

**Comments of the Indiana Assisted Living Association
Public Hearing
Report Required by HEA 1493-2017
Submitted Electronically 7/17/17**

The Indiana Assisted Living Association (INALA) appreciates the opportunity to submit these written comments and look forward to working with the Division of Aging (DA) and the Office of Medicaid Policy and Planning (OMPP) to improve Indiana's system of Long Term Services and Supports (LTSS).

INALA is a trade association promoting assisting living in Indiana. INALA believes assisted living provides a housing option to seniors that offers quality housing and caring assistance in the least restrictive manner, provided by individuals with the highest professional standards. We encourage residential environments that enhance social interaction and promote the quality of life. INALA supports all members regardless of company size, and encourages each to have a voice. We promote a healthy business climate that supports the least intrusive government regulatory environment for assisted living.

As the DA moves forward with this report, we urge the DA staff to continue consultation with interested providers, consumers and other stakeholders.

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

Assisted living provides safe, appropriate and cost effective use of Medicaid resources.

Assisted living provides an efficient and effective use of limited financial and workforce resources and optimizes the health and social well-being of seniors who reside in assisted living.

We are concerned that congregate living is currently thought of and presented as a less desirable option when case managers are working with seniors. We are concerned there is not sufficient qualified and capable workforce to provide care in non-congregate settings and that this reality is sometimes lost when trying to design the "ideal."

With all settings, congregate and non-congregate, we need to ensure an appropriate level of oversight to protect beneficiaries and ensure taxpayers that services are being delivered as expected.

As Indiana evaluates its current and future systems for LTSS, we should strive to balance the beneficiary's desired setting, optimal health and social outcomes, cost-effective service and an appropriate level of oversight.

Either licensed or unlicensed assisted living should qualify as a home and community based service providers.

With the current 1915(c) Aged and Disabled waiver, the only approved assisted living settings allowed are those licensed as Residential Care Facilities (RCF) by the Indiana Department of Health (ISDH). We encourage the DA to allow entities registered as Housing with Services Establishments, whether licensed or unlicensed, to be approved settings.

We encourage ISDH to change the RCF rules as required by SECTION 9 of HEA1493-2017 to ensure licensed RCFs may qualify as home and community based services providers. Working together, ISDH, DA and the provider community can create a set of rules that complies with the federal settings rule while modernizing and improving upon the existing RCF rule.

And we strongly encourage the DA to consult with the Center for Medicare and Medicaid Services (CMS) and their colleagues in other states to ensure a thorough understanding of the federal settings rule. As DA works to perfect their oversight process, we also encourage the DA to utilize clinical expertise in dementia care in making policy decisions.

Because INALA has a number of members with multi-state operations, we know that some of the positions taken by DA represent policy positions of DA staff rather than compliance with federal requirements. For example, DA's position on the content of residency agreements, physical plant requirements, memory care units and assessment for medication administration go beyond the requirements of the settings rule and are inconsistent with requirements in other states.

Policies should encourage all assisted living communities to qualify as a home and community based services provider.

Far too often INALA members have to help residents re-home because they have outlived their funds. Options for those individuals are nursing homes or a licensed RCF that accepts the Medicaid waiver. We believe an ideal system would allow Medicaid funding to follow those residents so they do not have to leave a community that they may have lived in for many years.

But current policy positions of the DA seem designed to drive out those settings which house only a few residents who are Medicaid waiver beneficiaries. Policy decisions inconsistent with the majority of states deter multi-state providers from participation. Excessively burdensome provider participation requirements also stop providers from participating.

Supporting assisted living residents who want to remain in their assisted living community should be as much a policy priority as supporting individuals who want to remain in a single family dwelling.

(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.

INALA supports the comments of Silver Birch Living about the eligibility assessment process. We would also like to offer the following comments.

Telephone Screening:

The telephone screening by the AAAs sometimes results in “case closed” because the senior says they do not need assistance. However, the assisted living community where the resident wants to move has already met the resident and family and knows how much assistance the resident is receiving. The AAAs should be encouraged to involve family members and other care providers on that initial assessment.

We are not experiencing a multitude of seniors trying to move into assisted living who do not need that level of services. As suggested by the Silver Birch Living comments, allow a broad range of professionals to do the assessment and plan of care. If necessary, a system could be created to audit results. From our perspective, we have a cumbersome process designed to screen out a few individuals who might seek assisted living but don’t need that level of service.

Continued eligibility

We believe case manager review is appropriate annually or when an individual’s condition changes. We also believe a case manager should be assigned to an assisted living building rather than having multiple case managers seeing multiple residents within the same building.

We should be realistic about the capacity of the case manager system and the turnover in case managers. Having case managers check in with residents every 90 days is not the best use of their time if the individual’s condition has not changed. That time could be better spent on initial assessments or in helping develop service plans when there is a change in condition.

Ideally a case manager develops a long-term relationship with an individual and sees them across care settings. This is not the reality given the turnover in case managers. It would be more efficient for the case manager to get to know a community and its residents and be able to work with residents where they live. Instead we have multiple case managers visiting multiple residents in the same assisted living community. It would enhance the case manager ability to routinely check in with multiple beneficiaries if case managers were assigned to particular communities.

(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.

Measurement of quality

INALA believes that there should be meaningful measures of the quality of services delivered. We understand work is ongoing across the country to develop quality measures, and we would be remiss not to note the need for good measures. At this time, we do not have a recommendation on the best way to measure quality. We would hope to see measures that incorporate both social and health outcome with an equal emphasis on both. We also would caution the DA to avoid data collection for the sake of collection and to balance any quality measures against the time required to collect the data.

Managed Care

We hope Indiana will learn from mistakes of other states and avoid jumping on the managed care bandwagon with LTSS. The promises of managed care; better care coordination, lower costs, and fewer people in nursing homes can be achieved with improvements in the current fee-for-service system. Moving people from nursing homes without a robust and efficient system to support those individuals is a recipe for disaster.

As we have seen with other aspects of managed care in Indiana, managed care does not provide a stable reimbursement or operating environment for providers. The current system of managed care in Indiana can be criticized for inadequate reimbursement, excessive bureaucracy, lack of state resources to oversee the contractors and cost cutting being more important than health outcomes. Indiana's current managed care system does not inspire confidence in its ability to protect seniors and the disabled should Indiana move in that direction.

(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.

INALA appreciates the work of DA and OMPP staff in seeking and implementing a 5% increase in reimbursement rates. We wholeheartedly concur that there must be a system of regular rate review. It is our understanding that the July 1, 2017 rate increase is only the second rate change since 2008.

We suggest the following general principles with regard to rates and look forward to working with the DA and OMPP on this issue.

- Level of care determinations by the AAAs determine the amounts providers are paid. We are concerned these are inconsistent among the AAAs and would encourage additional training and monitoring for any inconsistencies.
- There are multiple ways that Indiana could arrive at a rate methodology. We would encourage the DA to model different scenarios. Whatever methodology is selected, it should be easy for providers, regulators and legislators to understand and easy to administer. It should not create disincentives for providers to participate in the program.
- Illinois allows providers to enroll as SNAP vendors and collect SNAP benefits. Indiana should explore this possibility.
- Pay providers when a resident is temporarily absent from the assisted living community due to hospitalization or vacation. The provider has staffing and other costs that will be incurred regardless of whether the resident is present. If the provider is only collecting room and board when the resident is absent, the provider is losing money on the unit. Again creating disincentives for provider participation.
- Allow room and board amounts to vary based on the recipient's income. We have anecdotal reports of residents purchasing items they may not need in order to remain eligible for the waiver.

(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.

INALA supports the possibility of new Medicaid waivers. Even with uncertainty at the federal level about the future direction of the Medicaid program, Indiana should move forward and examine what is possible within the current system.

While other waivers may have promise, we believe the 1915(i) waiver would complement the current (c) waiver by allowing providers to serve those at risk for institutionalization without individuals having to meet nursing home level of care.

We look forward to continuing these discussion with the DA and OMPP and appreciate the opportunity to comment.

Respectfully submitted,

Liz Carroll, Executive Director
Indiana Assisted Living Association