60%	Use a Census Bureau labor index
Raw Food	10%	Census Bureau or Dept. of Agriculture food cost indexes
Direct Energy Costs	5%	Census Bureau or Dept. of Energy indexes
Other costs	25%	General CPI index to capture all other costs that include: supplies, insurance, maintenance, repairs and service contracts, software licensing, advertising, etc.

We recommend an annual process to increase rates based on the change in these indices. Utilizing such a methodology would align FSSA's rate setting with CMS' approved methods, lend transparency to the process, and eliminate the need for creating an expensive, time consuming administrative process for providers and the agency.

Other HCBS such as attendant care, adult day care and home-delivered meals could also use annual rate increases based on indices constructed from significant cost categories related to their service, with the change in underlying components based on publicly available information.



Silver Birch specifically recommends against creating a new administrative apparatus for cost reporting that would match the format for skilled care. We advocate for statewide rates and a simply constructed inflation index that is easy to communicate to several audiences: providers, FSSA leadership, CMS and the General Assembly.

*Collapse to One or Two Service Levels for Assisted Living:* Much energy is wasted on differences of opinion of in service level determinations. This process should be simplified to perhaps just one or two service levels. One alternative is a single service level with a supplement for memory care/ wandering.

*Lift limit on Room and Board Charges:* DA should consider lifting the limit on Room and Board charges for Assisted Living. Other states permit HCBS providers to collect more than the SSI minimum for “room and board”. This modification can make the HCBS program attractive to more providers.

**(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.**

We support the implementation of a 1915(i) waiver to replace the existing 1915(c) waiver for assisted living. This would offer two primary benefits to Indiana’s aged & disabled elderly and the ecosystem that serves them. It would:

1. eliminate the uncertainty associated with access to services, and
2. provide the FSSA more flexibility with regard to eligibility standards.

Turning to the first, the 1915(c) waiver is constrained by the number of slots granted to the State by CMS. Once an individual uses a waiver a slot for 1 day, that waiver slot is consumed for the entire year, irrespective of whether the individual continues to use waiver services. In years in which demand for A&D waiver services exceeds the number of waiver slots, AL waiver applicants must wait for a slot to become available at the beginning of the new fiscal year. In the interim, their health may deteriorate, necessitating institutionalization, a far more costly and less person-centered outcome. In fiscal years 2012 and 2013, the State had waiting lists numbering in the thousands for waiver slots, denying critical access to services.

During the second halves of Waiver Year 2016 and 2017, the State had to secure CMS approval of amendments to the A&D Waiver for more waiver slots to meet the demand for HCBS. The “cap on slots” creates uncertainty for seniors and their families who need access to services. In like fashion, it complicates case management, as case managers cannot advise seniors definitively of the availability of AL waiver services. Finally, for the providers that are investing tens of millions of dollars in create affordable assisted living communities, it creates uncertainty about whether they are able to provide services when there is demand for them.



Implementation of a 1915(i) program could eliminate this uncertainty and ensure access to services, preventing far more costly care in an institutional setting.

Secondly, implementation of a 1915(i) program would allow FSSA additional flexibility with regard to functional eligibility standards. Currently, AL waiver participants must meet an institutional level of care standard. Indiana's "institutional level of care" is a higher bar than neighboring states. It prevents many individuals with needs from accessing services, leading to adverse health outcomes and more costly care later. For example, what if a person requires assistance with two activities of daily living and home health is not an appropriate option? Today, some consumers with two ADLs are limited to CHOICE programs, although assisted living could be their most appropriate option and match the individual's preferences and needs.

The 1915(i) waiver would allow FSSA to adjust the level of care determination so the state-funded CHOICE program could be folded into the 1915(i) program, while generating a 2x federal match for CHOICE spending and expanding the CHOICE service offerings to include assisted living.

The migration to 1915(i) would also be the opportunity to move away from the requirement for ISDH-licensed RCF and open the opportunity for unlicensed assisted living.

Once again, thank you for the opportunity to provide our formal comments. We look forward to the opportunity to continue the discussion on these topics with the Division.

Respectfully submitted,

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