Members

Rep. William Crawford, Chairperson
Rep. Charlie Brown
Rep. Peggy Welch
Rep. Timothy Brown
Rep. Suzanne Crouch
Rep. Don Lehe
Sen. Patricia Miller
Sen. Ryan Mishler
Sen. Luke Kenley
Sen. Sue Errington
Sen. Vi Simpson
Sen. Connie Sipes

SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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MEETING MINUTES[1]

Meeting Date:	**August 12, 2010**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 404**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**1**

Members Present: **Rep. William Crawford, Chairperson; Rep. Charlie Brown; Rep. Peggy Welch; Rep. Suzanne Crouch; Rep. Don Lehe; Sen. Patricia Miller; Sen. Luke Kenley; Sen. Sue Errington; Sen. Vi Simpson; Sen. Connie Sipes.**

Members Absent: **Rep. Timothy Brown; Sen. Ryan Mishler.**

The first meeting of the Commission was called to order by Rep. William Crawford, Chairperson, at 10:10 AM. Casey Kline, Legislative Services Agency Attorney to the Commission, was called on to give the statutory duties of the Commission and the topics assigned by the Legislative Council for the interim session. Chairperson Crawford addressed the authority of the Commission and referred to material supplied by the Family and Social Services Administration (FSSA) in response to requests for program updates (Exhibit A). Written claims processing reports requested by the Chairperson from the various contractors were also distributed by FSSA (Exhibit B). He further outlined the Commission's work plan for the interim which will consist of two more meetings, one in September, with the final meeting occurring before October 31, 2010. Rep. Crawford recognized Mr. Justin Ohlemiller of Congressman Andre Carson's Office and Mr. Bill Gibson of Senator Lugar's staff. Each addressed the Commission on behalf of the Congressman and Senator, respectively. Rep. Crawford distributed copies of correspondence between his office and members of the Indiana congressional delegation (Exhibit C).

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[1] These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.

Update on Federal Stimulus Medicaid Federal Medical Assistance Percentage (FMAP) Extension-
Megan Ornellas, CFO, FSSA, reported that the federal FMAP extension passed the Congress. The bill will extend a phased-down version of the existing stimulus FMAP for six months, through June 2011. The stimulus FMAP will be reduced during each quarter, resulting in an estimated $200 M of additional federal funding for the Medicaid program. Commission discussion followed regarding the percentage of the stimulus add-on for each quarter. In response to a question, Ms. Ornellas explained that the current stimulus add-on rate is 9.69%, the add-on for the third quarter of SFY 2011 will be 6.87%, and the add-on rate will be 4.98% for the final quarter of SFY 2011. Rep. Crawford expressed his desire to have FSSA report the actual dollar amounts being claimed throughout the year, especially during the biennial budget session. It was emphasized that this represents one-time only funding (Exhibit D).

Federal Health Care Reform
FSSA update on Affordable Care Act (ACA) Implementation Activities-
Seema Verma, FSSA, reported on agency activities undertaken in preparation for the implementation of the federal ACA. She stated that a considerable amount of time was required to review the entire statute, adding that the first focus was on the potential fiscal impact to the state. Ms. Verma stated that the lack of a federal work plan outside of a loose framework defined in the bill and the lack of a federal schedule has been a problem as FSSA and Department of Insurance (IDoI) staff cannot plan a course of action, but find themselves responding to federal actions. FSSA and IDoI staff have been participating in a variety of meetings being held by the U.S. Dept. Of Health and Human Services and various national associations. The administration has formed an interagency task force comprised mainly of FSSA and IDoI, with participation as needed by the State Department of Health and the State Personnel Department. She reported that FSSA and IDoI are participating on a committee looking at the State Exchange requirement. She commented that the bill has many sections that allow for state options - the administration is focusing on the most immediate requirements in the ACA. She added that the state has applied for seven federal grants and is considering applying for an additional three grants. See Exhibit A for a list of state activities.

Ms. Verma reported on a series of meetings to be held by FSSA and IDoI during the week of August 23, 2010, for insurers, providers, advocacy groups, and other stakeholders that provide services. Additionally, an on-line survey has been prepared for providers and insurers to provide input into the state's ACA implementation process. She reported that IDoI is more immediately affected by provisions in the ACA. New insurance rules and regulations must take effect in September 2010, requiring the state to recertify all insurance plans in the state in the absence of final federal guidance. Ms. Verma stated that due to previous policies, Indiana is ahead of the implementation curve with regard to the provision or requirements for preventative services. The Medicaid information technology area will be impacted in a major way - a new national medical coding change will be required in 2013 along with requirements to move to electronic medical records. She commented that the state systems are old and need to be upgraded, the required changes will be expensive, and the source of the necessary funding is not known.

Commission discussion followed with questions regarding the insurance exchange, the federal high-risk pool requirements, and the Indiana high-risk pool. Ms. Verma clarified that the high-risk pool and the insurance exchange are separate issues. The exchange is required to be operational in 2014, with an operational assessment to be performed in the fall of 2013 by the federal oversight agency. The decision to operate an exchange and any subsequent design and implementation will need to be accomplished within those time lines. Rep. Crawford commented that the state would have had $90 M for a high-risk pool that the Governor declined. He added that this was not included in the Milliman Report. Ms. Verma clarified that the state did not lose money by not adding the ACA high-risk pool - Hoosiers may participate in the federally

operated high-risk pool. The state declined to participate in the program since it was known to be underfunded at inception. In response to questions regarding the future of the existing Indiana Comprehensive Health Insurance Association (ICHIA) high-risk pool, Ms. Verma suggested that these questions be addressed to the IDoI.

Commission members commented on the lack of inclusion of consumers in the meetings on the ACA implementation. Ms. Verma responded that these are the initial meetings of many that are anticipated and that consumers may be represented by advocacy groups that are also providers. It was also mentioned that there has been no invitation to legislators to collaborate with the administration. Ms. Verma responded that legislative involvement is intended but that the agencies do not have sufficient information to do this yet. Rep. Crawford recommended that the administration work with the federal congressional delegation.

Milliman Report on the Financial Analysis of the ACA-
Mr. Rob Damler reviewed the state budget impacts included in Table 1 of the report, which is included in Exhibit B. He explained the assumptions used in arriving at the individual line estimates and where federal clarification would be necessary to determine the final treatment of the individual estimates. The Chairman distributed written questions to the Commission members (Exhibit E). In response to commission questions, Seema Verma explained that the Milliman report was focused on the Medicaid program - it was not intended to estimate external savings that might be realized as a result of the ACA. Senator Kenley pointed out that Milliman has been performing Medicaid spending forecasts for Indiana for 10 years. Mr. Damler added that Milliman has performed similar studies of ACA Medicaid impacts for South Carolina and Nebraska and assisted other states with similar analyses. In response to numerous questions concerning the reasoning behind the inclusion of a general physician fee increase in the cost estimate, Mr. Damler explained that the ACA did not require fee increases to all physicians. However, Milliman included the additional cost in the estimate due to their belief that with additional Medicaid eligibles and a required temporary increase in primary care fees, access to other physician services would be negatively impacted without a general physician fee increase in the Medicaid program.

State Opportunities as Federal Health Law is Implemented - JoAnn Lamphere, DrPH, Director, State Government Relations & Advocacy, Health & Long-Term Care, AARP-
Dr. Lamphere's PowerPoint presentation is included as Exhibit F.

The Commission recessed at 11:55 AM.

Rep. Crawford reconvened the Commission at 1:20 PM. The Chairperson requested that Mr. Raymond Fletcher be given an opportunity to testify with regard to his Medicaid disability eligibility denial as he had traveled from Lake County. Mr. Fletcher related his experience with the Lake County Division of Family and Children. Rep. C. Brown asked for copies of his denial notice. Chairman Crawford requested that the FSSA staff in attendance also meet with Mr. Fletcher to get his contact information.

Disproportionate Share Hospital (DSH) Program Update-
Kristine Ellerbruch reported that FSSA is currently working on 2010 and 2011 DSH eligibility. She reviewed the process and stated that 18 appeals were filed after the initial determination. FSSA is currently working through the appeals process. FSSA is not able to report any level of payments since the final number of eligible hospitals has not been determined. The 2010 upper payment limit (UPL) statewide limit is being calculated. Ms. Ellerbruch stated that there are no changes to the cost methodology used from that used for 2009 (See Exhibit A). She added that the time line for calculations and payments is dependent on the outcome of the appeals process. Chairperson Crawford distributed written questions to Commission members (Exhibit G). In response to a question about the impact on the DSH program by the ACA, Ms. Ellerbruch

commented that there will be reductions in the DSH payments. In response to Rep. C. Brown's question regarding the treatment of the historical DSH hospitals, Ms. Ellerbruch explained that the historical DSH provisions expired in 2009 and that going forward these hospitals would be treated like all other eligible hospitals. She elaborated that if the new methodology would be detrimental to the historical class, there was a possibility that FSSA would continue to pay this group at the previous limits.

Healthy Indiana Plan (HIP) Update-
Responding to a question regarding what hospitals are being paid under the HIP program as opposed to DSH, Seema Verma stated that hospitals as a group are being paid more under the HIP program than they would have received as DSH distributions. The most recent HIP Dashboard was distributed (Exhibit H). Ms. Verma reported that 76% of HIP enrollees used preventive services, 94% expressed satisfaction with the program, and 76% liked the Power Account. In a study of the HIP service usage, she added that over 80% of HIP participants are using generic prescription drugs. Reporting on a study of emergency department (ED) use, she noted that HIP participants had a greater rate of ED use than that experienced by commercially insured individuals; however, as a group, HIP participants had a lower ED use rate than a comparable population and the general Medicaid population.

The Chairman distributed written questions (Exhibit I). Commission discussion and questions followed regarding the use of cigarette tax dollars, the FMAP rate used for HIP expenditures, and the status of enrollments for childless adults. Sen. Kenley requested an update of the status of the Indiana Check-up Plan Trust Fund and a reconstruction of the original program estimates in order to demonstrate where program enrollment and funding stands in relation to the original estimate. Additional questions were raised with regard to the treatment of the HIP program under the ACA and the actual amount of DSH funding the state relinquished to fund the childless adult population.

Children's Health Insurance Plan (CHIP)Update-
Pat Casanova, Director, Office of Medicaid Policy and Planning, reported that CHIP enrollment was increasing; currently, it is over 70,000 enrollees, exceeding the projections (Exhibit A). The enrollment statistics include eligibility up to 250% of the federal poverty level (FPL). She reported that the enhanced CHIP FMAP is currently 76.15%; the state match is provided by Tobacco Master Settlement funds. She added that Indiana is fully expending the available federal CHIP allotment. Ms. Casanova added that OMPP has requested of the federal Centers for Medicare and Medicaid Services (CMS) permission to expand the CHIP eligibility to 300% of FPL effective July 1, 2011. An additional 3,500 children are projected to enroll in the program as a result of this expansion.

Medicaid Waivers and CHOICE Program Update-
Ms. Casanova reported that waiver statistics were also included in Exhibit A. She added that the Aged and Disabled (A&D) waiver had 4,000 slots in 2006; there are currently 11,000 slots in this waiver. Additionally, there are 12,000 waiver slots under the Developmental Disability (DD) waiver, which was recently approved for a new five-year cycle by CMS. The Chairman distributed copies of written questions (Exhibit J). In response to a question regarding changes in the prevocational program, Ms. Casanova commented that no clients lost eligibility as a result of changes made in the supported employment follow-along (SEFA) implemented to be in compliance with federal standards.

Ms. Faith Laird, Director, Division of Aging, reported that the CHOICE program was initiated as a pilot program 23 years ago. In 1992, the program was expanded to provide home and community-based services in all counties. She added that the program served 9,000 clients in 2009, with 2,500 on the waiting list for services. In 2010, 11,500 clients received services, with 4,000 on the waiting list. She added that the Medicaid Aged and Disabled Waiver has 3,000 on

the waiting list for services and that 100% state CHOICE funds could be leveraged to provide for more Medicaid waiver slots. Ms. Laird cautioned against putting too much credence on the number of persons on the wait lists as the lists may include duplications and individuals who may or may not be receiving services. Commission questions followed about the status of funds left in the CHOICE account at year-end, whether this was reverted, and the application of a required spending reserve for FY 2011.

Generations Project Report-
John Cardwell and Nancy Griffin distributed two reports prepared by the Generations Project (Exhibits K & L). Mr. Cardwell's comments addressed survey results outlined in Exhibit K, Exhibits b1 and b2. He commented that 60% of CHOICE clients were reduced to receiving only case management services, indicating that CHOICE services are being degraded. He commented that at least one-half of current nursing home residents could be cared for at home at considerable savings to the state.

Mr. Paul Chase, Associate State Director for Public Policy, AARP Indiana-
Mr. Chase offered testimony opposing the administration's decision to apply a 15% required reserve to the CHOICE program funding in 2011. Mr. Chase's written testimony is included in Exhibit M.

Kristen LaEace, CEO, Indiana Association of Area Agencies on Aging (AAA)-
Ms. LaEace directed her comments to the cost differential between CHOICE clients and the cost of caring for nursing home patients. She pointed out that limiting access to CHOICE and Medicaid home and community-based waiver services forces clients into nursing facilities where they incur much higher cost to the state. Ms. LaEace's written testimony is available in Exhibit N. Commission discussion followed regarding increasing the flexibility of the AAAs to determine which funding stream to use to provide services to clients; CHOICE or Medicaid waiver.

Report on Medicaid Provider Reimbursement Changes-
Megan Ornellas referred to Exhibit A, which includes the list of proposed reductions for Medicaid providers in FY 2011. In response to Commission questions, Ms. Ornellas commented that prior to proposing the cuts, OMPP investigated whether access to care would be impacted. Reductions in primary care service reimbursement was avoided as much as possible. In reference to rate reductions for dentists, the OMPP looked at the rate structure in comparison to neighboring states. She added that the provider community understands why such reductions are necessary.

Referring to the FSSA Communications Policy Statement (Exhibit O), Chairperson Crawford expressed concern with the policy and questioned whether the policy applied to contractors such as health care providers. Ms. Ornellas and Ms. Casanova indicated that they were not familiar with the document but that it sounded like an internal policy.

The Chairperson asked for testimony from any providers with issues or concerns they wished to bring to the attention of the Commission. Rep. Welch asked if an update on the coordination of benefits within the Medicaid program could be provided at a future meeting. Rep. Crawford announced the next meeting of the Commission would be September 21, 2010, at 10:00 AM. There being no further business, the meeting was adjourned at 3:50 PM.

Exhibit A
Select Joint Commission on Medicaid Oversight
August 12, 2010

FSSA Responses to SJCMO: August 10, 2010

Q: Copy of any and all proposed and or currently pending Indiana Administrative Code Rules or FSSA directed policy changes that will impact Medicaid reimbursements or compensation to providers for SFY 2011. If actual drafts do not exist, a narrative description of what is being contemplated that will impact payments (if anything) for SFY 2011 will suffice.

Copy of any and all proposed and or currently pending Indiana Administrative Code Rules or FSSA directed policy changes that will impact elements or items of service for Medicaid recipients (either limitations in value or duration of benefit receipt, etc.)

Copies of any and all proposed and or currently pending Indiana Administrative Code Rules or FSSA directed policy changes that seek to change co-pays or other cost sharing contributions for service for Medicaid recipients for SFY 2011. If actual drafts do not exist a narrative description of what is being contemplated for SFY 2011 will suffice.

A: 6 rate reduction notices of intent have been filed. They are as follows with links to the notices.

- Hospital Rate Reduction http://www.in.gov/legislative/iac/20100324-IR-405100166NIA.xml.html
- Home Health Rate Reduction http://www.in.gov/legislative/iac/20100324-IR-405100166NIA.xml.html
- Outpatient Radiology Rate Change http://www.in.gov/legislative/iac/20100324-IR-405100167NIA.xml.html
- ICF/MR, CRFs/DD Rate Reduction http://www.in.gov/legislative/iac/20100324-IR-405100169NIA.xml.html
- Physician Administered Drugs Rate Change http://www.in.gov/legislative/iac/20100505-IR-405100250NIA.xml.html
- Dental Rate Reduction http://www.in.gov/legislative/iac/20100324-IR-405100168NIA.xml.html

Q: Copies of most recent executed MCO contracts for Hoosier Healthwise and HIP for the upcoming contract period beginning January 1, 2011. If the executed contracts are not available, drafts of the contract templates or a narrative summary of key contract provisions and any significant changes will suffice.

A: Please see attachment "HHW/HIP contract summary."

Q: Medicaid Waivers: Number of individuals on all Medicaid Waivers for each of the last three State Fiscal Years with estimates for State Fiscal Year 2011 (if available). Also, number of individuals on all Medicaid Waiver wait lists for each of the last three State Fiscal Years with estimates for State Fiscal Year 2011 (if available).

A:

Division of Aging: A&D Waiver Clients		
Year	**Clients Served**	**Clients on Wait List**
FY06	4,067	1,148
FY07	6,842	2247
FY08	7,604	1,836
FY09	9,614	227
FY10	11,034	3,052*

*State maxed out the number of A&D Waiver slots that CMS gave the State the authority to provide.

DDRS Waiver Clients			
Year	**Clients Served on Waiver**	**Clients on Wait List (Unduplicated Count)**	**On Waiting List & Active on a Waiver**
FY06	9,450	18,310	3,291
FY07	9,976	17,513	3,863
FY08	10,734	16,782	3,724
FY09	11,293	20,068	4,346
FY10	11,988	21,217	4,639

Q: CHIP-Number of individuals who are currently being covered between the 200% and 250% of FPL cohort (most recent data). Amount of funding (State and Federal) that is being expended to provide coverage to this cohort. Estimated number of individuals that could/would be covered if the coverage threshold were expanded to 300% of FPL from the current 250%

A: 5,453 individuals between 200% and 250% of FPL were enrolled in CHIP during June 2010. Total paid expenditures for this population during CY 2009 was $5.3 million.

Previous reports from Milliman estimate that 3,500 individuals between 250% and 300% of FPL would enroll over a 24 month period of time, or 146 per month.

Enrollment Trend: CHIP 200% to 250%								
01/09	03/09	05/09	07/09	09/09	11/09	02/10	04/10	06/10
2,077	2,175	2,681	3,177	3,752	4,237	4,717	5,197	5,453

Q: Amount of savings the State has achieved from the 5% cuts to Hospitals and other providers (State and Federal dollars). Projected savings for the duration of the effectiveness of the 5% reduction Rule.

A: Savings achieved from reductions to hospitals and providers saved $6.3M in SFY10 and are projected to save $35.4M in SFY11.

Q: Description of how Medicaid Spend-Down is currently being implemented and determined by FSSA. Numbers of individuals receiving Medicaid coverage via their eligibility through Spend Down and cost to the Medicaid program in terms of State and Federal dollars for the last three State fiscal years.

A: Please see attached document titled "Spend-Down Overview." Spend-down program expenditures and unduplicated enrollment are illustrated in the below table. Both expenditures and enrollment have grown approximately 20% since SFY 2008.

Spend-down	SFY 2008	SFY 2009	SFY 2010
Paid expenditures ($ millions)	$171.1	$179.8	$207.4
Unduplicated Individuals	52,300	59,700	62,800

Q: Copy of proposed (contemplated) Rule change regarding Third Part Liability (i.e., FSSA contemplated change to the 90 day claims process).

A: 405 IAC 1-1-15 does not address the exact timeframes in which providers must try to receive payment from a third party.

Q: Description of what the Indigent Care Trust Fund (ICTF) has been utilized for in the last two State Fiscal Years. Also, what is the most current, unencumbered balance in the ICTF.

A: MICTF receives collections from the HCI fund which excludes $3 million for the payment of physician and transportation providers. (IC 12-16-7.5-4.5(c)) IC 12-16-7.5-4.5 states that funds transferred to the state HCI fund are then transferred to the MICTF for purposes of IC 12-15-20-2(8)(G). Funds transferred into the MICTF from the state HCI fund are to be used to fund the Medicaid budget by $30 million and provide state share for private UPL payments.

The current unencumbered balance in the fund is $38,896,030.50. For SFY 09 and SFY10, MICTF transferred an average $30 million per year in Medicaid Assistance.

Q: Description of the impact for State Fiscal Year 2011 (if any, since the Indiana Medicaid Budget was predicated on the enhanced FMAP expiring December 31, 2010) if the enhanced FMAP is not extended past December 31, 2010.

A: It has been extended.

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION
FSSA
"People helping people help themselves"

MITCHELL E. DANIELS, JR., GOVERNOR
STATE OF INDIANA

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

Hoosier Healthwise and Healthy Indiana Plan 2011 Contract Highlights

The primary objective of the Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW) rebid is to integrate HIP and HHW to the greatest extent possible creating a "family health plan" that results in a seamless experience for Hoosier families.

Our overarching goals are identified in the statement of work (SOW) as follows:

- Improve health outcomes
- Promote primary and preventive care
- Foster personal responsibility and healthy lifestyles
- Assure the appropriate use of health care services
- Develop informed health care consumers by increasing health literacy and providing price and quality transparency
- Improve access to health care services
- Encourage quality, continuity and appropriateness of medical care
- Deliver coverage cost-effectively
- Identify high risk members and provide effective disease management, case management and care management for those that would benefit from such services
- Integrate physical and behavioral health services
- Develop innovative member and provider incentives
- Use technology to ease administrative burden and help accomplish program goals
- Develop innovative utilization management techniques that incorporate member and provider education to facilitate the right care, at the right time, in the right location
- Emphasize communication and collaboration with network providers
- Engage in provider and member outreach regarding preventive care, wellness and a holistic approach

The new contract is effective 1/1/11 – 12/31/14. At the State's discretion, the State may offer two one year renewals

The following managed care organizations (MCOs) were selected for participation in the new contract term:

— Anthem
— Managed Health Services
— MDwise

The following changes will support attainment of the overarching goals:

- MCO selection at point of application for HHW. Today, application choice is only on the HIP application. Member MCO selection has been very successful with an 85% election rate.
- Primary medical provider (PMP) assignments and selections to be made by MCO versus the Enrollment Broker. This will expedite member eligibility under the MCO, rather than remaining in traditional Medicaid until PMP selection is made. This will assist in establishing the MCO/member relationship and help the MCO understand the needs of that member sooner.
- Implementation of PMPs in HIP. PMPs were not a requirement in HIP under the previous contract, they now will be.
- MCOs to begin premium collection for CHIP & M.E.D Works. Again, this supports the relationship between MCO and member. Instead of members receiving eligibility and invoice info from multiple State agencies and non-State vendors; the MCO will be the point of contact.
- Reduce turnaround time for prior authorization processing to seven days. This will provide consistency across programs for the sake of providers and members.
- Implementation of POWER Account debit card for HIP.
- Adding email address to application.
- Adding option (box) to receive an electronic or paper provider directory.

In addition to providing administrative and fiscal responsibility, at minimum, MCO must offer disease management programs for HIP and HHW members for the following conditions:

- Asthma
- Depression
- Pregnancy
- ADHD
- Autism/Pervasive Developmental Disorder
- COPD
- Coronary Artery Disease
- Chronic Kidney Disease
- Congestive Heart Failure
- Diabetes

Medicaid Spend-down

What is spend-down?

Spend-down is the amount of medical expenses that Medicaid will not pay for *every month*.

Who has a spend-down?

Spend-down is part of the Medicaid program for persons who are age 65 or older, blind, or disabled. A person who applies for Medicaid must meet certain financial rules. These rules place limits on the amount of income and resources (assets) that can be owned for a person to qualify.

A person whose income is more than the income standard may still be eligible to receive some help with medical bills under Medicaid. If all other eligibility requirements are met, the individual will be enrolled in Medicaid with a spend-down.

In some cases, a member may have a "resource spend-down". This happens when the value of a person's resources such as bank accounts, life insurance value, etc., is more than the Medicaid limit but less than the limit of the federal SSI program. The "excess resource" amount is added to the income spend-down until resources are reduced to the allowable Medicaid limit.

How does it work?

Spend-down works like an insurance deductible. Medical providers file their claims for services with Medicaid and the spend-down amount is deducted. A claim to Medicaid is filed after Medicare or other insurance has processed the claim. Once the spend-down amount is satisfied in a month, Medicaid will pay for all other covered services. In a certain situations, members must provide bills or receipts to the Division of Family Resources. These expenses are then sent to the Medicaid computer to satisfy spend-down.

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DEFINITIONS

1. **Claim** – When you receive a medical service, your provider files a "claim" with the Indiana Medicaid program in order to receive payment. Claims can be filed electronically or on a paper claim form.

2. **Non-claim** – These are medical expenses that you must submit to the Division of Family Resources to apply to your spend-down. They are referred to as "non-claims" because they cannot be filed by your providers as regular claims to the Medicaid program. More about non-claims is on Page 5.

3. **Satisfy spend-down** – This is the process of incurring allowable medical expenses during a month up to your spend-down. Medicaid will pay for covered services once your spend-down is satisfied. Similar phrases that you likely will hear are "crediting spend-down" and "applied to spend-down". When the Medicaid computer processes a claim (or a non-claim), it checks first to see if spend-down is satisfied. If it is not, the amount of the medical expense "credits spend-down" or is "applied to spend-down". This process determines how much you will owe each of your medical providers whose claims were used to satisfy your spend-down.

4. **QMB** – This is a type of Medicaid that pays for the Medicare Part A and Part B premiums, coinsurance and deductibles. QMB stands for Qualified Medicare Beneficiary. Some members have only QMB Medicaid. However, some spend-down members have QMB coverage *in addition to* regular Medicaid. Members with both types of Medicaid will have their out-of-pocket costs for Medicare services paid for by QMB, not Medicaid spend-down. Providers bill Medicare first, then the claim goes to Medicaid. Any remaining balance is covered by QMB, so there is no expense to be applied to spend-down. If you are not sure whether you are a QMB, contact the Division of Family Resources.

5. **Couple Spend-down** – When both the husband and wife are on Medicaid spend-down, they have *one* spend-down for the both of them. Whenever one has a medical service, the amount of the expense is automatically credited for both spouses.

6. **Full Coverage Medicaid** – This refers to the member's benefit package under Medicaid. A member with full coverage can access all of Medicaid's covered services.

7. **Emergency Services Only Coverage** – This refers to the limited services that some immigrants have under Medicaid. With this coverage, the member may or may not have a spend-down.

8. **Medicaid Spend-down Summary Notice** – On the second business day of every month, the Spend-down Summary Notices are issued to members who had medical services that were applied to their spend-down during the previous

month. Once spend-down is satisfied for a month, the claims that Medicaid pays for services in that month do not show up on the Spend-down Summary Notice. More about the spend-down summary notice is on Page 8.

Examples and Frequently Asked Questions

Here is a common example of how spend-down works.

ED has a $55 spend-down.

Ed receives Social Security Disability, but doesn't have Medicare yet. He takes four prescription medications. On January 4, Ed goes to the pharmacy to get refills. His pharmacist charges him $55 plus $9.00 for the copayments. Here's what happened:

Rx 1: Cost was $75. Ed's $55 spend-down was applied to this prescription. The $3.00 co-payment was included. Medicaid paid the remaining cost of this prescription.
Rx 2: Cost was $78.00. Medicaid paid for this. Ed owes the $3.00 copayment.
Rx 3: Cost was $14.00. Medicaid paid for this. Ed owes the $3.00 copayment.
Rx 4: Cost was $54.00. Medicaid paid for this. Ed owes the $3.00 copayment.

The $9.00 in copayments is carried forward to the next month's spend-down. In February when Ed gets his refills, his starting spend-down balance is $46 because the $9 in co-payments from January has already been deducted.

The next example should be helpful to members who have QMB coverage.

NELL has a $115 spend-down.

Nell has QMB and full coverage Medicaid with a spend-down. On February 6, she goes to her doctor. There is no charge to her for this visit. Medicare will pay for part of it and QMB Medicaid will pay the remaining. Her doctor ordered an x-ray and she goes the next day to the hospital to get the x-ray. The hospital x-ray department does not charge her because Medicare will cover the service and QMB Medicaid will cover what Medicare did not pay. Later in the month, Nell goes to the dentist. She knows Medicare won't cover this visit and she knows she hasn't satisfied her spend-down for the month. Her dental office tells her they will bill Medicaid and when informed how much of the cost was applied to spend-down, they will send Nell a bill. The dental office further explains that they will expect payment from Nell when she receives her Spend-down Summary Notice. This Notice will show how Nell's medical expenses were applied to her spend-down and the amount her providers can bill her.

Nell will owe $115 to her medical providers. For the month of February, her only out-of-pocket cost for medical care was her dental care. When her monthly Spend-down Summary Notice arrives in the mail, it shows that she owes her dentist $115 of the total cost of $214.34.

Question: I'm on spend-down and don't have Medicare yet. My medical costs are mostly for medication. How will this work with my pharmacist?
Answer: All you have to do is go to the pharmacy and your pharmacist will take care of it. If you have not satisfied your spend-down, you should expect to pay your pharmacist. Pharmacies bill Medicaid when your prescription is filled and know right away how much you owe for your spend-down. Go back to the example of Ed on the previous page. This is how spend-down will work in this situation.

Question: I have QMB Medicaid and a spend-down. I'm on oxygen and before getting Medicaid I had to pay what Medicare didn't pay. Will the cost for oxygen meet my spend-down?
Answer: No. However, your QMB Medicaid will now cover the amount not paid by Medicare. Review the example on page 3 of Nell.

Question: Do the medical expenses of my family not on Medicaid count toward my spend-down?
Answer: If you live with your spouse, his or her medical expenses count toward meeting spend-down. For members who are children under age 18, their parents' expenses count toward meeting spend-down. Review the next example of Bart.

The following example shows how a non-claim of the member's spouse gets applied to spend-down.

BART has a $180 spend-down.

Bart satisfies his spend-down every month with physical therapy and counseling. His wife Betty doesn't have any insurance. In February, Betty goes to the doctor. The cost is $100. In March, Bart submits Betty's bills to the Division of Family Resources. His instructions are to apply them for April. Here's what happens:

April 1	Bart's spend-down balance is reduced to $80 because the $100 non-claim was applied to spend-down.
April 10	Bart's bi-weekly therapy visit costs $120.
May 4	Bart receives his monthly Spend-down Summary Notice that shows he owes $80 to his therapist. ($100 of his spend-down was already credited with his wife's expense.) The remainder of the bill was covered by Medicaid.

Question: I pay a health insurance premium. Do I get credit for this to satisfy my spend-down?
Answer: Yes. Health insurance premiums are automatically deducted in determining a member's spend-down. You don't have to show proof every month that you paid your premium. However, if for some reason, you decide to drop your health insurance or your premium amount changes, it is your responsibility to notify the Division of Family Resources within 10 days.

Expenses that are Submitted to the Division of Family Resources

"NON-CLAIMS"

Certain types of medical expenses cannot be filed directly to the Medicaid program. These are called "non-claims". Documentation of these non-claims must be given to the Division of Family Resources in order to satisfy spend-down. Most Local Offices have a spend-down clerk to do this job. However, in some situations, caseworkers may do it. So, be sure to ask your caseworker how to submit non-claims.

* If you live in a "modernized" county, call the Service Center at 1-800-403-0864 and ask for the general routing form that you will use to fax or mail in your non-claim expenses for spend-down.

For services that are subject to payment by Medicare or other insurance, the expense remaining after Medicare or other insurance has paid on the claim will be allowed. *If a statement from a provider is submitted before the provider files with the other insurance or Medicare, the expense cannot be allowed.*

Proof of a non-claim expense must include the following: 1) the type of the expense; 2) name and address of the provider; the amount owed after insurance or Medicare has paid. A bill, receipt, or statement that has no indication whether or not there is a legally liable third party, such as Medicare or other insurance, is not acceptable to meet spend-down.

Types of non-claims:

- Medical services paid for by a state or local program such as CHOICE or Township Trustee assistance. More information about how to send in proof for these expenses is on page 6.

- Medical services received from a provider who does not participate in the Medicaid program;

- Medical services received by non-member spouses and parents whose income was used to determine the spend-down amount;

- Bills for medical services received before the member became eligible for Medicaid;

- Co-payments required by other insurance coverage and Medicare.

What are the types of allowable non-claim medical expenses?

The full range of medical expenses will count to meet your spend-down obligation.

1. Medical care provided by physicians, psychiatrists, and other licensed medical practitioners;
2. Laboratory testing, x-rays, and other diagnostic procedures;
3. Dental services including dentures provided by a licensed dentist;
4. Hospitalization and outpatient treatment;
5. Nursing facility services and rehabilitative services;
6. Therapy services - respiratory, occupational, speech, physical, and audiology;
7. Prescription drugs and over the counter medication (including insulin) when prescribed by a licensed medical practitioner who is authorized under State law to prescribe legend drugs.
8. For Medicare beneficiaries, this includes drugs that are excluded from coverage under Medicare Part D. Excluded drugs include barbiturates and benzodiazepines. For those who are in the Part D "donut hole" where Medicare Part D is not paying, the cost of prescriptions is allowed to meet spend-down. More about spend-down and Part D is on Page 11.
9. The cost of postage incurred for mail-order prescriptions;
10. Medical supplies if ordered in writing by a licensed physician or dentist for treatment of a medical condition;
11. Durable medical equipment if ordered in writing by a licensed physician;
12. Home health care provided by a licensed home health agency;
13. Nursing services provided by a registered nurse or licensed practical nurse;
14. Audiology services and hearing aids if ordered in writing by a physician;
15. Prosthetic devices other than those dispensed for purely cosmetic purposes, if ordered in writing by a physician, optometrist, or dentist;
16. Vision care services, including eyeglasses, examinations, and diagnostic procedures;
17. Cost of transportation to obtain medical services that are allowable medical expenses. If transportation is provided by a business transportation carrier, the carrier's verified charge will be allowed. If the individual or friend, or family member drives the individual to medical services, mileage costs is allowed at the rate per mile established for state employee business travel.
18. The premium of the recipient's spouse who is on MEDWorks;
19. Co-payments required by other health insurance that covers the individual, including Medicare Rx co-payments.
20. Health and hospitalization insurance policy premiums
21. The POWER account contribution of your spouse who is on the Healthy Indiana Plan (HIP).

Non-allowable expenses include the following:

1. Special diets and nutritional supplements;
2. Emergency response systems;
3. Non medical home care such as companions, attendants, homemakers, etc.
4. Home and vehicle repairs/modifications to accommodate a handicapped individual.
5. For Medicare beneficiaries, drugs that are not on the Prescription Drug Plan's formulary.

The CHOICE Program and Township Trustee Assistance

If the CHOICE program or the Township Trustee paid for an allowable medical expense listed in the above section, the expense is allowable for spend-down. It is important to understand that CHOICE pays for some non-medical care such as companions, homemakers, and attendant care that are not allowable medical expenses for spend-down.

For CHOICE expenses, your case manager at the Area Agency on Aging (AAA) may be able to assist you with obtaining proof of the services and submitting it for spend-down. If not, you will need to contact your providers and obtain a copy of their invoice to the CHOICE program. In order to be used as a non-claim, the invoice or other statement from the provider must contain the procedure code for the specific type of home care you received along with a statement from the provider that he or she will bill CHOICE, not Medicaid. (Procedure codes are common in billing. Your medical provider will know what these are.) Remember, the proof must come from your providers, not a statement from the AAA.

When does a non-claim credit spend-down?

You have three options for when a non-claim will credit your spend-down.

1) The month after you give the bill or receipt to the Division of Family Resources. This is automatic if don't specify the month; or
2) The month when you received the service; or
3) The month you turn proof of the service in to the Division of Family Resources. Review again the example of Bart.

How do you decide which month to credit spend-down for a non-claim?

Here are some tips that might help:

1. If you satisfy your spend-down every month with your own medical expenses, then it's generally best to let the system apply a non-claim to the month after you turn it in. It will reduce your spend-down balance first thing that month.
2. If you know you won't satisfy your spend-down in the following month, then it won't be helpful to you to apply the non-claim to that month.
3. If your spend-down is already satisfied for the current month, it might work best for you to have the non-claim applied to the next month.

Andy has a $350 spend-down.

Andy doesn't meet his spend-down regularly. He has Medicare that pays for most of his medical costs but it won't pay for the dental care Andy has scheduled for May 10. He adds up his non-claims that he has not submitted previously:

For the past 6 months, his Part D copayments add up to $180. His wife who is not on Medicaid, bought new eyeglasses in March and paid $200. On April 6 Andy submits proof of these expenses that total $380. He wants them to credit his spend-down in May so that Medicaid can cover his dental care. His non-claim expenses are entered in the computer and on May 1, his spend-down balance is reduced to zero for the month of May.

The Medicaid Spend-down Summary Notice

The Medicaid Spend-down Summary Notices will be issued on the second business day of the month. If Medicaid processed spend-down claims or non-claims for you in the previous month, you will receive the Notice. **Keep your Spend-down Summary Notices.** Check them against the bills for payment that your providers send to you.

The main part of the Notice is a chart for each month in which you received services that Medicaid processed for your spend-down in the previous month. The chart(s) will show exactly how your medical expenses were applied to spend-down and how much you owe your medical providers. Your providers can bill you the amount in the column, "Amount Applied to spend-down". The Summary Notice does not list services that Medicaid paid *after* you have met your spend-down in a month.

When can providers bill members for services received?

Pharmacies can bill and expect payment from you when you pick up your medicine. The system they use processes Medicaid claims instantly and they know at the time how much you owe on the pharmacy bill to satisfy your spend-down. Other providers can bill you when they receive their notification from Medicaid of the amount that was applied to your spend-down. They can expect payment from you *after* you have received your Medicaid Spend-down Summary Notice that shows the amount applied to your spend-down for the service. If a provider has a general policy for *all* patients that service will be refused to someone with an unpaid bill, that policy cannot be applied to a Medicaid spend-down member before the member receives the Spend-down Summary Notice.

Question: I didn't get a Summary Notice this month. Is something wrong?
Answer: You will receive a Notice only if your providers filed claims in the month before you got the notice. For example, if you have Medicare, your providers will bill Medicare first. It will probably be a month or two before the claim is filed with Medicaid to apply toward your spend-down. So, you might not get a Summary Notice every single month.

Question: My doctor sent me a bill but the service I received from him did not show up on my Spend-down Summary Notice. What should I do?
Answer: Contact your doctor's office. Your providers may be notified of the amount of their claim that was applied to your spend-down before the Spend-down Summary Notices are issued. However, they know that they cannot expect payment from you until you are notified.

Question: What should I do if I have checked with my medical provider and Member Services and I still disagree with how an expense was applied to my spend-down?

Answer: You have the right to file an appeal and have a fair hearing with an Administrative Law Judge. The Spend-down Summary Notice tells you how to file an appeal.

Question: I hold power of attorney for my mother and take care of all her business including Medicaid. Will I get the Spend-down Summary Notices?
Answer: Yes. The Notices are mailed to authorized representatives of Medicaid members. If you don't receive the Notices, contact your caseworker at the Division of Family Resources and make sure that you are listed in the eligibility computer to receive the Notices. Keep your caseworker updated on any address changes. If you live in a modernized county, contact the Service Center.

Below is an example of the chart on the Medicaid Spend-down Summary Notice. The example is April's Summary Notice for expenses processed in March.

Medical Expenses Processed for your (month/year) Spend-down

(1) Date of Service	(2) Date Processed	(3) Provider/ Service	(4) Amount Charged	(5) Paid by other insurance	(6) Billed to Medicaid	(7) Amount Applied to Spend-down	(8) See Notes Section	(9) Future Credit	(10) Possible Refund
01-05-06	03-01-06	L. Brown,M.D. spouse office visit	$100.00			$100.00	N		
03-04-06	03-04-06	B. Pharmacy 222 Apple Dr. Anytown prescription	$53.39	$0.00	$53.39	$50.39	F		
03-04-06	03-04-06	B. Pharmacy 222 Apple Dr. Anytown Co-pay	$3.00	$0.00	$0.00	$3.00	C		

1) Date of Service
This is the date that you received the medical service.

2) Date Processed
This is the date that the computer processed the provider's claim and determined how much Medicaid would pay and how much should be applied to your spend-down. If the expense is a non-claim that you gave to the Division of Family Resources, this date will be the date that the Medicaid computer posted the amount to your spend-down.

3) Provider/Service
This column shows the name and address of the provider of the service. Sometimes this might be a corporate billing office or the name of the group practice that the provider is in. If you don't recognize the name or address shown in this column, please contact your provider. Also, a brief description of the service will be in this column.

4) Amount Charged
This is how much the provider charged for the service. If Medicare or other insurance has paid or will pay, this is the charge for the service before that payment.

5) Paid by Other Insurance
The amount paid by Medicare or other insurance will be shown in this column. Compare this amount to the explanation of benefits or notice that you received from Medicare or other insurance. Any amount over the Medicare or insurance allowed amount, sometimes called the "write off", will not appear on your Spend-down Summary Notice.

6) Billed to Medicaid
This column shows the amount that was billed to the Medicaid program. If Medicare or other insurance did not cover the service, the amount listed will be the provider's full charge. If Medicare or other insurance paid first on the claim, the amount in this column will be the amount remaining. For non-claims this column will be blank.

7) Amount Applied to Spend-down
This is the amount that your provider can bill you. When Medicaid processed this claim you had not satisfied your spend-down yet. Compare this amount to what your provider billed you for the service. Your provider is not permitted to bill you more than what was applied to your spend-down.

8) See Notes Section
This column may display letters like, A, B, C, etc. If there is a letter in this column, you need to check the Notes Section. There is a section of the Spend-down Summary Notice called the "Notes Section". It will show a brief explanation of information about the specific claim. In the above example, The Notes Section would look like this:

Notes Section:

N This is a non-claim expense that you provided to your local Office of Family Resources.

F The co-payment amount for this service is itemized on a separate line.

C This co-payment amount is itemized on the Summary Notice as a separate line item and is part of the total medical expense for the service you received.

Note "N" is displayed for Dr. Brown's service because it was a non-claim that you turned in to Division of Family Resources. In this example, the service was in January, the member turned in the bill in February, and told his spend-down clerk to apply it for March spend-down.

Note "F" is displayed for B.Pharmacy because there was a co-payment for this service.

Note "C" explains that the amount in the column is the co-payment that was charged for B.Pharmacy's expense.

9) Future Credit

Any amount shown in this column has been carried forward to be applied to spend-down in a future month. Usually, it will be applied to the next month.

10) Possible Refund

If changes were made to claims previously processed, and you might be due a refund from the provider, the amount of the refund will be in this column. A "Note" will be listed on the Spend-down Summary Notice that explains the reason for the refund. This can happen if your spend-down amount was lowered, you turned in a non-claim for the month, or the system made a claim processing correction. Your provider is also notified when this happens.

Spend-down and Medicare Rx (Medicare Part D)

When you meet your spend-down, you become automatically eligible for the "*Extra Help*" (Low Income Subsidy) that pays for the basic Part D premium, deductible, and some or all of the copayments. You will hear the terms "dual eligible" or "dual". That means you are eligible for Medicaid and Medicare and therefore entitled to the *Extra Help.* Also, the coverage gap, known as the donut hole is eliminated for duals. After you meet your spend-down, your eligibility for the *Extra Help* will continue through the calendar year. If you meet your spend-down in July or any month thereafter, you become qualified for the *Extra Help* for the next calendar year.

If you have coverage under the Medicare Savings Program as a "QMB" or "SLMB", then you are automatically eligible for the "*Extra Help*" regardless of whether you meet your spend-down.

When I have Medicare Rx, can my prescriptions still be used to satisfy my spend-down?

Generally, no. Federal law does not permit Medicaid to pay for Medicare approved prescription drugs. Under the spend-down rules, if a medical expense is subject to payment by Medicare, it cannot be used to satisfy spend-down. The exception is that Indiana Medicaid will cover Medi*care* excluded drugs that Medi*caid* covers. The co-payments that you will owe under your Medicare Rx plan can be used for your spend-down. Submit your bills and or receipts to the Division of Family Resources as explained on Page 5.

Questions and Help with Problems

There are specialists who can help you if you have questions about your Spend-down Summary Notice or how your medical bills have credited your spend-down. Call ***Member Services*** at 1-800-457-4584 (toll-free) or (317)713-9627 (Indianapolis calling area).

FSSA Responses to the Select Joint Commission on Medicaid Oversight
August 11, 2009

Healthy Indiana Plan

- 2010 update of DSH/HIP report (arrayed by provider) that Pat Nolting of FSSA provided to the Medicaid Supplemental Committee in October of 2009.
  - Please see attached report titled "HIP Hospital Data."
- Healthy Indiana Plan: Copy of most current "dashboard" report on HIP (i.e. if the "dashboard" is close to being updated, the most current information is preferred).
  - Please see attached July dashboard.
- Current (i.e, unencumbered balance) in the Indiana Check-Up Plan Trust Fund derived from the Cigarette tax. Anticipated unencumbered balance at the conclusion of the SFY 2011.
  - The current balance in the ICUP Trust Fund is $237.9M. The anticipated balance at the conclusion of SFY2011 is estimated to be $227M.
- Copy of any policy changes or operational changes that FSSA has undertaken or contracted to undertake which seek to increase the enrollment of "Caretaker" adults in the HIP program.
  - The below contract language was added to the Hoosier Healthwise and HIP contract rebid:

    6.0 Member Services

    6.1 Marketing and Outreach

    OMPP encourages Contractors to promote its plans as a solution for the entire family and should include information about both programs in its marketing and outreach activities. All promotional efforts must jointly market the Contractor's Hoosier Healthwise and HIP products and services. All marketing efforts must be targeted to the general community in the Contractor's entire service area. In accordance with 42 CFR 438.104, the Contractor cannot conduct, directly or indirectly, door-to-door, telephone or other "cold-call" marketing enrollment practices. Cold-call marketing is defined in 42 CFR 438.104 as any unsolicited personal contact by the Contractor with a potential Medicaid enrollee. Additionally, the Contractor must not distribute any marketing materials without first obtaining OMPP approval.

    2.5.2 Staff Positions

    In addition to the required key staff described in Section 2.5.1, the Contractor must employ those additional staff necessary to ensure the Contractor's compliance with the State's performance requirements. Suggested staff may include but are not limited to:

Member marketing and outreach staff to manage joint marketing and outreach efforts for the Hoosier Healthwise and HIP programs, paying particular attention to eligible HIP parents and caretaker relatives.

- Number of individuals with a disability diagnosis receiving services (and costs denominated in both Federal and State dollars) through the Healthy Indiana Plan, even though they are legally eligible for coverage under the Medicaid program.
    - No individual with a known disability diagnosis is permitted to be part of HIP.
- What is the current number of HIP enrollees whose incomes are less than 133% of the federal poverty level?
    - As of the end of June, there were 40,172 members at less than 138% FPL.
- What is the current waiting list for Caretaker adults? How will Health Care Reform impact them?
    - As of July 31, 2010, there were 51,211 individuals on the HIP wait list. These individuals will be eligible for Medicaid coverage in 2014. On May 17, 2010, Secretary Murphy sent a letter to CMS Director seeking further guidance on the Healthy Indiana Plan. We have not received official guidance, and the letter is attached for your information.

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Anne Wallermann Murphy, Secretary

May 17, 2010

Cindy Mann, Director
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Director Mann:

We were pleased to read that Indiana is not required to terminate its Healthy Indiana Plan, which is currently approved through December 31, 2012. We stand ready to work with CMS to implement the Patient Protection and Affordable Care Act (PPACA) and hope we can find a way to use the successful HIP plan as the vehicle for covering the newly eligible population in 2014.

Led by Republican Senator Patricia Miller and Democrat Representative Charlie Brown, and passed in 2007 with overwhelming bipartisan support by the Indiana General Assembly, HIP is the hallmark of State led innovation. HIP provides a CMS- approved benchmark equivalent benefits plan to adults under 200% of the federal poverty level (FPL). Consumer choice drives participants to take into consideration quality and cost when making their health care choices. Based on their ability to pay, participants are required to make monthly contributions into an account (the POWER account) that funds the plan's deductible. Members have the opportunity to lower their contributions if there is a balance in their account, and they complete their requisite preventative health care services. HIP is not an entitlement program but a tightly capped demonstration program funded by an increase in the State cigarette tax. As expected, tax revenues have declined as smoking rates are declining which we can all celebrate.

As HIP has begun its third year enrollment with over 45,000 participants, there is evidence that the POWER account and the foundation of consumer driven tenets are driving personal responsibility. Emergency room usage is lower in HIP than in our other Medicaid programs and is lower than other comparable State Medicaid programs. Over 98% of individuals have made their POWER account contributions on time and those individuals experienced a 27% decrease in emergency room use over their 12-month enrollment period. Over 76% of HIP participants received their required preventative services and over 94% of HIP members report satisfaction with the program. HIP provides an alternative to traditional Medicaid programs and shows

strong potential for consumer driven plans to impact patient behavior and encourage personal responsibility.

HIP is a home-grown program that works for Indiana and provides the natural vehicle to provide coverage for Hoosiers that will become Medicaid eligible under PPACA. Indiana has invested over $27 million dollars on the implementation of HIP and continues to make enhancements in the program. Common sense dictates that we take advantage of that investment and find a way to work with CMS to expand HIP.

Moving forward we have several specific questions that need to be addressed:

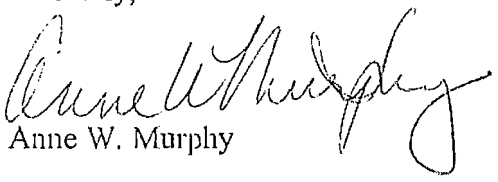
1. In order to provide a smooth transition, after the waiver ends in 2012, how would CMS suggest we handle the time period between 2013 and 2014 for current HIP participants? Indiana is interested in the continuation of the waiver, if HIP can be the coverage vehicle for all the newly eligible individuals under PPACA.

2. Will CMS classify the 45,000 current HIP participants, the majority of which fall under 133% FPL as newly eligible and therefore reimbursed at the higher FMAP? We would point out that the HIP program is not an expansion population but a demonstration project operating under the 1115(b) waiver rule. We caveat this request with the understanding that our funding is limited to the cigarette tax revenue and therefore we might need to curtail enrollment at some point in time.

While it is no secret that Indiana has serious reservations about the negative impact this legislation will have on our federal and state budgets, it is now the law of the land and we will implement the requirements set forth. We have many contractual arrangements hanging in the balance as it relates to HIP as well as the costs and administrative burden of determining eligibility and serving as many as 500,000 new enrollees. For our planning purposes, it is imperative that we receive a concrete and clear understanding soon from CMS on these issues.

Thank you for your attention to this matter.

Sincerely,



Anne W. Murphy

HIP MONTHLY DASHBOARD

COB: Saturday, July 31, 2010 | Year: 3 Day 212 | Day 943 of project

HEALTHY INDIANA PLAN

Submitted Applications

Valid Applications
Total: 255,946

Pending
Timely: 4,684 86.7%
Untimely: 721 13.3%
Total: 5,405

Conditional Active
1,984

Open Eligible Total:
46,516

Applications
Invalid 14,877
Duplicates 10,473

Denials
To Date Project: 193110
July 7,045

Conditional Breakdown
Anthem Total 1,142
MDwise Total 796
ESP Total 46
Caretaker Total 1,980
Non-Caretaker Total 4

Terminations
To Date Project 29,107
July 1,942

Non-Caretaker Shutdown Status
Closed: 3/12/2009
Total Denied for Shutdown
59,275 as of end of: July
Total on Wait List: 51,211

(provided by multiple resources)

* Waitlist Opened: 5,000 waitlist applicants were issued an invitation to reapply to HIP 11/2009.

Benefit Period Details

Redeterminations

Current Month
July
Total 4,013
ELIGIBLE 2678 67%
NOT ELIBLGE 1,179 29%
IN PROCESS 156 4%

Year to Date
Total: 26,901
IN PROCESS 732 2%
NOT SUBMITTED 4,795 18%
SUBMITTED 22,747 82%
ELIGIBLES of SUBMITTED 17952 79%
NOT ELIGIBLES of SUBMITTED 4,795 21%

Denials

Top 5 - July 2010
1 Non-Caretaker Cap reached
2 Did not verify income
3 No proof of Citizenship
4 Failure to provide ins info
5 Failure to make PAC payment

Top 5 - Year to Date 2010
1 Non-Caretaker Cap reached
2 Did not verify income
3 No proof of Citizenship
4 Failure to make PAC payment
5 Ins in prev 6 months

*PAC=POWER Account Contribution

Enrollee Details (Data provided by HP)

Total Enrolled

Total:	45,658	
Anthem:	30,040	65.8%
Mdwise:	14,625	32.0%
ESP:	993	2.2%

FPL Description

<=100	31,489	69.0%
101-125	5,586	12.2%
126-150	3,865	8.5%
>150	4,711	10.3%

Zero Contributions

21.5% of total fully eligibles

July	9,814
<=100% FPL:	9,697
101-125% FPL:	62
126-150% FPL:	21
>150% FPL:	34

Employer Contributions

Anthem:	$511
MDwise:	$234
ESP:	$0

Age:

<20:	22	0.0%
20-29:	7,367	16.1%
30-39:	12,983	28.4%
40-49:	13,127	28.8%
50-59:	9,284	20.3%
60+	2,874	6.3%

Sex

M:	15,728	34.4%
F:	29,929	65.6%

Race

Asian:	590	1.3%
Black:	4,884	10.7%
Hispanic:	1,376	3.0%
Indian:	28	0.1%
Other:	709	1.6%
White:	38,070	83.4%

Caretaker Adult

Yes:	27,373	60.0%
No:	18,284	40.0%

Enrollee Detail Data Will Differ From Open Eligible Data

Terminations

Top 5 - July 2010
1 Hip packet not returned
2 Other current health Insurance
3 Medicare Part A or B currently
4 Employer offers health ins.
5 Closure System determined close

Top 5 - Year to Date 2010
1 Hip packet not returned
2 Failure to make PAC payment
3 Other current health Insurance
4 Open MA - Applied HIP
5 Employer offers health ins.

For Questions / Concerns / Comments please contact : Darren Klingler (Darren.Klingler@FSSA.IN.GOV)

Dashboard Updated : 8/10/2010 by Loreyne Hunter

Healthy Indiana Plan - Hospital Expenditures by Incurred Date
SFY 2008

NPI	Hospital Name	Total Payment
1366407603	PARKVIEW HOSPITAL	$ 357,652.32
1306898960	ST VINCENT HOSPITAL W 86TH ST	$ 315,880.86
1144266024	CLARIAN HEALTH PARTNERS-IU/METH HOSP	$ 311,054.23
1306897335	LUTHERAN HOSPITAL OF INDIANA	$ 215,449.00
1225195340	BALL MEMORIAL HOSPITAL INC ACH	$ 170,435.84
1689776882	ST CATHERINE HOSPITAL	$ 158,864.10
1972500452	COMMUNITY HOSPITAL OF ANDERSON	$ 131,607.55
1477551489	ELKHART GENERAL HOSPITAL INC	$ 130,039.60
1497726020	RUSH MEMORIAL HOSPITAL	$ 123,123.10
1619163854	COMMUNITY HOSPITAL NORTH	$ 121,525.40
1679578850	ST JOHNS HEALTH SYSTEM	$ 115,172.77
1003918210	COMMUNITY HOSPITAL-MUNSTER	$ 113,600.99
1467504555	METHODIST HOSPITALS INC-NORTHLAKE	$ 106,160.24
1558463745	ST MARY MEDICAL CENTER	$ 99,384.05
1902878994	HOWARD REGIONAL HEALTH SYSTEMS	$ 92,944.54
1063457380	REID HOSPITAL AND HEALTH CARE SERVICES	$ 91,455.00
1205816832	INDIANA HEART HOSPITAL, THE	$ 90,396.62
1205860335	BLOOMINGTON HOSPITAL INC. - ACH	$ 87,742.62
1619975331	UNION HOSPITAL -TERRE HAUTE - ACH	$ 85,257.67
1053361642	DEACONESS HOSPITAL - EVANSVILLE - ACH	$ 82,529.94
1780625442	SAINT JOSEPH HOSPITAL & HLTH CTR - HOSP	$ 82,412.92
1356428429	HENRY COUNTY MEM HOSP	$ 81,699.56
1235109778	COMMUNITY HOSPITAL SOUTH INC	$ 77,798.48
1497798847	FLOYD MEMORIAL HOSPITAL	$ 77,126.68
1427082957	ST MARYS MEDICAL CENTER OF EVANSVILLE	$ 76,331.66
1336119478	COMMUNITY HOSPITAL OF INDIANA - EAST	$ 71,650.49
1730140591	MORGAN HOSPITAL AND MEDICAL CENTER	$ 71,559.02
1548205842	DUNN MEMORIAL HOSPITAL	$ 69,087.16
1073678330	JEWISH HOSPITAL - LOUISVILLE	$ 68,593.96
1861465999	DAVIESS COMMUNITY HOSPITAL	$ 66,700.02
1770533994	ST VINCENT CLAY HOSPITAL	$ 62,108.05
1538253521	ST ELIZABETH CENTRAL	$ 58,233.52
1619920949	DUKES MEMORIAL HOSPITAL	$ 55,757.21
1356435341	LAFAYETTE HOME HOSPITAL (ACH)	$ 54,798.27
1952300477	DECATUR CO MEMORIAL HOSPITAL - ACH	$ 54,759.23
1467485003	HANCOCK REGIONAL HOSPITAL	$ 53,676.51
1285684829	ST VINCENT JENNINGS HOSPITAL, INC.	$ 52,341.29
1215151154	PORTER HOSPITAL, LLC	$ 50,201.90
1073550133	TERRE HAUTE REGIONAL HOSPITAL	$ 48,351.73
1609826783	ST. VINCENT RANDOLPH HOSPITAL	$ 46,743.50
1306928213	PULASKI MEMORIAL HOSPITAL	$ 44,587.08
1225032881	GOOD SAMARITAN HOSPITAL-VINCENNES	$ 43,352.55
1699876094	TIPTON HOSPITAL	$ 43,161.74
1811077431	ST MARGARET MERCY HEALTH CARE CTR-SOUT	$ 41,697.54
1497759260	SULLIVAN COUNTY COMMUNITY HOSPITAL	$ 40,354.69
1023060472	ST JOSEPH MEDICAL CTR - FT WAYNE-ACH	$ 39,868.58
1295772093	MEMORIAL HOSPITAL OF SOUTH BEND	$ 39,620.37
1477508596	ST VINCENT MERCY HOSPITAL INC - ELWOOD	$ 38,897.41
1669475950	HENDRICKS REGIONAL HEALTH	$ 38,539.26
1386749893	ST FRANCES HOSPITAL & HEALTH CENTERS	$ 38,038.44
1336190727	ST VINCENT FRANKFORT HOSPITAL INC	$ 37,580.34
1841245594	ST JOSEPHS REGIONAL MEDICAL CENTER SB	$ 37,097.12
1003895947	MEMORIAL HOSPITAL & HEALTH CARE CENTER	$ 36,327.08
1124062419	WASHINGTON COUNTY MEMORIAL HOSP	$ 36,311.88
1134186315	CLARK MEMORIAL HOSPITAL-ACH	$ 35,879.92
1982681748	ST VINCENT HEART CENTER OF IND LLC	$ 35,613.11

Healthy Indiana Plan - Hospital Expenditures by Incurred Date
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NPI	Hospital Name	Total Payment
1508825720	FAYETTE REGIONAL HEALTH SYSTEM	$ 35,202.36
1770679201	MARION GENERAL HOSPITAL	$ 34,840.76
1003821729	PARKVIEW HUNTINGTON HOSPITAL	$ 34,213.62
1033115993	JAY COUNTY HOSPITAL	$ 33,464.10
1144277971	LA PORTE HOSPITAL AND HEALTH SERVICES	$ 30,170.61
1538110556	DUPONT HOSPITAL	$ 28,793.59
1558368449	MARGARET MARY COMMUNITY	$ 28,381.10
1568407310	WISHARD MEMORIAL HOSPITAL	$ 27,382.20
1558346007	GIBSON GENERAL HOSPITAL	$ 27,011.93
1154396604	SCOTT MEMORIAL HOSPITAL	$ 26,653.29
1639124134	ST VINCENT CARMEL HOSPITAL INC	$ 25,811.25
1740268846	GOSHEN GENERAL HOSPITAL	$ 24,951.43
1164475711	KOSCIUSKO COMMUNITY HOSPITAL	$ 24,787.92
1518913565	ST. VINCENT WILLIAMSPORT HOSPITAL	$ 24,249.89
1356320469	LOGANSPORT MEMORIAL HOSPITAL	$ 22,956.53
1346248986	JOHNSON MEMORIAL HOSPITAL	$ 22,930.26
1457366189	PARKVIEW NOBLE HOSPITAL	$ 22,756.14
1336205798	ST. ANTHONY MED CENTER OF CROWN POINT	$ 22,728.06
1063443455	CLARIAN WEST MEDICAL CENTER	$ 22,421.35
1699757401	WITHAM MEMORIAL HOSPITAL	$ 21,639.75
1306921911	ST MARGARET MERCY HEALTHCARE CTR-NORTI	$ 19,775.90
1700883717	RIVERVIEW HOSPITAL	$ 19,728.17
1831123942	MONROE HOSPITAL	$ 19,707.18
1710051941	ST ANTHONY MEMORIAL HEALTH CTRS-ACH	$ 19,315.21
1104998624	COLUMBUS REGIONAL HOSPITAL - ACH	$ 18,094.68
1871574822	BLACKFORD COMMUNITY HOSPITAL INC	$ 17,580.12
1912984451	BLOOMINGTON HOSPITAL OF ORANGE COUNTY	$ 17,213.90
1699738088	MEMORIAL HOSPITAL (SEYMOUR)	$ 16,849.81
1699722405	VALLE VISTA HEALTH SYSTEM	$ 15,649.37
1306844519	WEST CENTRAL COMMUNITY HOSPITAL-ACH	$ 14,958.53
1174555692	MAJOR HOSPITAL	$ 14,815.07
1679678197	ST FRANCIS HOSPITAL & HEALTH CENTERS	$ 14,608.77
1386683316	CAMERON MEMORIAL COMMUNITY HOSPITAL	$ 14,490.39
1518916048	KINGS DAUGHTERS HOSPITAL - ACH	$ 14,333.42
1205931706	ST FRANCIS HOSP & HEALTH CENTERS	$ 14,317.61
1811962228	JASPER COUNTY HOSPITAL	$ 14,131.31
1710983945	WHITE CO MEMORIAL HOSP	$ 13,266.09
1689696148	ADAMS CO MEMORIAL HOSP - ACH	$ 12,760.97
1376594366	BLUFFTON REGIONAL MEDICAL CENTER	$ 12,374.87
1912947490	PUTNAM COUNTY HOSPITAL	$ 11,824.22
1457539751	FOUR CO COUNSELING CTR	$ 11,634.95
1326142498	DEARBORN COUNTY HOSPITAL - ACH	$ 11,572.15
1588774558	ST. CLARE MEDICAL CENTER	$ 11,325.39
1205844495	PARKVIEW WHITLEY HOSPITAL	$ 10,962.44
1467407395	OAKLAWN PSYCHIATRIC CENTER-PSYCH HOSP	$ 10,898.29
1770581902	HOWARD REG HEALTH SYSTEM	$ 10,459.04
1902897937	DEKALB MEMORIAL HOSPITAL INC	$ 9,594.39
1699779017	PERRY CO MEMORIAL HOSPITAL	$ 9,451.60
1861554438	UNIVERSITY MEDICAL CENTER INC	$ 9,068.84
1174571129	ST JOSEPH'S REG MED CTR - PLYMOUTH	$ 8,609.23
1548260284	BEDFORD REGIONAL MEDICAL CENTER	$ 7,836.34
1205828803	WARRICK HOSPITAL INC	$ 7,526.50
1609873124	WESTVIEW HOSPITAL	$ 7,357.16
1255369245	SAINT CATHERINE REGIONAL HOSPITAL	$ 7,154.92
1891796108	MEADOWS HOSPITAL-PSYCH HOSP	$ 6,773.39
1679674956	PARKVIEW LAGRANGE HOSPITAL	$ 6,755.59

Healthy Indiana Plan - Hospital Expenditures by Incurred Date
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NPI	Hospital Name	Total Payment
1548232838	REHABILITATION UNIT	$ 6,638.66
1245259878	WABASH COUNTY HOSPITAL	$ 6,105.38
1114023512	WOMEN'S HOSPITAL, THE	$ 5,901.91
1538127709	ST JOSEPH COMMUNITY HOSPITAL-MISHAWAKA	$ 5,504.41
1336113513	REHABILITATION UNIT	$ 5,492.92
1003866740	ST VINCENT'S HOSPITAL - STRESS CENTER	$ 4,935.76
1588732747	COMMUNITY MENTAL HEALTH CENTER (011)	$ 4,932.85
1568492916	CLARIAN NORTH MEDICAL CENTER	$ 4,727.66
1568417004	COMMUNITY HOSPITAL OF BREMEN	$ 4,625.98
1952447013	GRANT-BLACKFORD MENTAL HLTH - PSY HOSP	$ 3,791.19
1851378137	HARRISON COUNTY HOSPITAL	$ 3,702.56
1184695389	GREENE COUNTY GENERAL HOSPITAL	$ 3,520.28
1265413405	WOODLAWN HOSPITAL - ACH	$ 2,521.56
1639172810	OTIS R BOWEN CENTER - PSYCH HOSP	$ 1,977.12
1053318972	DEACONESS CROSS POINTE CENTER LLC	$ 1,844.70
1801822440	MICHIANA BEHAVIORAL HEALTH CENTER	$ 1,805.18
1932213600	RUSH UNIVERSITY MEDICAL CENTER	$ 1,687.30
1508979683	INDIANA ORTHOPAEDIC HOSPITAL	$ 1,039.09
1548278476	ALTON MEMORIAL HOSPITAL	$ 921.04
1255406369	REHABILITATION HOSPITAL OF INDIANA	$ 889.19
1508807272	REHABILITATION UNIT	$ 794.37
1265539498	BAPTIST HOSPITAL EAST - LOUISVILLE	$ 695.03
1902033582	STARKE MEMORIAL HOSPITAL-ACH	$ 563.96
1073565131	MADISON HOSPITAL CORP	$ 556.11
1437253507	PSYCHIATRIC UNIT	$ 525.00
1689629990	WABASH VALLEY HOSPITAL INC	$ 520.86
1891799227	NORTON HOSPITAL	$ 503.77
1174706576	LUTHERAN MUSCULOSKELETAL CENTER LLC	$ 482.75
1619949104	PSYCHIATRIC UNIT	$ 370.75
1154377166	FLOYD MEDICAL CENTER	$ 261.00
1295803377	ALLEGAN GENERAL HOSPITAL	$ 211.70
1912937624	HILTON HEAD REGIONAL MEDICAL CENTER	$ 208.37
1497784144	MERCER CO JOINT TWNSHP COMM HOSP	$ 112.45
1689781346	NORTHEASTERN CENTER INC	$ -
	Total	**$ 5,989,627.52**

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NPI	Hospital Name	Total Payment
1144266024	CLARIAN HEALTH PARTNERS-IU/METH HOSP	$ 6,655,939.61
1568407310	WISHARD MEMORIAL HOSPITAL	$ 3,489,845.65
1225195340	BALL MEMORIAL HOSPITAL INC ACH	$ 3,398,677.99
1366407603	PARKVIEW HOSPITAL	$ 3,136,878.17
1467504555	METHODIST HOSPITALS INC-NORTHLAKE	$ 2,587,241.53
1306898960	ST VINCENT HOSPITAL W 86TH ST	$ 2,318,171.76
1205860335	BLOOMINGTON HOSPITAL INC. - ACH	$ 2,220,734.93
1689776882	ST CATHERINE HOSPITAL	$ 2,115,565.12
1003918210	COMMUNITY HOSPITAL-MUNSTER	$ 2,094,422.94
1477551489	ELKHART GENERAL HOSPITAL INC	$ 2,015,674.49
1679578850	ST JOHNS HEALTH SYSTEM	$ 1,924,826.27
1053361642	DEACONESS HOSPITAL - EVANSVILLE - ACH	$ 1,918,525.68
1427082957	ST MARYS MEDICAL CENTER OF EVANSVILLE	$ 1,736,990.07
1306897335	LUTHERAN HOSPITAL OF INDIANA	$ 1,717,637.85
1619163854	COMMUNITY HOSPITAL NORTH	$ 1,560,785.87
1972500452	COMMUNITY HOSPITAL OF ANDERSON	$ 1,417,673.27
1336119478	COMMUNITY HOSPITAL OF INDIANA - EAST	$ 1,340,329.10
1295772093	MEMORIAL HOSPITAL OF SOUTH BEND	$ 1,294,890.86
1619975331	UNION HOSPITAL -TERRE HAUTE - ACH	$ 1,269,153.60
1558463745	ST MARY MEDICAL CENTER	$ 1,250,840.68
1134186315	CLARK MEMORIAL HOSPITAL-ACH	$ 1,191,286.09
1902878994	HOWARD REGIONAL HEALTH SYSTEMS	$ 1,131,181.86
1063457380	REID HOSPITAL AND HEALTH CARE SERVICES	$ 1,128,053.00
1538253521	ST ELIZABETH CENTRAL	$ 1,123,492.95
1356435341	LAFAYETTE HOME HOSPITAL (ACH)	$ 1,123,454.83
1386749893	ST FRANCES HOSPITAL & HEALTH CENTERS	$ 1,099,619.02
1235109778	COMMUNITY HOSPITAL SOUTH INC	$ 1,080,901.90
1215151154	PORTER HOSPITAL, LLC	$ 1,041,879.08
1619920949	DUKES MEMORIAL HOSPITAL	$ 1,031,435.43
1073550133	TERRE HAUTE REGIONAL HOSPITAL	$ 1,024,524.40
1356428429	HENRY COUNTY MEM HOSP	$ 980,910.24
1780625442	SAINT JOSEPH HOSPITAL & HLTH CTR - HOSP	$ 955,545.75
1497798847	FLOYD MEMORIAL HOSPITAL	$ 937,998.53
1538110556	DUPONT HOSPITAL	$ 894,470.56
1770679201	MARION GENERAL HOSPITAL	$ 888,686.42
1205931706	ST FRANCIS HOSP & HEALTH CENTERS	$ 884,515.30
1023060472	ST JOSEPH MEDICAL CTR - FT WAYNE-ACH	$ 862,199.13
1700883717	RIVERVIEW HOSPITAL	$ 848,167.95
1306921911	ST MARGARET MERCY HEALTHCARE CTR-NORTI	$ 836,235.91
1225032881	GOOD SAMARITAN HOSPITAL-VINCENNES	$ 818,370.72
1710051941	ST ANTHONY MEMORIAL HEALTH CTRS-ACH	$ 779,176.71
1467485003	HANCOCK REGIONAL HOSPITAL	$ 749,283.01
1730140591	MORGAN HOSPITAL AND MEDICAL CENTER	$ 740,967.88
1740268846	GOSHEN GENERAL HOSPITAL	$ 738,724.47
1841245594	ST JOSEPHS REGIONAL MEDICAL CENTER SB	$ 729,389.64
1497726020	RUSH MEMORIAL HOSPITAL	$ 669,541.98
1336205798	ST. ANTHONY MED CENTER OF CROWN POINT	$ 665,229.96
1770533994	ST VINCENT CLAY HOSPITAL	$ 657,345.39
1548260284	BEDFORD REGIONAL MEDICAL CENTER	$ 647,336.23
1205816832	INDIANA HEART HOSPITAL, THE	$ 646,772.91
1568492916	CLARIAN NORTH MEDICAL CENTER	$ 646,292.34
1639124134	ST VINCENT CARMEL HOSPITAL INC	$ 634,469.78
1508825720	FAYETTE REGIONAL HEALTH SYSTEM	$ 596,770.83
1477508596	ST VINCENT MERCY HOSPITAL INC - ELWOOD	$ 594,839.75
1609826783	ST. VINCENT RANDOLPH HOSPITAL	$ 573,606.54
1003895947	MEMORIAL HOSPITAL & HEALTH CARE CENTER	$ 566,212.16

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NPI	Hospital Name	Total Payment
1164475711	KOSCIUSKO COMMUNITY HOSPITAL	$ 565,850.94
1144277971	LA PORTE HOSPITAL AND HEALTH SERVICES	$ 550,446.99
1548205842	DUNN MEMORIAL HOSPITAL	$ 532,985.92
1982681748	ST VINCENT HEART CENTER OF IND LLC	$ 509,413.25
1598710964	ST VINCENT SETON SPECIALTY HOSPITAL INC	$ 496,504.81
1124062419	WASHINGTON COUNTY MEMORIAL HOSP	$ 483,889.57
1346248986	JOHNSON MEMORIAL HOSPITAL	$ 474,741.19
1568664613	ORTHOPAEDIC HOSPITAL AT PARKVIEW NORTH	$ 472,492.14
1285684829	ST VINCENT JENNINGS HOSPITAL, INC.	$ 458,841.98
1497759260	SULLIVAN COUNTY COMMUNITY HOSPITAL	$ 458,297.33
1952300477	DECATUR CO MEMORIAL HOSPITAL - ACH	$ 451,431.99
1154396604	SCOTT MEMORIAL HOSPITAL	$ 447,901.88
1518913565	ST. VINCENT WILLIAMSPORT HOSPITAL	$ 425,253.13
1669475950	HENDRICKS REGIONAL HEALTH	$ 424,481.32
1699722405	VALLE VISTA HEALTH SYSTEM	$ 411,160.42
1336190727	ST VINCENT FRANKFORT HOSPITAL INC	$ 408,756.93
1518916048	KINGS DAUGHTERS HOSPITAL - ACH	$ 400,894.00
1699876094	TIPTON HOSPITAL	$ 400,666.27
1356320469	LOGANSPORT MEMORIAL HOSPITAL	$ 394,293.38
1174555692	MAJOR HOSPITAL	$ 389,269.41
1104998624	COLUMBUS REGIONAL HOSPITAL - ACH	$ 388,120.17
1265413405	WOODLAWN HOSPITAL - ACH	$ 382,104.70
1811077431	ST MARGARET MERCY HEALTH CARE CTR-SOUT	$ 380,257.77
1326142498	DEARBORN COUNTY HOSPITAL - ACH	$ 379,621.40
1306928213	PULASKI MEMORIAL HOSPITAL	$ 377,640.29
1619072493	FAIRBANKS HOSPITAL INC	$ 375,442.92
1699757401	WITHAM MEMORIAL HOSPITAL	$ 364,236.10
1558368449	MARGARET MARY COMMUNITY	$ 354,526.66
1063443455	CLARIAN WEST MEDICAL CENTER	$ 346,843.26
1861465999	DAVIESS COMMUNITY HOSPITAL	$ 343,530.40
1003944109	FRANCISCAN PHYSICIANS HOSPITAL LLC	$ 337,414.61
1033115993	JAY COUNTY HOSPITAL	$ 337,325.15
1326296211	CLARIAN-ARNETT HEALTH SYSTEM	$ 334,264.07
1558346007	GIBSON GENERAL HOSPITAL	$ 322,894.56
1871574822	BLACKFORD COMMUNITY HOSPITAL INC	$ 321,170.18
1386699684	SETON SPECIALTY HOSPITAL INC	$ 307,584.88
1699738088	MEMORIAL HOSPITAL (SEYMOUR)	$ 304,293.03
1912984451	BLOOMINGTON HOSPITAL OF ORANGE COUNTY	$ 296,335.12
1891799227	NORTON HOSPITAL	$ 295,915.46
1003821729	PARKVIEW HUNTINGTON HOSPITAL	$ 294,120.41
1306844519	WEST CENTRAL COMMUNITY HOSPITAL-ACH	$ 287,583.87
1861554438	UNIVERSITY MEDICAL CENTER INC	$ 275,809.60
1386683316	CAMERON MEMORIAL COMMUNITY HOSPITAL	$ 272,616.73
1679678197	ST FRANCIS HOSPITAL & HEALTH CENTERS	$ 253,090.61
1457366189	PARKVIEW NOBLE HOSPITAL	$ 242,544.00
1831123942	MONROE HOSPITAL	$ 238,174.77
1073678330	JEWISH HOSPITAL - LOUISVILLE	$ 230,077.68
1699779017	PERRY CO MEMORIAL HOSPITAL	$ 221,308.21
1679674956	PARKVIEW LAGRANGE HOSPITAL	$ 216,377.60
1851378137	HARRISON COUNTY HOSPITAL	$ 206,983.93
1376594366	BLUFFTON REGIONAL MEDICAL CENTER	$ 204,881.23
1902897937	DEKALB MEMORIAL HOSPITAL INC	$ 193,837.77
1811962228	JASPER COUNTY HOSPITAL	$ 192,364.74
1912947490	PUTNAM COUNTY HOSPITAL	$ 187,470.51
1689696148	ADAMS CO MEMORIAL HOSP - ACH	$ 185,184.75
1710983945	WHITE CO MEMORIAL HOSP	$ 176,461.47

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NPI	Hospital Name	Total Payment
1558446021	KINDRED HOSPITAL INDIANAPOLIS	$ 174,365.72
1174571129	ST JOSEPH'S REG MED CTR - PLYMOUTH	$ 172,842.07
1205844495	PARKVIEW WHITLEY HOSPITAL	$ 158,356.71
1184695389	GREENE COUNTY GENERAL HOSPITAL	$ 157,264.62
1255406369	REHABILITATION HOSPITAL OF INDIANA	$ 155,795.29
1588774558	ST. CLARE MEDICAL CENTER	$ 149,597.56
1609873124	WESTVIEW HOSPITAL	$ 142,467.80
1205828803	WARRICK HOSPITAL INC	$ 141,828.21
1801822440	MICHIANA BEHAVIORAL HEALTH CENTER	$ 138,681.33
1255369245	SAINT CATHERINE REGIONAL HOSPITAL	$ 128,735.04
1841215985	WELLSTONE REGIONAL HOSPITAL	$ 114,334.41
1811908957	DOCTORS HOSPITAL	$ 104,342.01
1568417004	COMMUNITY HOSPITAL OF BREMEN	$ 92,056.15
1245259878	WABASH COUNTY HOSPITAL	$ 84,673.69
1114023512	WOMEN'S HOSPITAL, THE	$ 83,491.59
1891796108	MEADOWS HOSPITAL-PSYCH HOSP	$ 81,623.73
1639172810	OTIS R BOWEN CENTER - PSYCH HOSP	$ 79,529.82
1902033582	STARKE MEMORIAL HOSPITAL-ACH	$ 78,566.06
1770581902	HOWARD REG HEALTH SYSTEM	$ 78,550.99
1689781346	NORTHEASTERN CENTER INC	$ 69,601.31
1174706576	LUTHERAN MUSCULOSKELETAL CENTER LLC	$ 68,198.42
1033154026	UNIVERSITY HOSPITAL, INC - CINCINNATI	$ 62,644.37
1417032996	KINDRED HOSPITAL - INDIANAPOLIS SOUTH	$ 60,666.12
1124292446	THE HEART HOSP AT DEACONESS GATEWAY LL(	$ 52,555.42
1073565131	MADISON HOSPITAL CORP	$ 50,516.24
1457539751	FOUR CO COUNSELING CTR	$ 49,251.73
1467407395	OAKLAWN PSYCHIATRIC CENTER-PSYCH HOSP	$ 49,038.59
1003866740	ST VINCENT'S HOSPITAL - STRESS CENTER	$ 48,333.15
1952447013	GRANT-BLACKFORD MENTAL HLTH - PSY HOSP	$ 46,603.25
1497859649	NORTHWESTERN MEMORIAL HOSPITAL	$ 45,904.23
1689776841	MEMORIAL MEDICAL CTR-SAVANNAH, GA	$ 45,433.72
1710012505	RENAISSANCE SPEC HOSP/CENTRAL INDIANA	$ 44,157.69
1821223439	CRITICAL ACCESS HEALTH SERVICE CORP	$ 38,121.89
1285613612	OWENSBORO MEDICAL HEALTH SYSTEM	$ 36,904.05
1588732747	COMMUNITY MENTAL HEALTH CENTER (011)	$ 33,609.42
1972605178	REHABILITATION UNIT SUBPART	$ 33,564.48
1689857385	PHYSICIANS MEDICAL CENTER	$ 31,840.91
1619949104	PSYCHIATRIC UNIT	$ 29,172.56
1508979683	INDIANA ORTHOPAEDIC HOSPITAL	$ 28,214.47
1497807572	PORTER STARKE SERVICES INC	$ 27,007.61
1578562625	SOUTHERN INDIANA REHAB HOSP-NEW ALBANY	$ 26,966.56
1629170824	PSYCHIATRIC UNIT SUBPART	$ 26,716.55
1396714663	BETHESDA HOSPITALS INC-ACH-CINCINNATI	$ 26,551.57
1710039508	REHABILITATION UNIT	$ 24,407.52
1215012828	SUBPART-PSYCHIATRIC UNIT	$ 21,987.65
1831195908	NORTON SUBURBAN HOSP	$ 21,599.64
1689629990	WABASH VALLEY HOSPITAL INC	$ 15,681.07
1548232838	REHABILITATION UNIT	$ 14,480.87
1386643294	KENT COUNTY MEMORIAL HOSPITAL	$ 14,320.46
1366420531	OCONOMOWOC MEMORIAL HOSPITAL	$ 13,662.28
1093801797	MEMORIAL HOSPITAL CARBONDALE	$ 13,584.94
1083759633	METHODIST HOSPITAL-HENDERSON,KY	$ 13,024.02
1700979465	BAPTIST HOSPITAL - FL	$ 12,619.41
1508835828	GOOD SAMARITAN HOSPITAL - CINCINNATI	$ 12,385.13
1932213600	RUSH UNIVERSITY MEDICAL CENTER	$ 12,122.68
1265539498	BAPTIST HOSPITAL EAST - LOUISVILLE	$ 11,856.44

Healthy Indiana Plan - Hospital Expenditures by Incurred Date
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NPI	Hospital Name	Total Payment
1992776405	STONECREST MEDICAL CENTER	$ 11,763.84
1184726390	REHABILITATION UNIT	$ 11,315.05
1952307027	NORTON AUDUBON HOSP	$ 11,227.57
1578663597	MERCY FRANCISCAN HOSPITAL WESTERN HILLS	$ 10,906.36
1942385554	SUBPART-REHAB UNIT	$ 9,948.68
1295780476	SKYLINE MEDICAL CENTER	$ 9,277.84
1629003470	IROQUOIS MEMORIAL HOSP & RESIDENT HOME	$ 9,240.66
1780633289	THE CHRIST HOSPITAL	$ 9,150.42
1376703215	METROSOUTH MEDICAL CENTER	$ 9,072.20
1649345448	RIVERSIDE HOSPITAL CORPORATION	$ 8,291.08
1629011234	MERCY HOSPITAL OF DEFIANCE	$ 8,025.78
1649221680	REHABILITATION HOSP OF FT WAYNE	$ 7,589.08
1134220031	LAKELAND HOSPITAL AT NILES & ST JOSEPH	$ 7,307.89
1811971302	MEDICAL COLLEGE OHIO	$ 7,103.42
1285662981	LAKESHORE COMMUNITY HOSPITAL INC	$ 6,276.44
1225020605	REHABILITATION UNIT	$ 5,632.27
1851344907	NORTH MEMORIAL MED CTR	$ 5,151.01
1376619288	REHABILITATION UNIT	$ 5,062.31
1437253507	PSYCHIATRIC UNIT	$ 4,860.96
1548407216	REGIONAL MENTAL HEALTH CENTER	$ 4,799.25
1033284666	SUBPART-PSYCHIATRIC UNIT	$ 4,502.75
1073688354	MIAMI VALLEY HOSPITAL	$ 4,213.72
1952471914	GOOD SAMARITAN HOSPITAL-DAYTON	$ 4,194.57
1558302570	LEE MEMORIAL HOSPITAL - FL	$ 4,064.61
1588771919	ST JAMES HOSPITAL & HEALTH CENTERS	$ 3,412.39
1508956509	UNIVERSITY OF CHICAGO MEDICAL CTR	$ 3,182.60
1770575201	PSYCHIATRIC UNIT	$ 3,169.92
1588601991	STS MARY & ELIZABETH HOSPITAL	$ 3,081.58
1437122009	RAPID CITY REGIONAL HOSPITAL	$ 2,911.14
1295710580	MACNEAL HOSPITAL	$ 2,843.86
1245216183	MCCULLOUGH HYDE MEMORIAL HOSPITAL INC	$ 2,769.73
1053318972	DEACONESS CROSS POINTE CENTER LLC	$ 2,459.60
1427000884	PROVENA UNITED SAMARITANS MED CENTER	$ 2,314.87
1891796710	REEDSBURG AREA MEDICAL CENTER	$ 2,241.34
1952307852	MUNSON MEDICAL CENTER	$ 2,179.03
1265540488	UNION COUNTY HOSPITAL	$ 2,176.48
1518911338	UNIVERSITY OF KENTUCKY HOSPITAL	$ 1,507.86
1467560128	SOUTH SUBURBAN HOSP-HAZEL CREST	$ 1,401.24
1578504056	ST. JOHN'S REGIONAL HEALTH CENTER	$ 1,332.63
1447231956	REGIONAL MED CENTER	$ 1,295.02
1891892741	JACKSON PURCHASE MEDICAL CENTER	$ 1,290.70
1598756686	INGALLS MEMORIAL HOSPITAL	$ 1,190.62
1629056890	WAUKESHA MEMORIAL HOSPITAL	$ 1,150.22
1679525919	CLEVELAND CLINIC FOUNDATION	$ 1,101.95
1306938071	FLORIDA HOSPITAL	$ 1,043.37
1972589489	MEMORIAL MEDICAL CTR OF WEST MICHIGAN	$ 983.42
1407897309	HENNEPIN COUNTY MEDICAL CENTER	$ 878.55
1972542264	GENESIS MEDICAL CENTER	$ 862.31
1134172406	MEDICAL CENTER OF ARLINGTON	$ 815.48
1659387975	JFK MEDICAL CENTER	$ 813.10
1487628616	HEALTHSOUTH DEACONESS REHAB HOSPITAL	$ 777.70
1467552471	MERCY HOSPITAL FAIRFIELD	$ 760.88
1225087190	ST FRANCIS HOSPITAL	$ 732.59
1992738959	FISHER TITUS MEDICAL CENTER	$ 679.75
1114924958	STURGIS HOSPITAL	$ 664.60
1861431751	UNIV OF ILL AT CHICAGO HOSP & CLINICS	$ 663.81

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NPI	Hospital Name	Total Payment
1508941097	ALEGENT HLTH BERGAN MERCY MEDICAL CTR	$ 646.34
1962596056	WADSWORTH RITTMAN HOSPITAL	$ 644.68
1366436123	OUR LADY OF THE LAKE REGIONAL MED CTR	$ 633.58
1356366314	LEXINGTON MEDICAL CENTER	$ 606.19
1366496937	TRIDENT MEDICAL CENTER	$ 566.32
1114981768	BAPTIST MEMORIAL HOSPITAL-UNION CITY	$ 556.40
1376644385	ST ALEXIUS MEDICAL CENTER	$ 502.26
1114958584	CLARIAN HEALTH PARTNERS-RILEY HOSPITAL	$ 474.22
1831151455	UMASS MEMORIAL MEDICAL CTR	$ 469.81
1619038247	LAKE CUMBERLAND REGIONAL HOSPITAL	$ 433.82
1982650024	SUMMIT MEDICAL CENTER	$ 420.92
1235212721	MOUNTAIN VISTA MEDICAL CENTER LP	$ 420.56
1144397134	MEMORIAL HOSPITAL-COLORADO	$ 405.46
1477537363	PHOENIX BAPTIST HOSPITAL	$ 399.84
1760651301	SCOTT COUNTY HOSPITAL	$ 389.44
1093810327	UNIVERSITY MEDICAL CENTER AT BRACKENRID	$ 383.32
1871672618	HOLLAND COMM HOSPITAL	$ 335.32
1376586404	CAVERNA MEMORIAL HOSPITAL	$ 325.39
1780746420	SPRING VIEW HOSPITAL	$ 323.09
1720032345	H C A SOUTHERN HILLS MEDICAL CENTER	$ 316.88
1770581894	T J SAMSON COMMUNITY HOSPITAL	$ 312.04
1467537886	MERCY MEDICAL CENTR NORTH IOWA	$ 308.22
1427064641	CLINTON MEMORIAL HOSPITAL - OH	$ 297.44
1871547703	GREENVIEW REGIONAL HOSPITAL	$ 277.31
1811939887	ST RITA'S MEDICAL CTR	$ 267.40
1447299649	WESLEY MEDICAL CENTER	$ 264.98
1730145392	COMMUNITY MEMORIAL HOSPITAL	$ 241.38
1316966518	SYCAMORE HOSPITAL	$ 215.16
1568416311	BORGESS MEDICAL CENTER	$ 181.28
1982609442	KOSAIR CHILDREN'S HOSPITAL	$ 180.84
1902841414	MIDMICHIGAN MEDICAL CENTER	$ 177.98
1760443980	SKAGGS COMMUNITY HEALTH CENTER	$ 173.96
1912964768	MOUNT SINAI MEDICAL CENTER	$ 170.68
1467492421	ST ELIZABETH MED CENTER-NORTH	$ 163.94
1225159601	CARROLL COUNTY MEMORIAL HOSPITAL	$ 162.00
1184621161	WAYNE HOSPITAL	$ 152.16
1386641207	ST CLARE HOSPITAL & HEALTH SERVICES	$ 152.09
1780635078	FLAGSTAFF MEDICAL CENTER	$ 144.48
1912014564	ILLINOIS MASONIC MED CTR-CHICAGO	$ 139.17
1285621623	PIKEVILLE METHODIST HOSPITAL	$ 135.29
1730166224	MERCY HOSP MED CENTER - CHICAGO	$ 129.80
1346247962	KENTUCKY RIVER MEDICAL CENTER	$ 127.95
1972585347	ST MARY'S JEFFERSON MEMORIAL HOSPITAL	$ 122.92
1548212988	CHILDRENS HOSPITAL MEDICAL CENTER	$ 121.30
1811034291	ST BERNARD HOSPITAL	$ 107.06
1104867167	FORT HAMILTON HOSPITAL	$ 87.93
1275566200	BANNER ESTRELLA MEDICAL CENTER	$ 87.30
1083644579	BATTLE CREEK HEALTH SYSTEM	$ 86.39
1861447179	ST LUKES MEDICAL CENTER/MILWAUKEE	$ 58.43
1972576247	BAPTIST HOSPITAL OF COCKE COUNTY	$ 44.62
1992700983	BAYLOR MEDICAL CENTER AT IRVING	$ 41.74
1629007430	OHIO COUNTY HOSP CORPOR	$ 41.50
1174511620	METHODIST HOSPITAL UNION COUNTY	$ 38.12
1023049236	MASSACHUSETTS GENERAL HOSPITAL	$ 34.62
1871656082	DIVISION OF ST MARYS HOSPITAL	$ 33.63
1619931466	HARDIN MEMORIAL HOSPITAL	$ 12.95

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1164539730	LUTHERAN GENERAL HOSPITAL-PARK RIDGE,IL	$ -
1376521575	LOYOLA UNIVERSITY MEDICAL CENTER	$ -
1912007931	MERCY FRANCISCAN HOSPITAL MT AIRY	$ -
	Total	**$ 99,366,298.77**

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1144266024	CLARIAN HEALTH PARTNERS-IU/METH HOSP	$ 7,500,835.39
1568407310	WISHARD MEMORIAL HOSPITAL	$ 4,393,371.54
1225195340	BALL MEMORIAL HOSPITAL INC ACH	$ 3,307,594.38
1306898960	ST VINCENT HOSPITAL W 86TH ST	$ 2,502,397.46
1366407603	PARKVIEW HOSPITAL	$ 2,122,300.59
1467504555	METHODIST HOSPITALS INC-NORTHLAKE	$ 2,063,332.44
1679578850	ST JOHNS HEALTH SYSTEM	$ 1,992,317.06
1205860335	BLOOMINGTON HOSPITAL INC. - ACH	$ 1,951,439.60
1427082957	ST MARYS MEDICAL CENTER OF EVANSVILLE	$ 1,939,557.57
1053361642	DEACONESS HOSPITAL - EVANSVILLE - ACH	$ 1,929,229.49
1003918210	COMMUNITY HOSPITAL-MUNSTER	$ 1,789,458.95
1689776882	ST CATHERINE HOSPITAL	$ 1,759,630.71
1306897335	LUTHERAN HOSPITAL OF INDIANA	$ 1,732,142.38
1295772093	MEMORIAL HOSPITAL OF SOUTH BEND	$ 1,569,097.29
1477551489	ELKHART GENERAL HOSPITAL INC	$ 1,464,326.52
1558463745	ST MARY MEDICAL CENTER	$ 1,358,793.96
1063457380	REID HOSPITAL AND HEALTH CARE SERVICES	$ 1,273,011.61
1972500452	COMMUNITY HOSPITAL OF ANDERSON	$ 1,251,018.96
1619975331	UNION HOSPITAL -TERRE HAUTE - ACH	$ 1,245,449.85
1841245594	ST JOSEPHS REGIONAL MEDICAL CENTER SB	$ 1,170,104.78
1336119478	COMMUNITY HOSPITAL OF INDIANA - EAST	$ 1,130,850.45
1619163854	COMMUNITY HOSPITAL NORTH	$ 1,091,132.05
1780625442	SAINT JOSEPH HOSPITAL & HLTH CTR - HOSP	$ 1,087,421.43
1902878994	HOWARD REGIONAL HEALTH SYSTEMS	$ 1,086,458.10
1497798847	FLOYD MEMORIAL HOSPITAL	$ 1,062,736.36
1215151154	PORTER HOSPITAL, LLC	$ 1,050,756.33
1134186315	CLARK MEMORIAL HOSPITAL-ACH	$ 1,042,986.91
1073550133	TERRE HAUTE REGIONAL HOSPITAL	$ 1,034,596.81
1356435341	LAFAYETTE HOME HOSPITAL (ACH)	$ 1,021,174.81
1386749893	ST FRANCES HOSPITAL & HEALTH CENTERS	$ 1,017,533.00
1205931706	ST FRANCIS HOSP & HEALTH CENTERS	$ 1,016,619.93
1639124134	ST VINCENT CARMEL HOSPITAL INC	$ 991,834.27
1538253521	ST ELIZABETH CENTRAL	$ 977,389.64
1356428429	HENRY COUNTY MEM HOSP	$ 914,689.74
1770679201	MARION GENERAL HOSPITAL	$ 909,452.40
1710051941	ST ANTHONY MEMORIAL HEALTH CTRS-ACH	$ 892,002.68
1538110556	DUPONT HOSPITAL	$ 858,560.42
1700883717	RIVERVIEW HOSPITAL	$ 849,422.71
1740268846	GOSHEN GENERAL HOSPITAL	$ 846,066.88
1619920949	DUKES MEMORIAL HOSPITAL	$ 845,073.88
1336205798	ST. ANTHONY MED CENTER OF CROWN POINT	$ 825,646.66
1144277971	LA PORTE HOSPITAL AND HEALTH SERVICES	$ 816,566.70
1225032881	GOOD SAMARITAN HOSPITAL-VINCENNES	$ 743,419.49
1548260284	BEDFORD REGIONAL MEDICAL CENTER	$ 732,163.54
1306921911	ST MARGARET MERCY HEALTHCARE CTR-NORTI	$ 683,148.49
1023060472	ST JOSEPH MEDICAL CTR - FT WAYNE-ACH	$ 654,085.99
1982681748	ST VINCENT HEART CENTER OF IND LLC	$ 653,984.16
1730140591	MORGAN HOSPITAL AND MEDICAL CENTER	$ 653,525.10
1467485003	HANCOCK REGIONAL HOSPITAL	$ 616,641.75
1811077431	ST MARGARET MERCY HEALTH CARE CTR-SOUT	$ 584,746.30
1063443455	CLARIAN WEST MEDICAL CENTER	$ 582,644.11
1235109778	COMMUNITY HOSPITAL SOUTH INC	$ 566,425.46
1003895947	MEMORIAL HOSPITAL & HEALTH CARE CENTER	$ 550,001.34
1508825720	FAYETTE REGIONAL HEALTH SYSTEM	$ 526,880.41
1477508596	ST VINCENT MERCY HOSPITAL INC - ELWOOD	$ 525,123.92
1497726020	RUSH MEMORIAL HOSPITAL	$ 520,319.79

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1568492916	CLARIAN NORTH MEDICAL CENTER	$ 495,028.56
1699738088	MEMORIAL HOSPITAL (SEYMOUR)	$ 492,498.01
1205816832	INDIANA HEART HOSPITAL, THE	$ 491,616.57
1104998624	COLUMBUS REGIONAL HOSPITAL - ACH	$ 486,701.27
1770533994	ST VINCENT CLAY HOSPITAL	$ 486,447.79
1174555692	MAJOR HOSPITAL	$ 477,200.39
1548205842	DUNN MEMORIAL HOSPITAL	$ 472,487.81
1164475711	KOSCIUSKO COMMUNITY HOSPITAL	$ 463,421.25
1346248986	JOHNSON MEMORIAL HOSPITAL	$ 452,470.70
1326142498	DEARBORN COUNTY HOSPITAL - ACH	$ 415,700.41
1518916048	KINGS DAUGHTERS HOSPITAL - ACH	$ 410,427.27
1568664613	ORTHOPAEDIC HOSPITAL AT PARKVIEW NORTH	$ 403,308.92
1609826783	ST. VINCENT RANDOLPH HOSPITAL	$ 394,501.63
1356320469	LOGANSPORT MEMORIAL HOSPITAL	$ 363,201.72
1154396604	SCOTT MEMORIAL HOSPITAL	$ 362,491.75
1174571129	ST JOSEPH'S REG MED CTR - PLYMOUTH	$ 355,140.13
1851378137	HARRISON COUNTY HOSPITAL	$ 348,297.21
1326296211	CLARIAN-ARNETT HEALTH SYSTEM	$ 341,547.60
1861465999	DAVIESS COMMUNITY HOSPITAL	$ 341,341.23
1952300477	DECATUR CO MEMORIAL HOSPITAL - ACH	$ 330,550.23
1669475950	HENDRICKS REGIONAL HEALTH	$ 321,941.53
1699757401	WITHAM MEMORIAL HOSPITAL	$ 321,199.97
1497759260	SULLIVAN COUNTY COMMUNITY HOSPITAL	$ 316,218.87
1033115993	JAY COUNTY HOSPITAL	$ 316,108.43
1386683316	CAMERON MEMORIAL COMMUNITY HOSPITAL	$ 301,678.75
1265413405	WOODLAWN HOSPITAL - ACH	$ 298,115.31
1003821729	PARKVIEW HUNTINGTON HOSPITAL	$ 297,401.72
1619072493	FAIRBANKS HOSPITAL INC	$ 293,902.21
1689696148	ADAMS CO MEMORIAL HOSP - ACH	$ 289,886.40
1518913565	ST. VINCENT WILLIAMSPORT HOSPITAL	$ 285,221.69
1558368449	MARGARET MARY COMMUNITY	$ 278,536.32
1376594366	BLUFFTON REGIONAL MEDICAL CENTER	$ 270,510.00
1710983945	WHITE CO MEMORIAL HOSP	$ 269,798.99
1861554438	UNIVERSITY MEDICAL CENTER INC	$ 268,467.51
1457366189	PARKVIEW NOBLE HOSPITAL	$ 265,826.39
1679678197	ST FRANCIS HOSPITAL & HEALTH CENTERS	$ 265,142.70
1871574822	BLACKFORD COMMUNITY HOSPITAL INC	$ 263,664.14
1912984451	BLOOMINGTON HOSPITAL OF ORANGE COUNTY	$ 248,016.72
1679674956	PARKVIEW LAGRANGE HOSPITAL	$ 243,841.63
1699876094	TIPTON HOSPITAL	$ 242,421.78
1336190727	ST VINCENT FRANKFORT HOSPITAL INC	$ 240,553.76
1912947490	PUTNAM COUNTY HOSPITAL	$ 239,833.22
1205844495	PARKVIEW WHITLEY HOSPITAL	$ 238,875.76
1821223439	CRITICAL ACCESS HEALTH SERVICE CORP	$ 236,461.16
1285684829	ST VINCENT JENNINGS HOSPITAL, INC.	$ 234,290.06
1891799227	NORTON HOSPITAL	$ 234,183.82
1699779017	PERRY CO MEMORIAL HOSPITAL	$ 233,334.77
1558346007	GIBSON GENERAL HOSPITAL	$ 224,545.91
1902033582	STARKE MEMORIAL HOSPITAL-ACH	$ 219,424.69
1831123942	MONROE HOSPITAL	$ 212,640.99
1306928213	PULASKI MEMORIAL HOSPITAL	$ 187,793.23
1073678330	JEWISH HOSPITAL - LOUISVILLE	$ 186,960.53
1699722405	VALLE VISTA HEALTH SYSTEM	$ 184,273.17
1902897937	DEKALB MEMORIAL HOSPITAL INC	$ 182,944.87
1306844519	WEST CENTRAL COMMUNITY HOSPITAL-ACH	$ 178,040.91
1689857385	PHYSICIANS MEDICAL CENTER	$ 172,854.65

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1811962228	JASPER COUNTY HOSPITAL	$ 154,572.34
1639172810	OTIS R BOWEN CENTER - PSYCH HOSP	$ 154,163.21
1588774558	ST. CLARE MEDICAL CENTER	$ 153,931.29
1598710964	ST VINCENT SETON SPECIALTY HOSPITAL INC	$ 145,838.29
1568417004	COMMUNITY HOSPITAL OF BREMEN	$ 143,794.15
1205828803	WARRICK HOSPITAL INC	$ 141,058.67
1124292446	THE HEART HOSP AT DEACONESS GATEWAY LL(	$ 139,265.80
1194978940	OUR LADY OF PEACE HOSPITAL	$ 132,658.58
1255369245	SAINT CATHERINE REGIONAL HOSPITAL	$ 130,117.57
1184695389	GREENE COUNTY GENERAL HOSPITAL	$ 125,097.41
1174706576	LUTHERAN MUSCULOSKELETAL CENTER LLC	$ 119,084.80
1932213600	RUSH UNIVERSITY MEDICAL CENTER	$ 111,350.54
1558446021	KINDRED HOSPITAL INDIANAPOLIS	$ 99,117.25
1003866740	ST VINCENT'S HOSPITAL - STRESS CENTER	$ 97,788.41
1255406369	REHABILITATION HOSPITAL OF INDIANA	$ 95,245.79
1609873124	WESTVIEW HOSPITAL	$ 94,020.14
1427388982	ST VINCENT SALEM HOSPITAL INC	$ 93,848.89
1770581902	HOWARD REG HEALTH SYSTEM	$ 84,712.00
1114023512	WOMEN'S HOSPITAL, THE	$ 83,660.43
1841215985	WELLSTONE REGIONAL HOSPITAL	$ 82,869.65
1467407395	OAKLAWN PSYCHIATRIC CENTER-PSYCH HOSP	$ 80,255.54
1760659205	KENTUCKIANA MEDICAL CENTER LLC	$ 73,049.30
1891796108	MEADOWS HOSPITAL-PSYCH HOSP	$ 72,679.55
1801822440	MICHIANA BEHAVIORAL HEALTH CENTER	$ 68,404.72
1245259878	WABASH COUNTY HOSPITAL	$ 68,047.18
1811908957	DOCTORS HOSPITAL	$ 63,762.30
1972605178	REHABILITATION UNIT SUBPART	$ 59,266.07
1073565131	MADISON HOSPITAL CORP	$ 53,566.51
1285613612	OWENSBORO MEDICAL HEALTH SYSTEM	$ 52,312.54
1447359997	OHIO STATE UNIVERSITY HOSPITALS THE	$ 50,264.39
1033154026	UNIVERSITY HOSPITAL, INC - CINCINNATI	$ 40,842.82
1508835828	GOOD SAMARITAN HOSPITAL - CINCINNATI	$ 40,827.93
1780633289	THE CHRIST HOSPITAL	$ 39,936.30
1487628616	HEALTHSOUTH DEACONESS REHAB HOSPITAL	$ 38,984.02
1033284666	SUBPART-PSYCHIATRIC UNIT	$ 36,611.54
1689781346	NORTHEASTERN CENTER INC	$ 36,387.36
1265532915	SUBPART-REHAB UNIT	$ 30,733.88
1578562625	SOUTHERN INDIANA REHAB HOSP-NEW ALBANY	$ 26,040.23
1417032996	KINDRED HOSPITAL - INDIANAPOLIS SOUTH	$ 26,013.00
1649221680	REHABILITATION HOSP OF FT WAYNE	$ 23,331.84
1003944109	FRANCISCAN PHYSICIANS HOSPITAL LLC	$ 22,684.48
1568416311	BORGESS MEDICAL CENTER	$ 21,870.32
1689629990	WABASH VALLEY HOSPITAL INC	$ 21,360.46
1508956509	UNIVERSITY OF CHICAGO MEDICAL CTR	$ 20,341.01
1952471914	GOOD SAMARITAN HOSPITAL-DAYTON	$ 20,129.71
1548375082	EHS CHRIST COMMUNITY HOSPITAL	$ 18,454.95
1588732747	COMMUNITY MENTAL HEALTH CENTER (011)	$ 17,388.79
1588601991	STS MARY & ELIZABETH HOSPITAL	$ 17,372.98
1578504056	ST. JOHN'S REGIONAL HEALTH CENTER	$ 17,225.77
1457539751	FOUR CO COUNSELING CTR	$ 16,605.57
1548232838	REHABILITATION UNIT	$ 16,094.52
1467537506	CARONDELET ST MARYS HOSPITAL	$ 15,997.30
1871689539	REHABILITATION UNIT	$ 15,836.99
1184726390	REHABILITATION UNIT	$ 15,493.99
1134220031	LAKELAND HOSPITAL AT NILES & ST JOSEPH	$ 15,178.07
1124062419	WASHINGTON COUNTY MEMORIAL HOSP	$ 14,646.91

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1952390239	CHARLESTON AREA MED CTR	$ 12,972.16
1376619288	REHABILITATION UNIT	$ 12,748.38
1831195908	NORTON SUBURBAN HOSP	$ 12,517.90
1497859649	NORTHWESTERN MEMORIAL HOSPITAL	$ 11,906.96
1033225172	REHABILITATION UNIT	$ 10,011.85
1710012505	RENAISSANCE SPEC HOSP/CENTRAL INDIANA	$ 9,067.15
1215012828	SUBPART-PSYCHIATRIC UNIT	$ 8,734.98
1467493551	ST VINCENT MEDICAL CTR - TOLEDO	$ 7,774.92
1578663597	MERCY FRANCISCAN HOSPITAL WESTERN HILLS	$ 7,363.28
1770575201	PSYCHIATRIC UNIT	$ 7,350.20
1043218944	PITT COUNTY MEMORIAL HOSPITAL	$ 7,316.05
1629170824	PSYCHIATRIC UNIT SUBPART	$ 6,553.15
1265517759	ALEGENT HLTH MERCY HOSP-COUNCIL BLUFFS	$ 5,951.48
1982650024	SUMMIT MEDICAL CENTER	$ 5,846.23
1629003470	IROQUOIS MEMORIAL HOSP & RESIDENT HOME	$ 5,611.49
1649345448	RIVERSIDE HOSPITAL CORPORATION	$ 5,506.81
1376703215	METROSOUTH MEDICAL CENTER	$ 5,247.74
1861447179	ST LUKES MEDICAL CENTER/MILWAUKEE	$ 5,018.77
1427000884	PROVENA UNITED SAMARITANS MED CENTER	$ 4,971.44
1497807572	PORTER STARKE SERVICES INC	$ 4,966.01
1245216183	MCCULLOUGH HYDE MEMORIAL HOSPITAL INC	$ 4,937.08
1952307027	NORTON AUDUBON HOSP	$ 4,617.49
1336109107	SENTARA CAREPLEX HOSPITAL	$ 4,479.76
1730145392	COMMUNITY MEMORIAL HOSPITAL	$ 4,446.80
1558313213	PRINCETON COMMUNITY HOSPITAL	$ 3,664.38
1093705428	JACKSON MADISON COUNTY GENERAL HOSPITA	$ 3,111.80
1285689794	GATEWAY MEDICAL CENTER	$ 3,036.88
1730132234	MEMORIAL HERMANN NORTHWEST HOSPITAL	$ 2,747.37
1083759633	METHODIST HOSPITAL-HENDERSON,KY	$ 2,739.18
1548407216	REGIONAL MENTAL HEALTH CENTER	$ 2,701.79
1932340882	MERIDIAN SERVICES CORP	$ 2,664.45
1235139312	JENNIE STUART MED CTR	$ 2,149.76
1306938071	FLORIDA HOSPITAL	$ 1,949.19
1851344907	NORTH MEMORIAL MED CTR	$ 1,931.42
1508979683	INDIANA ORTHOPAEDIC HOSPITAL	$ 1,918.82
1003878539	UNIVERSITY OF MICHIGAN MEDICAL CENTER	$ 1,807.82
1831132133	HACKLEY HOSPITAL	$ 1,742.03
1184709057	ORLANDO REGIONAL MEDICAL CENTER	$ 1,598.28
1992703540	DUKE UNIVERSITY HOSPITAL-NC	$ 1,496.12
1669427258	BRANDON REGIONAL HOSPITAL	$ 1,442.97
1225159601	CARROLL COUNTY MEMORIAL HOSPITAL	$ 1,401.31
1861431751	UNIV OF ILL AT CHICAGO HOSP & CLINICS	$ 1,376.51
1275531956	COOKEVILLE REGIONAL MEDICAL CENTER	$ 1,256.76
1841224870	BANNER GOOD SAMARITAN MEDICAL CENTER	$ 1,169.93
1447275037	SOUTH COAST HOSPITALS GROUP INC - INPT	$ 1,146.88
1114924958	STURGIS HOSPITAL	$ 1,111.11
1972542264	GENESIS MEDICAL CENTER	$ 1,083.39
1518911338	UNIVERSITY OF KENTUCKY HOSPITAL	$ 1,054.99
1184621161	WAYNE HOSPITAL	$ 1,034.69
1548254931	MARY RUTAN HOSPITAL	$ 1,021.17
1467492421	ST ELIZABETH MED CENTER-NORTH	$ 1,020.74
1104870187	COLUMBIA SUNRISE MOUNTAINVIEW	$ 981.06
1619038247	LAKE CUMBERLAND REGIONAL HOSPITAL	$ 931.38
1154384899	UNIVERSITY MEDICAL CENTER - TUCSON, AZ	$ 922.66
1073588711	EDWARD W SPARROW HOSPITAL	$ 880.06
1588771919	ST JAMES HOSPITAL & HEALTH CENTERS	$ 860.25

Healthy Indiana Plan - Hospital Expenditures by Incurred Date
SFY 2010
Paid Through July 2010

NPI	Hospital Name	Total Payment
1649367269	FLORIDA HOSPITAL DELAND	$ 847.68
1154365062	ST ELIZABETH FLORENCE	$ 838.45
1700950060	ATRIUM MEDICAL CENTER	$ 811.96
1679525919	CLEVELAND CLINIC FOUNDATION	$ 789.01
1053339507	GRANDVIEW HOSPITAL AND MEDICAL CENTER	$ 764.38
1225066327	MERCY GENERAL HEALTH PARTNERS	$ 753.68
1952307852	MUNSON MEDICAL CENTER	$ 694.13
1144228446	LAKELAND REGIONAL MEDICAL CTR	$ 685.74
1134104672	INGHAM REGIONAL MEDICAL CENTER	$ 674.14
1467552471	MERCY HOSPITAL FAIRFIELD	$ 670.32
1134144801	HENRY FORD HOSPITAL	$ 654.14
1265539498	BAPTIST HOSPITAL EAST - LOUISVILLE	$ 618.41
1861450579	GERALD CHAMPION REGIONAL MEDICAL CENTEI	$ 606.54
1730166224	MERCY HOSP MED CENTER - CHICAGO	$ 584.81
1790715381	GWINNETT HOSPITAL SYSTEM-DULUTH	$ 557.93
1073511762	BAYLOR MEDICAL AT GRAPE VINE	$ 530.95
1104867167	FORT HAMILTON HOSPITAL	$ 526.84
1093716979	DEKALB MEDICAL CENTER	$ 523.32
1689621450	OSCEOLA REGIONAL MEDICAL CENTER	$ 492.88
1073576740	MARICOPA MEDICAL CENTER	$ 489.86
1649299827	BARNES-JEWISH HOSPITAL	$ 480.67
1720085137	NAPLES COMMUNITY HOSPITAL	$ 473.41
1417946021	EXEMPLA SAINT JOSEPH HOSPITAL	$ 471.96
1871672618	HOLLAND COMM HOSPITAL	$ 448.78
1568553519	SILVER CROSS HOSPITAL	$ 430.60
1811939887	ST RITA'S MEDICAL CTR	$ 409.89
1144397134	MEMORIAL HOSPITAL-COLORADO	$ 401.07
1568537348	CUMBERLAND RIVER HOSPITAL	$ 382.04
1487760906	CAPE CORAL HOSPITAL-FL	$ 362.64
1649220724	METHODIST HOSPITAL - MN	$ 360.10
1578670543	GOOD SAMARITAN HOSP	$ 356.99
1396714663	BETHESDA HOSPITALS INC-ACH-CINCINNATI	$ 354.49
1477531580	UNIVERSITY OF COLORADO HOSP AUTHORITY	$ 354.44
1972517365	COVENANT MEDICAL CENTER	$ 340.64
1598756686	INGALLS MEMORIAL HOSPITAL	$ 303.88
1831189638	SUMMERLIN HOSPITAL MEDICAL CENTER	$ 299.94
1619931466	HARDIN MEMORIAL HOSPITAL	$ 298.27
1073688354	MIAMI VALLEY HOSPITAL	$ 291.19
1619923919	METROPOLITAN HOSPITAL	$ 279.22
1992789200	MARYVALE HOSPITAL	$ 277.08
1740230119	OAKWOOD HOSP & MEDICAL CTR-DEARBORN	$ 276.08
1831116441	BRONSON METHODIST HOSP	$ 271.75
1801884655	FIRELANDS REGIONAL MEDICAL CENTER	$ 265.86
1285621623	PIKEVILLE METHODIST HOSPITAL	$ 263.24
1568562551	MERCY HOSPITAL CLERMONT	$ 259.57
1316966518	SYCAMORE HOSPITAL	$ 256.32
1295710580	MACNEAL HOSPITAL	$ 256.31
1700979465	BAPTIST HOSPITAL - FL	$ 248.82
1518911031	ST PETERSBURG GENERAL HOSPITAL	$ 240.83
1326022765	ARROWHEAD HOSPITAL	$ 231.76
1003908625	MERCY HOSPITAL CADILLAC	$ 228.53
1245294826	SARASOTA MEMORIAL HOSPITAL	$ 225.91
1093740128	COX LESTER E MEDICAL CTR	$ 203.61
1558365890	METHODIST HEALTHCARE-MEMPHIS HOSPITAL	$ 201.28
1285662981	LAKESHORE COMMUNITY HOSPITAL INC	$ 195.11
1093791170	WEST VALLEY HOSPITAL	$ 183.84

Healthy Indiana Plan - Hospital Expenditures by Incurred Date
SFY 2010
Paid Through July 2010

NPI	Hospital Name	Total Payment
1639151301	ST MARY'S MEDICAL CTR OF CAMPBELL CO	$ 174.07
1366496937	TRIDENT MEDICAL CENTER	$ 171.59
1477537363	PHOENIX BAPTIST HOSPITAL	$ 171.16
1083644579	BATTLE CREEK HEALTH SYSTEM	$ 166.32
1306925540	TRI-COUNTY BAPTIST HOSPITAL	$ 164.12
1477539971	ELIZA COFFEE MEMORIAL HOSPITAL	$ 161.25
1538208210	RIVERSIDE MEDICAL CTR	$ 160.65
1992701429	ST JOSEPH LONDON	$ 157.38
1912007931	MERCY FRANCISCAN HOSPITAL MT AIRY	$ 154.02
1497784144	MERCER CO JOINT TWNSHP COMM HOSP	$ 151.16
1043292899	ST MARY'S MEDICAL CTR-KNOXVILLE	$ 151.02
1942267760	VAN WERT COUNTY HOSPITAL	$ 148.07
1275566200	BANNER ESTRELLA MEDICAL CENTER	$ 138.54
1467560128	SOUTH SUBURBAN HOSP-HAZEL CREST	$ 131.57
1548212988	CHILDRENS HOSPITAL MEDICAL CENTER	$ 128.53
1801807870	LODI COMMUNITY HOSPITAL	$ 126.82
1386641207	ST CLARE HOSPITAL & HEALTH SERVICES	$ 125.76
1912954553	ST ANNE MERCY HOSPITAL	$ 122.98
1689653305	WILLIAM BEAUMONT HOS	$ 103.59
1154324507	AVERA QUEEN OF PEACE HOSPITAL	$ 100.69
1184691610	CAPE CANAVERAL HOSPITAL	$ 99.50
1528031226	BAY MEDICAL CENTER	$ 94.31
1932112125	CENTURA HLTH PENROSE ST FRANCIS HLTH	$ 88.07
1114929494	TWIN LAKES REGIONAL MED CTR	$ 82.91
1548265739	MUNROE REGIONAL MEDICAL CENTER	$ 78.99
1275581852	ROLLING PLAINS MEMORIAL HOSPITAL	$ 77.42
1780658443	ST JOSEPH MERCY HOSPITAL - SMHC	$ 58.76
1093748642	MCPHERSON HOSPITAL	$ 58.40
1447221056	HUNTSVILLE HOSPITAL	$ 55.73
1194749580	MCKAY-DEE HOSPITAL	$ 50.27
1003834508	CITRUS MEMORIAL HOSPITAL	$ 43.43
1154435824	UNIVERSITY OF ALABAMA HOSPITAL	$ 41.36
1720078041	BAY MEDICAL CENTER	$ 40.99
1366436123	OUR LADY OF THE LAKE REGIONAL MED CTR	$ 22.70
	Total	**$ 95,634,956.25**

Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Anne Waltermann Murphy, Secretary

"People helping people help themselves"

June 22, 2010

Senator Vi Simpson
Senator Sue Errington
State House
200 W. Washington Street
Indianapolis, IN 46204

Dear Senators:

Thank you for your letters requesting the status of the Indiana Family Planning Waiver. The waiver, which had been submitted and was being negotiated with the federal government, has been put on hold until the State has the funds to implement the program. Due to the current fiscal situation of the State, FSSA no longer has the resources to fund the implementation that would be necessary to operate the waiver services. We cannot add or expand other programs when, at the same time, we are cutting and reducing rates and services.

We appreciate your recognition that the Patient Protection and Affordable Care Act (PPACA) allows states to implement the family planning waiver services using the state plan amendment instead of the cumbersome federal waiver process. At this time, FSSA is evaluating the PPACA. As the requirements and options in the legislation are numerous, the state plan amendment for family planning is one of the many PPACA provisions under evaluation.

We recognize the importance of maternal and child health, and for this reason FSSA has taken numerous steps over the last few years to support the health of mothers and their children. FSSA has implemented presumptive eligibility which allows a pregnant woman to receive prenatal services while her Medicaid application is being processed. It also allows the provider to bill for services during this time. Similar to the philosophy behind presumptive eligibility, FSSA implemented a standardized babygram form for hospitals and health centers to add newborns to existing Medicaid cases when a mother gives birth. FSSA has also implemented the notification of pregnancy form wherein a provider is reimbursed for completing and submitting a comprehensive risk assessment form, which is used by the managed care organizations to identify and address risk factors, and ultimately, to improve birth outcomes.

I thank you again for your concern on behalf of the women of Indiana and look forward to sharing further details with you regarding our implementation of the PPACA as they become available.

Sincerely,

Anne W. Murphy, Secretary

cc: Senator Jean Breaux and Senator Earline Rogers

FSSA Responses to the Select Joint Commission on Medicaid Oversight
August 11, 2010

- Description of the planning process FSSA has developed to manage the implementation of the programmatic and structural changes resulting from federal health care reform (HCR). Include correspondence with the US Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) or other HCR-related entities. Include plans for identifying and accessing competitive and non-competitive grants for which the state is eligible. Discuss how the agency is working with health community stakeholders to do the planning and steps being taken to ensure the protection of patients' privacy with regard to medical records and systems.

    - Since the Affordable Care Act's passage last spring, the State has been studying the ACA legislation and evaluating its provisions, fiscal impact and grant opportunities, alongside current programming, policy and statute. FSSA & the Indiana Department of Insurance have been coordinating their evaluation of the legislation, alongside other applicable state agencies. Various subcommittees meet on a regular basis to discuss specific provisions in the legislation such as Medicaid Eligibility, Medicaid Expansion and the Health Care Exchange.

      On August 24, 25 and 27th, at 10am in State House Room 233, stakeholder meetings will be held for insurers, providers and business leaders each to express their thoughts and concerns regarding the legislation. RSVPs and written feedback are being requested prior to the meetings. An online questionnaire will be made available to employers, insurers and providers as follow-up to the stakeholder meetings at the end of the month. Additionally, a website will soon be made available to the general public.

      Please see the attached two documents. One is a letter to CMS Director Cindy Mann regarding the Healthy Indiana Plan. The second document is a summary of work that was given to the Health Finance Commission at their June 15th meeting, but has been updated to reflect work since that date. The requested information regarding grants is provided in response to the request "List federal funding opportunities" below.

- What is the status of implementing the provision of family planning services in the State's Medicaid plan as required by SEA 572 (2005)? Has OMPP initiated plans to adopt the family planning provision under the HCR legislation, which allows for implementation by an amendment to the state's Medicaid plan (eliminating the requirement for a waiver) and provides for a 90% federal match?

    - Please see attached letter dated June 22, 2010 where Secretary Murphy responded to the same inquiry from Senators Vi Simpson & Sue Errington.

- List federal funding opportunities that assist with planning and preparation for reform. Identify grant details, barriers preventing application, the type of the assistance the agency needs to apply/participate, and a list of those opportunities, if any, for which Indiana has applied.
    - The ACA provides a number of funding and grant opportunities, many for which details have not yet been released. As agencies evaluates grant opportunities, consideration include whether or not there is a match, any maintenance of effort requirement and whether the State has the resources to maintain the program once the grant ends. A list of grants for which FSSA or other agencies have applied follows:
        - Grants to States for Health Insurance Premium Review, Cycle 1 – IDOI
        - Expansion of MIPPA - IDOI
        - ADRC Options for Counseling and Assistance Programs – FSSA
        - ADRC Nursing Home Transition and Diversion Program – FSSA
        - ADRC Evidence-Based Care Transition Programs – FSSA
        - Maternal, Infant and Early Childhood Home Visiting Program – DCS
        - Strengthening Public Health Infrastructure for Improved Health Outcomes – ISDH
    - Grants the State is currently considering:
        - Planning Grant for State Exchanges: Resources for State to Build New Competitive Health Insurance Marketplace
        - Consumer Assistance Grant
        - Supplemental Funding for Health Communities

INDIANA'S PARTICIPATION IN HEALTH CARE REFORM & AFFORDABLE CARE ACT (ACA) IMPLEMENTATION DISCUSSIONS

MARCH

15 & 16: Lawren Mills, Office of the Governor, attended the National Governor's Association (NGA) conference, *State Summit on Health Reform Implementation.*

23: Medicaid Director Casanova participated in a National Association of Medicaid Directors (NASMD) call on Health Care Reform.

24 – 28: Robyn Crosson, Department of Insurance (IDOI), attended the National Association of Insurance Commissioners (NAIC) Spring Conference where healthcare reform was a major topic of several meetings.

29: FSSA Secretary Anne Murphy and Medicaid Director Casanova attended a NASMD conference in Washington D.C., which included a face-to-face meeting with the Centers of Medicare and Medicaid Services (CMS).

APRIL

5: IDOI held first meeting post NAIC to discuss ACA related resource needs, planning and implementation.

14: FSSA held a meeting with the agency's Executive Team where Seema Verma provided a summary of the legislation and implementation timeline.

15: Health and Human Services (HHS) held first of weekly calls concerning ACA, specifically High Risk Pools on this date.

16: IDOI met with Governor's policy director concerning ACA and resources.

19: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

19: IDOI met with UHC to discuss ACA.

21: IDOI Financial Division participated in NAIC Blanks Committee call concerning ACA financial reporting.

22: IDOI & FSSA participated in a call with HHS concerning High Risk Pools and ACA provisions.

26: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

27: IDOI held webinar for insurers who file premiums with IDOI and mandates electronic reporting as first step in transparency enhancement program.

27: IDOI Financial Division participated in NAIC Blanks Committee call concerning ACA financial reporting.

27: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

28: IDOI met with State Personnel to discuss resource needs resulting from ACA.

29: IDOI, FSSA and other interested parties participated in weekly HHS call.

30: IDOI served on panel for NAIFA concerning IDOI responsibilities and ACA.

30: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

30: IDOI made High Risk Pool election.

30: IDOI responded to Chairman Crawford's High Risk Pool inquiry.

MAY

3: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

4: FSSA & IDOI participated in an NGA ACA call.

5: FSSA participated in a Managed Care TAG Health Care Reform call.

5: IDOI participated in Commissioners Call concerning ACA.

5: IDOI presented to House Republican Legislative Assistants at their invitation concerning IDOI's functions and ACA.

6: FSSA & IDOI participated in weekly the HHS ACA call.

6: Medicaid Director Casanova participated in NASMD Executive Committee and Medical Director Executive Committee conference call.

7: IDOI spoke with developer for California's health exchange.

10: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

10: IDOI participated in a panel discussion regarding ACA impact to the Dept.

11: IDOI participated in NAIC Accident & Health B-Committee call concerning ACA.

13: FSSA & IDOI participated in the weekly HHS ACA call.

13: IDOI met with internal team to discuss calculation of Medical Loss Ratio (MLR) for purposes of rebating.

13 & 14: Seema Verma provided a summary of the ACA and implementation timeline to Medicaid and Division of Family Resources leadership teams.

14: IDOI met with all divisions to discuss NAIC calls and status of sub-groups and committees.

17: IDOI met with Aetna insurance to discuss MLR calculation and Exchanges.

17: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

17: FSSA sent a letter to CMS Director Cindy Mann requesting additional guidance regarding the Healthy Indiana Plan.

18: FSSA, IDOI & SPD participated in an HHS call regarding the Early Retiree Reinsurance Program.

18: IDOI participated in HHS webinar concerning Web Portal.

18: IDOI attended seminar regarding ACA national impact.

19: FSSA participated in a CMS HCR webinar.

19: IDOI participated in National Association of Health Underwriter presentation concerning ACA and its impact on IDOI.

19: IDOI participated in a call with United Healthcare concerning the calculation of MLR.

19: IDOI participated in joint meeting of NAIC Finance and Health Committees concerning ACA.

20: FSSA & IDOI participated in the weekly HHS call.

21: FSSA & IDOI participated in an NGA health care reform call.

21: IDOI attended monthly IIAC Autism meeting and discusses updates membership on ACA and IDOI impact.

23: Medicaid Director Casanova attended NASMD Boot Camp in Washington D.C, which included discussions regarding Health Care Reform.

24-25: Medicaid Director Casanova attended the 2010 NASMD Spring Conference in Washington D.C.

24: FSSA ACA Oversight Team met & Governor's Office executive HCR work group met.

24: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

25: IDOI participated in NAIC Sub-Group conference call.

26: FSSA representative participated in Lewin Group health care reform webinar.
26: IDOI met with AAPPO to discuss MLR calculations.
27: FSSA & IDOI participated in the weekly HHS call.
27: FSSA ACA Eligibility work group, led by Medicaid Director Casanova, DFR Director Boggs and Seema Verma, met for the first time.

JUNE

1: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
1: IDOI met with Physicians Health Plan to discuss dependent age 26 regulations and interpretation.
2: IDOI provided internal training to Company Compliance and Consumer Services personnel on the Dependent Age 26 Regulations.
2: IDOI participated in conference call with URAC concerning the calculation of MLR and costs that improve the quality of healthcare.
2: IDOI participated in conference call with NCQA concerning the calculation of MLR and costs that improve the quality of healthcare.
2: IDOI participated in NCSL webinar concerning ACA.
2: IDOI responded to HHS Web Portal request.
3: IDOI, FSSA, ICHIA and Governor's Office met concerning High Risk Pool and ACA.
3: IDOI participated in NAIC Speed to Market conference call concerning rate review disclosure form required by ACA.
3: IDOI participated in conference call with Utah concerning their small business health exchange.
3: FSSA participated in a CMS teleconference regarding Health Care Reform Implementation.
3: FSSA & IDOI participated in the weekly HHS call.
4: IDOI met with all Senate legislative assistants concerning IDOI's various functions in state government and ACA.
7: IDOI participated in conference call involving NAIC and HHS concerning grants available through ACA.
7: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
7 & 8: A representative from FSSA attended the National Medicaid Congress's Special National Health Reform Edition conference in Washington, D.C.
8: FSSA ACA Oversight Team met.
9: IDOI participated in NAIC ACA webinar concerning grants and health reform provisions.
9: IDOI submitted its comments on the proposed calculation of MLR and rebates.
10: FSSA ACA Medicaid Disability work group, led by Director Casanova & Seema Verma, met for the first time.
10: Seema Verma provided a summary of the ACA and implementation timeline to the Division of Aging.
10: FSSA & IDOI participated in the weekly HHS call.
10: IDOI participated in NAIC Financial Solvency conference call concerning financial impact and reporting of carriers resulting from ACA.
11: IDOI participated in conference call with Aetna concerning the definition of MLR.
11: IDOI participated in NAIC Sub-Group for Exchanges.
14: FSSA & IDOI met to discuss ACA implications.

14: FSSA & IDOI representatives participated in an HHS call regarding grandfathering and ACA implementation.
14: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
14: IDOI participated in conference call with HHS concerning grants.
15: IDOI Compliance and Financial Divisions met to discuss MLR and financial reporting under ACA.
15: IDOI & FSSA participated in a technical call with HHS concerning grants.
16: FSSA ACA long-term care work group, led by Medicaid Director Casanova, DDRS Director Julia Holloway and Seema Verma met for the first time.
16: FSSA representatives participated in a CMS call regarding coverage gap.
16: IDOI participated in webinar with Choice Administrators regarding Exchanges.
17: FSSA representatives participated in an HHS call regarding National Criminal Background Checks and the ACA.
17: FSSA and IDOI participated in the weekly HHS call.
18: FSSA ACA Medicaid Expansion work group, led by Medicaid Director Casanova and Seema Verma met for the first time.
18: IDOI participated in NAIC call concerning ACA grants.
21: FSSA ACA Oversight Team met.
21: IDOI met with a technology provider concerning premium review transparency enhancements.
21: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
21: IDOI ACA team met internally to discuss plan for grant application.
22: IDOI met with actuarial firm to discuss improved premium review processes.
22: IDOI met with technology vendor to discuss premium review transparency enhancements.
22: FSSA ACA Eligibility work group met.
23: Governor's Office ACA executive work group met.
23: IDOI met with Compliance and Consumer Services personnel to discuss Grandfathering regulations and IDOI interpretation.
24: FSSA ACA Medicaid Disability work group met.
24: FSSA and IDOI participated in the weekly HHS call.
24: IDOI participated in the weekly HHS call.
25: IDOI participated in conference calls with law firms and interested parties where such parties express concerns over state v. federal exchanges.
25: FSSA ACA Medicaid Program Integrity work group met for the first time.
28: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
28 & 29: Robyn Crosson (IDOI) & a representative from FSSA attended ACA NGA conference in Washington, D.C.
30: IDOI presented to House legislative assistants on IDOI role and ACA.
30: IDOI met with interested groups regarding Exchanges.

JULY

1: FSSA & IDOI Health Exchange work group met.
1: IDOI participated in Rate Review Disclosure Forms Sub-Committee of NAIC.
1: IDOI and FSSA participated in weekly HHS call.

1: Medicaid Director Casanova participated in NASMD Executive Committee and Medical Director Executive Committee conference call.
5: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
6: IDOI participated in Standard Definitions Sub-Committee of NAIC.
6: FSSA ACA Medicaid Expansion & Medicaid Disability work groups met.
6: FSSA participates in a CMS call regarding healthcare.gov
7: FSSA ACA Pharmacy work group met for the first time.
7: IDOI Compliance and Financial Services Divisions met to discuss MLR and financial reporting pursuant to ACA.
7: IDOI participated in NAIC Commissioner's call concerning ACA.
7: IDOI participated in NAIC Financial Committee reporting call.
7: IDOI submitted Rate Review Grant.
8: FSSA & IDOI participated in the weekly HHS call.
8: IDOI provided suggested consumer definitions for NAIC Definitions Sub-Group.
8: IDOI participated in NAIC Explanation of Coverage Sub-Group.
12: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
13: IDOI participated in NAIC Consumer Definitions call.
13: IDOI participated in HHS call concerning protection of medical information.
14: IDOI meets with provider representatives to discuss claims issues and ACA.
14: FSSA participated in HHS call regarding the new preventive care provisions.
15: FSSA and IDOI testified at the Health Finance Commission
15 IDOI participated in the weekly HHS call.
15: IDOI participated in a conference in Ft Wayne regarding the impact of ACA to the IDOI.
16: IDOI participated in NAIC pre-Definitions call.
16: IDOI provided commentary for the Unreasonable Rate Increase Form to NAIC.
20: IDOI participated in NAIC Standard Definitions call.
20: IDOI participated in a producer seminar regarding the impact of ACA to the IDOI.
20: FSSA ACA Medicaid Disability and Eligibility subcommittees met.
21: Interagency committee met to discuss ACA. FSSA Executive team met to discuss the ACA.
22: FSSA & IDOI participated in the weekly HHS call.
26: FSSA representatives participated in a CMS call regarding Health Acquired Conditions.
27: FSSA and IDOI HCR Exchange Subcommittee met.
27: IDOI participated in NAIC Standard Definitions call.
29: FSSA & IDOI participated in the weekly HHS call.
29: FSSA Medicaid Expansion Subcommittee met.
30: IDOI participated in NAIC Explanation of Coverage call.

AUGUST
2: IDOI participated in NAIC Standard Definitions call.
3: Seema Verma attended HHS meeting concerning Exchanges in Minneapolis.
3: IDOI participated in Indiana Chamber of Commerce Health Insurance Committee meeting concerning ACA.
4: IDOI participated in NAIC Speed to Market call concerning unreasonable premium increase reporting.
4: IDOI participated in NAIC ACA status call.

4: IDOI participated in NAIC financial committee meeting concerning documentation to be used to calculate rebates under ACA.
4: Medicaid Director Pat Casanova attended NASMD Executive Team meeting in Philadelphia.
5: FSSA & IDOI participated in the weekly HHS call.
5: FSSA and IDOI participated in HHS call concerning Exchange Grants.
5: IDOI participated in NAIC Explanation of Coverage call.
6: Governor responded to Secretary Sebelius' premium review authority inquiry.
6: IDOI meetings held to analyze the benefits and responsibilities imposed if IDOI applies for the Consumer Protection Grant.
9: Governor's Office executive team met to discuss ACA.
11: IDOI & FSSA met to discuss various ACA issues, including the Health Care Exchange.

Select Joint Commission on Medicaid Oversight Requests

DSH

- Copy of the most up-to-date DSH distribution methodology with accompanying list of hospitals that will be recipients of DSH with the revision of the methodology.
    - Please see that attached report titled "Anticipated 2010 HCI/UPL/DSH Payment Summary and Calculation."

Division of Aging

- Number of individuals served by CHOICE for each of the last three State Fiscal Years with estimates for State Fiscal Year 2011. Also, number of individuals on CHOICE waiting list for the last three years and estimated numbers on waiting list for State Fiscal Year 2011 (if available).

YEAR	CLIENTS SERVED	WAIT LIST
SFY08	10,158	4,571
SFY 09	8,944	2,513
SFY10	11,558	4,052

The Division of Aging anticipates approximately same number on the wait list for SFY2011.

Hoosier Rx

- Does the Hoosier Rx program pays the cost of prescriptions that fall in the so called "doughnut hole" or only the premium co-pay costs (up to $70)? Also, what were the SFY 2009 and SFY 2010 expenditures for the premium co-pay costs and also the prescription drug product costs (if applicable) through Hoosier Rx?
    - HoosierRx pays only Medicare Part D monthly premiums – up to $70 per member, per month. "Co-pay" refers to the beneficiary's portion of the cost of the prescription drugs (which Medicaid does not pay), not the monthly premium.
    - SFY 2009 premium expenditures were $799,797.77.
    - SFY 2010 premium expenditures were $789,173.98.

Pharmacy Carve-Out

- Estimate of savings State has achieved thus far (if any) by the MCO pharmacy "carve-in" which became effective January 1, 2010. Also, updated projection of savings for State Fiscal Year 2011.

- Due to the ACA legislation, the State lost $0.4M in savings during FY10, and the updated projection for FY11 is $28.4M.

- Copies of any documents (including e-mails) sent to FSSA by providers expressing concerns with the pharmacy "carve-in" and any perceived adverse impacts on clients arising from the switch to the State assumption of pharmacy provision from the MCOs.

  - Please see attached document, "Pharmacy Carve-Out Emails."

- Provide data on pharmacy denials to include data for 2008, 2009, and year to date 2010: It should also include the reasons for the denial (e.g., administrative, generic equivalent, exceeds limits, etc.)

  - The data requested cannot be obtained. Pharmacy data for CY 2008 and 2009 is a mix of encounter data from the managed care organizations (MCOs) and data for the fee-for-service (FFS) population. Pharmacy data for CY 2010 is all fee-for-service data. The data for CYs 2008 and 2009 cannot be compared to CY 2010 due to differences in denial reasons and differences in data sources.

- Does the contract with the pharmacy vendor include a provision for penalties or fines to be imposed on the vendor if the vendor does not meet performance measures in resolving provider/member complaints? If so, provide a report of any penalties or fines (if any) imposed to date (if any).

  - Below are the pharmacy benefit manager contract requirements. Staff researched back to July 2007 and found no liquidated damages related to this topic.

    Pharmacy Benefit Manager Contract Requirements
    Written, E-Mailed Inquiries
    NOTE: This standard does not apply to written or e-mailed inquiries from drug manufacturers and any entity acting on behalf of a drug manufacturer.

Standard: The PBM contractor will research and issue responses to all written or e-mailed inquiries. Responses must be clear, concise, correct, and consistent. Ninety-five percent (95%) of written or e-mailed inquiries must be responded to within five (5) business days and one hundred percent (100%) must be responded to within ten (10) business days of receipt of the inquiry. The PBM contractor will provide a monthly report to the State no later than 10 (ten) business days following the end of each month, such report, categorized and tabulated as satisfactory to OMPP, documenting inquiries received and noting those for which responses were not issued within the applicable time frame.

Measure: One failure for each month for which the standard is not met.

Damages: $1,000 (one thousand dollars) per failure.

Response to Inquiries from Drug Manufacturers and Any Entity Acting on Behalf of a Drug Manufacturer

Standard: The PBM contractor shall respond to all Medicaid prescription drug program-related inquiries, including surveys, from drug manufacturers and any entity acting on behalf of a drug manufacturer, as well as any other interested parties as requested by the OMPP. The PBM contractor shall utilize a dedicated e-mail address for this purpose, or an alternative OMPP-approved mode. Response to all e-mailed inquiries or surveys must be issued within 3 (three) business days of receipt by the PBM contractor of the inquiry or survey.

Measure: One failure for each month in which the requirement is not met.

Damages: $1,000 (one thousand dollars) per failure.

High-Risk Pool

- Provide an overview of high risk pool waiver programs, such as hemophiliac case management, HIV, etc. Specifically:
  a. How many patients are being served?
  b. What has been the cost savings to the State?
  c. Can these members be enrolled in managed care?
  d. Is the program administered by a State agency or third-party? If it is managed by a third party, when was the last time the program was put out to bid? Does the current vendor have MBE/WBE subcontracts? If not, why? If it is run by a State agency, has there been consideration of putting it out for bid? What are the benefits and disadvantages of putting it out for bid?
  - All questions in regards to the high risk pool waiver programs should be directed ICHIA.

From: Mark A Hollinden [mailto:mark.hollinden@abbott.com]
Sent: Wednesday, January 13, 2010 8:41 AM
To: Sharp, Michael L (Mike)
Subject: Fw: Pharmacy Consolidation Feedback

Mike,

I thought I would share some feedback I am getting from our field sales teams with respect to the transition over to FFS Medicaid.

One direct quote came from one of our managers in N. Indiana. It is as follows: "Our customers are thrilled (mostly the staff because they are the ones that deal with the extra work of prior auths, call-backs, etc...! As we know, it makes their lives easier. Physicians are surprised there are so many branded products on the formulary as they thought it is pretty well all generics. They are excited to actually treat their patients more aggressively as deemed appropriate by them!"

I think that pretty much sums up everything I have been hearing. Basically, most of the feedback has been related to how easy the transition has been for physicians/staff and how patients, as a whole, have been treated fairly. It appears that both physicians and patients were expecting a major collective headache with this change but from what I am hearing from our sales people and managers who work directly with the physicians, the change has been very smooth and overall positive. I've even heard several comments that the Prior Auth process is much easier!

Well done Mike. I know this was a major undertaking and it appears to be experiencing a very successful first month.

Mark A Hollinden
Gov't Reimbursement & Policy Executive
Pharmaceutical Products Division
Integrated Managed Healthcare Group

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Cell 502-741-3127
mark.hollinden@abbott.com

From: Dingle, Kelly [mailto:DingleK@MedImmune.com]
Sent: Thursday, January 14, 2010 5:26 PM
To: Sharp, Michael L (Mike)
Subject: Pharmacy Consolidation Feedback

Mike,

I hope this message finds you well. We are two weeks into the Pharmacy Consolidation and I have received nothing but positive feedback. I knew physicians would be pleased, simply due to the overall streamlining of policy and procedure, however when queried providers were most impressed by the efficiencies of ACS. The PA process is "effortless" and "quick".

I have attached a word document with initial feedback from my field representatives. I will maintain this log and continue to share all input.

Great job Mike! You have made the professional lives of Indiana Medicaid providers easier, and therefore they have the time and resources available to provide better care for your members.

<<Indiana Pharmacy Consolidation Feedback.doc>>

Kelly M. Dingle
Managed Care Account Manager
MedImmune
847-727-9923
847-720-4372 (fax)
dinglek@medimmune.com

<<Indiana Pharmacy Consolidation Feedback.doc>>

January 14, 2009

Provider feedback
Pharmacy Consolidation

- Offices are very happy to have 1 set of guidelines for all patients. Dr's feel that has resulted in less man hours figuring out medicaids process. They are also happy to hear they decided to cover their kids at a higher level of care than what AAP has recommended. Also VERY PLEASED at the quick turn around ACS offers when prior authing.

- Offices I've seen are impressed with the turn around time for approvals. The process seems to be much simpler than the Managed Medicaid process. The only problem I've seen is offices thinking the approval is sent to distributor automatically. A simple reminder fixed the problem

- I have many positives I could send to you, but here are just a few for now.
  Many of the clinics have voiced relief that denied babies who they were worried about now qualify for either starting doses or for dosing for the remainder of the season.
  Drs have been pleased to learn that we are able to give April doses, especially since we are experiencing such a delayed onset of the RSV season.
  The Wishard clinic was planning to continue buying and billing and using MDWise. When I informed them that they could bill the state and go through ACS, they jumped on that. Using MDWise was difficult, contentious, and time-consuming (and they hated dealing with the MDWise pharmacists as well as the PerformRx folks. The ACS process and rapid turn-around reduces work time tremendously for them and allows the nurses to take care of patients instead of doing paperwork.

- Transition - The transition overall has gone very well.

  Processing - The processing has been very quick with ACS and the distributors, primarily the optioncares, have done a stellar job in getting the babies set-up and drug delivered.

  Approval- the approval process has gone well with the approval process, ACS, etc. The challenge here has been how to work with the Synagis clinics that are also RBMC affiliated. But the change has happened and now is going well.

  Positives -
  - The patients are getting the drug in an expedient manner. No waiting for the RBMC / SPD to slow the process down or deny
  - The PCPs LOVE the fact that their babies are getting approved and protected from RSV
  - The referral process and time frame to get these babies approved and started on therapy is very quick and much easier than previously!

  Negatives -
  - The PCPs wish the commercial patients had the same ability to get dosed as now the Medicaid patients

From: Hancock, Emily F
Sent: Friday, February 12, 2010 5:34 PM
To: Simmons, Alice M
Cc: Hancock, Emily F
Subject: FW: Due 2/12 (Intranet Quorum IMA00294134)

Dear Alice:
Please close this IQ with satisfactory resolution. I e-mailed Dr. Harris this afternoon with the following response. See below.

Dear Dr. Harris,

Your recent inquiry concerning Indiana Medicaid's Pharmacy Benefit Management was referred to me for response. I feel very fortunate to have this opportunity to address your concerns and provide a satisfactory resolution going forward.

I first met you when I was a St. Vincent associate at the Institute on Aging and you were doing a rotation in the IOA. I also knew your husband when I served on the Alzheimer's Association Board of Directors while he was the Board president.

I separated your inquiry below, by question, and provided some discussion points to consider. I would be most happy to speak to you personally, at your convenience, should you desire further dialogue.

1. The Preferred Drug List on the Indiana Medicaid website is incomplete. It lists drugs where there is a preferred vs nonpreferredoption (such as an inhaler for asthma) but doesn't list meds wherethere is no preference (specifically, amoxicillin a very commonlyprescribed antibiotic is not on the list). The explanation I was given was that if it isn't on the list then it is covered is not inadequate response in my opinion. As a primary care provider, if I have a question about whether my prescription is going to be covered for my patient I would like to be able to confirm this accurately on a Preferred Drug List. Previously, when MDWise managed the formulary, the list was complete in this way.

Your question centers around the differences in the terms "formulary" and "preferred drug list (PDL)". The Indiana Medicaid pharmacy benefit is extremely broad in coverage, and the drugs that are covered go beyond the therapeutic classes that are subject to the PDL. Being "subject" to the PDL means that a rigorous scientific review accompanies a fiscal review and federal rebate agreement by our Pharmacy and Therapeutics committee before being designated "preferred". Commonly prescribed medications for which the original patent has expired and multiple generic equivalents exist will not be subject to the PDL. Amoxicillin is a good example of this, because it has over 50 manufacturers with different trade names.

Resolution:
In order to make the scope of drug coverage more apparent to prescribers, the Office of Medicaid Policy and Planning recently revised the appearance of the on-line PDL by enhancing it

with a "user's guide" at the beginning. This guide specifies and clarifies the basic coverage parameters under which the Indiana Medicaid pharmacy benefit operates. By having this information at the beginning of the PDL (as opposed to at the end of the document, which was previously the case), we believe the significant breadth of coverage will be more apparent and more easily understood.

At your convenience, please review the revised PDL document which can be accessed via this link: http://www.indianapbm.com/# Click on the "Pharmacy Services" button at the top of the page, then "Preferred Drug List" and "Current PDL" from the resulting drop-down menu. We would like to hear from you regarding whether or not this additional information will likely be of assistance to you and your colleagues and, certainly, if you have any suggestions for improvements or enhancements to the PDL list itself that you believe would enhance its utility to prescribers.

> 2. A second issue with the drug list is that medications for Mental Health (antidepressants and antipsychotics) are not shown on the drug list. Prior to 1/1/10, it seemed that all medications for Mental Health drugs were covered, but this week we have been getting denials for Abilify (an antipsychotic) with a reason for denial of "needing to try a less costly product" but I can't find what my alternative options are to pick from. This is delaying a patient receiving a medication that was prescribed for them.

Could you elaborate where you are seeing a denial for Abilify with the need to try a less costly product? Is this on the screen with St. Vincent's electronic medical record software? Or are patients being denied at the pharmacy with a subsequent requirement for Prior Authorization? If you could provide me the patient's name and Medicaid identification number, I could look into this issue. The State of Indiana is considered "open access" for mental health drugs, however, the Mental Health Quality Advisory Committee (MHQAC) that is part of the Drug Utilization Review Board has certain edits in place that guide appropriate utilization. Cost is not the driver in the State's utilization edits, and I am not familiar with an edit requiring you to try a less costly product.

Indiana *law requires* all mental health drugs to be considered as "on" the PDL and in "preferred" status. As such, they were not made a part of the physical document; this, in order to not make an already large document even larger. For information on limits that apply to mental health drugs, you may want to refer to the Mental Health Quality Advisory Committee's (MHQAC) web page at
http://www.indianamedicaid.com/ihcp/PharmacyServices/MentalHealthInfo.asp?comm=gac .

If you ever have specific questions regarding a prior authorization requirement applicable to a fee-for-service drug, please contact our PBM Contractor's (ACS) Clinical Call Center at 1-866-780-2198. The Call Center's operating hours are (excluding holidays) 8:00AM to 8:00PM, Monday through Friday, and 10:00AM to 6:00PM Saturdays, and agents there are always glad to explain the rationale for any given prior authorization requirement.

> 2. My third issue is in making me write for brand name medications when a generic is available. A specific example is Flonase orfluticasone. Prior to 1/1/10 I wrote for fluticasone as is

mandated by the generic utilization policy of Medicaid. I have no problem with using the generic. Now, since 1/1/10 my patients pharmacies are calling me and requiring that I give a fresh prescription for brand name Flonase. I understand there is probably a pharmacy manufacturer rebate making brand name cheaper than generic in these specific circumstances, but why can't the pharmacy be allowed to convert from the generic to the brand name without delaying the dispensing by having to contact my office for a freshly written prescription.

If you are aware of specific incidences where you were asked to write a fresh prescription, I would be happy to investigate this further. Two possible scenarios might have happened. There is federal (CMS) requirement that prescriptions be written on tamper-proof prescription pads (TRPP) that affected many Hoosier Health Wise members when the State took over managing the pharmacy benefit. MDWise was not subject to this CMS requirement when they were managing the pharmacy benefit. This may be have been the reason you were asked for a new prescription. I have added a link to the bulletin issued concerning this.
http://www.indianamedicaid.com/ihcp/Bulletins/BT200948.pdf

The other scenario is that the pharmacy did not understand they could dispense the brand name without your approval, in which case, we will address this in our regular communications with enrolled pharmacies. The Office of Medicaid Policy and Planning does not intend for prescribers to have to keep up with the type of changes you referenced in your example. If you had written for generic fluticasone, and the Medicaid preferred drug was Flonase, your patient should have received Flonase without a phone call to you.

The pharmacy benefit has both federal and state supplemental "rebate" programs, the net effect of which is to ultimately decrease the cost to the State of drugs. Given these programs, it is the case that, under certain circumstances, it is net/net less costly to the State for the State to reimburse for a brand name drug than its generic equivalents.

The pharmacy claims processing system is set up to enforce these situations, and typically pharmacies are quite adept at understanding the circumstances under which they may need to dispense a brand name drug. If you are aware of any specific pharmacies that may benefit from receiving information from our fiscal contractor's (EDS/HP) Customer Assistance unit, please let us know as we would be glad to ensure that necessary contacts are made.

I am frustrated as a provider and am currently very unimpressed with the changes in pharmacy benefits for Medicaid members. Although I have not tried to reach the new Pharmacy Benefit helpdesk personally, my partners tell me their experience has been frustrating due to a lack of guidance given to providers calling with questions or needing alternatives. I also heard from a provider that delays in PA's forSynagis resulted in delays in administration for some high risk children. The providers felt that the customer service was not helpful in answering questions regarding Synagis and which pharmacies could supply it to provider offices.

Our goal is to make it as easy as possible for physician and pharmacy providers to render and receive payment for the services they provide to Medicaid beneficiaries. Should you or your colleagues have any specific information pertaining to the Synagis PA and billing issues mentioned above, we would certainly appreciate receiving it so we can investigate it and take any corrective action that may be necessary. We are always open to receiving comments or suggestions that you believe would enhance service to physician and pharmacy providers, so please consider this response an invitation in that regard.

Dr. Harris, thank you for taking time from your practice to make us aware of your concerns. I hope the information in this response proves helpful in addressing those concerns.

Sincerely,
Emily Hancock

Emily F. Hancock, RPh, PharmD, MPA
Manager, Pharmacy Interventions and Outcomes
The Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration
Voice Mail: 317-233-0097
e-Mail: emily.hancock@fssa.in.gov

Anticipated 2010 HCI/UPL/DSH Payment Summary and Calculations

HCI-funded UPL payments

In 2010, for the same reason as in 2008 and 2009, no HCI add-on payments will be made.

Other Private UPL payments

In 2010, private hospitals with more than 70,000 Medicaid days will continue to receive $10,000,000. However, the UPL payments based on Medicaid inpatient days will not be made in 2010 for the same reason as in 2008 and 2009.

Clarian will continue to be paid by agreement with the state; however, beginning in SFY 2010, the statute gives OMPP discretion over the manner in which the other "historical DSH providers" will be paid. At this time, the agency has not made a decision whether these hospitals will receive private UPL payments by agreement or through the safety net pool. Before making that decision, the OMPP wants to assess the impact of both payment methodologies on the historical hospitals. That assessment requires final information regarding the 2010-2011 DSH eligibility determination and the hospital specific limit (HSL, or cap) information from the hospitals. The 1/3, 2/3, and 3/3 factors (based on number of consecutive periods a hospital has been DSH eligible) for determining how much of its cap each hospital is eligible to receive will continue. Due to a new eligibility period beginning in 2010, hospitals that remain DSH eligible will progress to their next consecutive period (either 2/3 or 3/3). That is, a hospital at the 1/3 level in 2009 that remains DSH eligible would be at the 2/3 level in 2010. The 2010 safety net payments will likely be subject to proration, similar to 2008 and 2009, depending on the calculated hospital specific limits and available private UPL.

Municipal UPL payments

Municipal hospitals are eligible to receive 100% of their OBRA cap (or hospital specific limit) through a combination of UPL and DSH payments. However, similar to 2009, we expect that the combined 2010 non-state government owned/operated (NSGO) UPL and remaining DSH funds will be lower than the total municipal hospital caps, resulting in proration for SFY 2010 municipal payments.

DSH payments

In 2010, we do not expect that the IMDs will use the full 33% of the DSH allotment that they are allowed. Any DSH allotment not used by the IMDs would be used for municipal DSH payments. The non-state psychiatric pool of $2 million will be allocated by MIUR using the same formula as in previous years. The state operated psychiatric hospitals will be reimbursed for their uncompensated costs, and the remaining DSH allotment will be used for payments to the municipal hospitals.

We do not expect enough remaining DSH funds in 2010 to pay the municipal hospitals up to 100% of their hospitals specific limits, resulting in proration of payments to municipal hospitals. As in 2009, we expect to prorate municipal UPL and DSH payments so that all hospitals receive the same net percentage of their cap.

We also expect that in 2010, as in 2009, the DSH payments to the IMDs and municipal hospitals will exhaust all DSH funds available to the state. If that is the case, no DSH payments would be made to private hospitals.

Waiver Expenditures

2008	Expenditures
Aged and Disabled	59,567,672
Autism	13,964,778
Developmentally Disabled	406,211,249
Support Services	24,030,870
Traumatic Brain Injury	3,480,286

2009	Expenditures
Aged and Disabled	84,372,418
Autism	16,815,190
Developmentally Disabled	454,725,823
Support Services	26,593,305
Traumatic Brain Injury	3,758,140

2010 [1]	Expenditures
Aged and Disabled	123,415,219
Autism	18,362,462
Developmentally Disabled	458,984,569
Support Services	32,770,417
Traumatic Brain Injury	4,447,232

[1] 2010 numbers subject to change due to potential adjustments and late billing/claims processing.

Exhibit B
Select Joint Commission
on Medicaid Oversight
August 12, 2010

Select Joint Commission on Medicaid Oversight

August 12, 2010

Provider Network Access
and
Claims Processing

Rachel N. Geiger, RN, MSHCA, CPHQ, MHP, CLNC
Provider Network Management Director

Anthem®

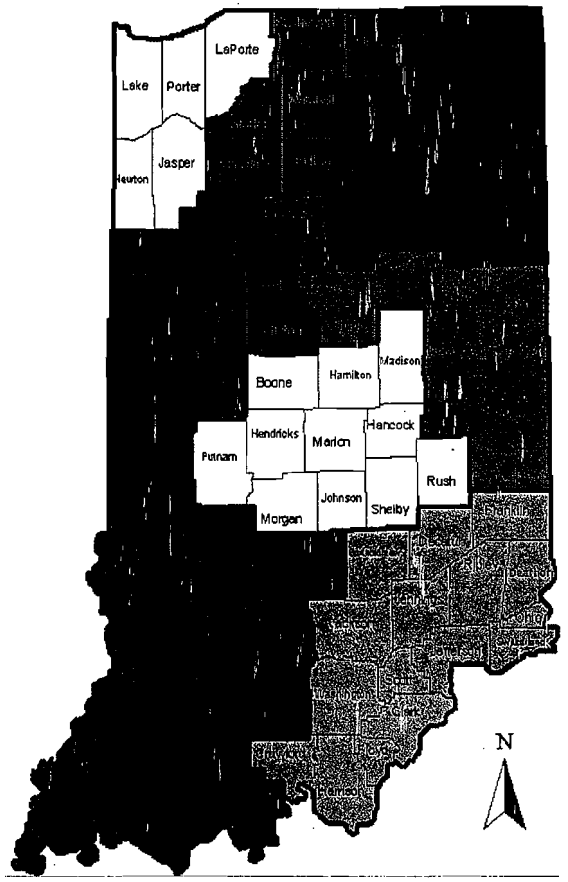
Anthem Enrolled Providers by Region

Region	PMPs	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist (Magellan network)	Urologist
East Central	62 1/170	65 1/162	30 1/351	22 1/479	52 1/203	10 1/1,054
Northeast	100 1/200	173 1/115	17 1/1,174	45 1/443	60 1/333	46 1/434
Southeast	110 1/177	104 1/187	39 1/500	37 1/527	87 1/224	61 1/319
West Central	54 1/152	29 1/284	21 1/392	3 1/2,745	31 1/266	14 1/588

The ratios above indicate one provider to X number of members.

Anthem.

Hoosier Healthwise Regions



1				5			8
Northwest Region	North Central Region	Northeast Region	West Central Region	Central Region	East Central Region	Southwest Region	Southeast Region

Anthem.

Anthem Claims Payment Timeliness – Physical Health

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	97.02%	99.21%
% Electronic Claims Paid Within 21 Days	99.30%	99.92%
% Denied	8.62%	14.06%

A UB-04 is a nationally recognized claim form for facility/institutional claims, for example hospital charges. A CMS 1500 is a nationally recognized claim form for professional service charges, for example physician services.

Anthem Top 10 Claims Denial Reasons – Physical Health

Facility (UB-04)	Professional (CMS 1500)
1. Members coverage terminated	1. Provider's NPI is not attested
2. Authorization is required	2. Members coverage terminated
3. Duplicate Claim	3. Duplicate Procedure
4. The provider is not eligible to perform the service billed	4. Services submitted exceed the filing limit
5. Services submitted exceed the filing limit	5. The provider is not eligible to perform the service billed
6. Not covered services; not member's Responsibility	6. Duplicate Claim
7. Authorization has been denied by Physician reviewer	7. Second (or subsequent) duplicate procedure on claim
8. Diagnosis inconsistent with patient's age/gender	8. Authorization is required
9. Consent form required	9. Not covered services; not member's Responsibility
10. Required Diagnosis not on claims (Pkg P, non pregnancy related services)	10. Authorization has been denied by Physician reviewer

Claims Payment Timeliness – Behavioral Health (Magellan, Anthem subcontractor)

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	100%	100%
% Electronic Claims Paid Within 21 Days	100%	100%
% Denied	4.80%	10.15%

A UB-04 is a nationally recognized claim form for facility/institutional claims, for example hospital charges. A CMS 1500 is a nationally recognized claim form for professional service charges, for example physician services.

Top 10 Claims Denial Reasons – Behavioral Health

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Clinical department denial	1. Patient not eligible
2. Duplicate expense previously considered	2. Duplicate , previously submitted and processed or still in process
3. Participating provider - No authorization on file	3. Participating provider - No authorization on file
4. Participating provider - bill received after timely filing limit	4. Duplicate expense previously considered
5. Medical expense resubmit	5. Non-participating provider - No authorization on file
6. Patient not eligible	6. NPI attestation needed
7. Coordination of benefits - Requested primary carrier's EOB	7. Participating provider - bill received after timely filing limit
8. Non covered Behavioral Health DX	8. Coordination of benefits - Requested primary carrier's EOB
9. Medicaid-NPI attestation needed	9. Non-participating provider - no out of network benefit
10. Non-participating provider - No authorization on file	10. Non covered Behavioral Health diagnosis

Select Joint Commission on Medicaid Oversight (SJCMO) Presentation

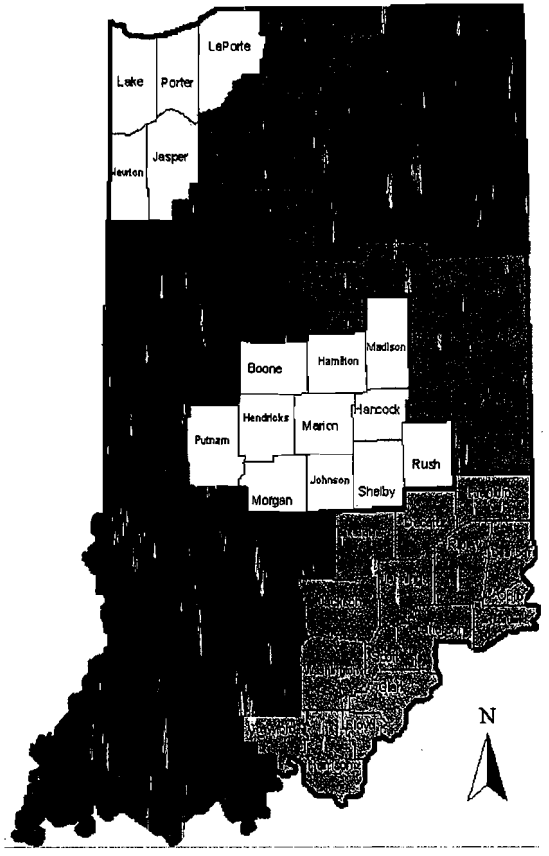
August 12, 2010

MCO Enrolled Providers By Region

Region	PMPs	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Northwest	243 1 / 169	121 1 / 339	41 1 / 1000	16 1 / 2564	59 1 / 695	20 1 / 2051
North Central	87 1 / 173	89 1 / 169	37 1 / 406	7 1 / 2149	36 1 / 418	18 1 / 836
Northeast	185 1 / 203	439 1 / 85	22 1 / 1704	22 1 / 1704	101 1 / 371	14 1 / 2678
West Central	124 1 / 194	61 1 / 395	28 1 / 861	5 1 / 4821	51 1 / 473	8 1 / 3013
Central	434 1 / 250	1888 1 / 58	382 1 / 284	237 1 / 458	268 1 / 405	144 1 / 754
East Central	113 1 / 230	212 1 / 123	32 1 / 812	21 1 / 1237	67 1 / 388	12 1 / 2165
Southwest	92 1 / 127	77 1 / 152	33 1 / 354	41 1 / 285	137 1 / 85	11 1 / 1063
Southeast	99 1 / 194	100 1 / 192	24 1 / 799	24 1 / 799	112 1 / 171	59 1 / 325

The ratios above indicate one provider to X number of members.

Hoosier Healthwise Regions



1				5			8
Northwest Region	North Central Region	Northeast Region	West Central Region	Central Region	East Central Region	Southwest Region	Southeast Region

Claims Payment Timeliness
Physical Health: January – June 2010

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	97%	99%
% Electronic Claims Paid Within 21 Days	98%	99%
% Denied	4%	5%

A UB-04 is a nationally recognized claim form for facility/institutional claims, for example hospital charges. A CMS 1500 is a nationally recognized claim form for professional service charges, for example physician services.

Top 10 Claims Denial Reasons
Physical Health : January – June 2010

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Incorrect Billing	1. Duplicate claim
2. Claim lacks information which is needed for adjudication	2. Claim lacks information which is needed for adjudication
3. Non-covered charges	3. Non-covered charges
4. Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	4. Service denied as care may be covered by another payer per coordination of benefits
5. Service denied as care may be covered by another payer per coordination of benefits	5. Coverage not in effect at the time the service was provided
6. Charges exceed fee schedule/maximum allowable	6. Incorrect Billing
7. Duplicate claim	7. Exceeds filing limit
8. Payment denied/reduced for absence of, or exceeded pre-certification/or authorization	8. Charges exceed fee schedule/maximum allowable
9. Coverage not in effect at the time the service was provided	9. Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
10. Exceeds filing limit	10. Payment denied/reduced for absence of, or exceeded pre-certification/or authorization

Incorrect billing denials are due to claims being submitted with invalid procedure codes, invalid revenue codes, unmatched procedure code/modifiers, invalid bill types, or an inconsistent diagnosis to procedure code.

Claims Payment Timeliness
Behavioral Health: January – June 2010

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	96%	99%
% Electronic Claims Paid Within 21 Days	97%	100%
% Denied	10%	6%

Top 10 Claims Denial Reasons
Behavioral Health: January – June 2010

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Claim lacks information which is needed for adjudication	1. Duplicate claim
2. Exceeds filing limit	2. Claim lacks information which is needed for adjudication
3. Payment denied/reduced for absence of, or exceeded pre-certification/or authorization	3. Exceeds filing limit
4. Service denied as care may be covered by another payer per coordination of benefits	4. Service denied as care may be covered by another payer per coordination of benefits
5. Duplicate claim	5. Coverage not in effect at the time the service was provided
6. Improper Billing	6. Payment denied/reduced for absence of, or exceeded pre-certification/or authorization
7. Non-covered charges	7. Incorrect Billing
8. Coverage not in effect at the time the service was provided	8. Non-covered charges
9. Benefit maximum for this time period has been reached	9. Benefit maximum for this time period has been reached
10. Payment adjusted because the benefit for this service is included in the payment/allowance for another service	10. Charges exceed fee schedule/maximum allowable

Incorrect billing denials are due to claims being submitted with invalid procedure codes, invalid revenue codes, unmatched procedure code/modifiers, invalid bill types, or an inconsistent diagnosis to procedure code.

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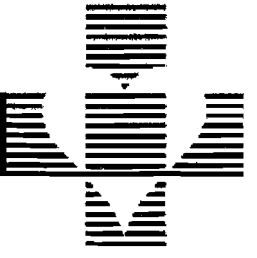
Select Joint Commission on Medicaid Oversight

August 12, 2010



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MCO Enrolled Providers By Region

Region	PMPs (Per Members)	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Northwest	139 1/188	39 1/670	8 1/3,270	6 1/4,360	32 1/817	10 1/2,616
North Central	167 1/236	39 1/1,014	45 1/879	11 1/3,597	49 1/807	15 1/2,638
Northeast	115 1/186	37 1/580	15 1/1,432	25 1/859	35 1/618	8 1/2,685
West Central	85 1/158	26 1/518	15 1/898	7 1/1,925	22 1/612	5 1/2,696
Central	283 1/178	123 1/411	43 1/1,176	43 1/1,176	126 1/401	54 1/937
East Central	88 1/290	44 1/580	24 1/1,063	13 1/1,963	55 1/464	7 1/3,646
Southwest	83 1/168	18 1/777	23 1/608	9 1/1,555	68 1/205	20 1/699
Southeast	78 1/216	12 1/1,408	21 1/804	11 1/1,536	55 1/307	15 1/1,126

The ratios above indicate one provider to X number of members.

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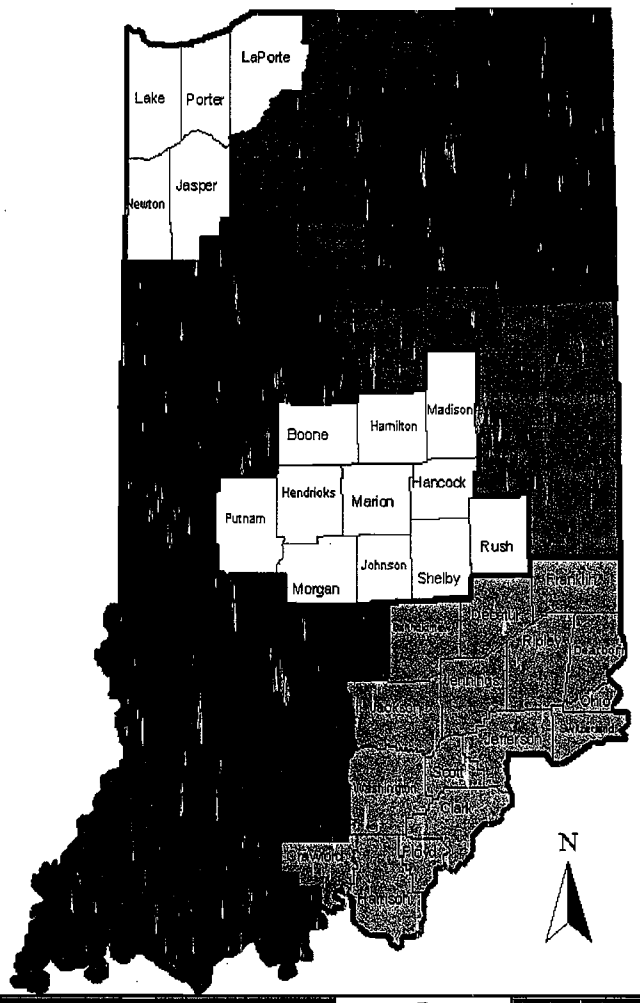
Hoosier Healthwise Regions



1	2	3	4	5	6	7	8
Northwest Region	North Central Region	Northeast Region	West Central Region	Central Region	East Central Region	Southwest Region	Southeast Region

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Claims Payment Timeliness – Physical Health

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	98.44%	98.99%
% Electronic Claims Paid Within 21 Days	99.70%	99.86%
% Denied	6.84%	8.97%

A UB-04 is a nationally recognized claim form for facility/institutional claims, for example hospital charges. A CMS 1500 is a nationally recognized claim form for professional service charges, for example physician services.

All claim payment figures are Q1 and Q2 2010

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Top 10 Claims Denial Reasons – Physical Health

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. AUTHORIZATION NOT ON FILE	1. THE TIME LIMIT FOR FILING HAS EXPIRED
2. THE TIME LIMIT FOR FILING HAS EXPIRED	2. BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB
3. BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB	3. AUTHORIZATION NOT ON FILE
4. NON COVERED SERVICE FOR PACKAGE B MEMBER	4. COVERAGE NOT IN EFFECT ON DATE OF SERVICE
5. COVERAGE NOT IN EFFECT ON DATE OF SERVICE	5. NON COVERED SERVICE FOR PACKAGE B MEMBER
6. NOT A MCO COVERED BENEFIT	6. THIS IS NOT A VALID MODIFIER FOR THIS CODE
7. CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING	7. CODE WAS DENIED BY CODE AUDITING SOFTWARE
8. DENIED BY MEDICAL SERVICES	8. MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH, PLEASE RESUBMIT
9. MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH, PLEASE RESUBMIT	9. CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING
10. PLEASE RESUBMIT TO CENPATICO FOR CONSIDERATION	10. PLEASE RESUBMIT TO CENPATICO FOR CONSIDERATION

All claim payment figures are Q1 and Q2 2010

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Claims Payment Timeliness – Behavioral Health

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	98.15%	99.57%
% Electronic Claims Paid Within 21 Days	99.63%	99.74%
% Denied	7.38%	11.48%

A UB-04 is a nationally recognized claim form for facility/institutional claims, for example hospital charges. A CMS 1500 is a nationally recognized claim form for professional service charges, for example physician services.

All claim payment figures are Q1 and Q2 2010

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Top 10 Claims Denial Reasons – Behavioral Health

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. DUPLICATE CLAIM/SERVICE	1. DUPLICATE CLAIM/SERVICE
2. REVENUE CODE CAN ONLY BE BILED ONCE PER DAY	2. BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB
3. THE TIME LIMIT FOR FILING HAS EXPIRED	3. BENEFIT LIMIT FOR SERVICES WITHOUT AN AUTHORIZATION HAS BEEN MET
4. COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED	4. COVERAGE NOT IN EFFECT ON DATE OF SERVICE
5. BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB	5. SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT
6. PLEASE RESUBMIT TO THE MEDICAL PLAN FOR CONSIDERATION	6. THE TIME LIMIT FOR FILING HAS EXPIRED
7. AUTHORIZATION NOT ON FILE	7. AUTHORIZATION NOT ON FILE
8. DISCHARGE PLANNING SERVICE NEEDS TO BE BILLED WITH THE INPATIENT STAY	8. BENEFIT MAXIMUM HAS BEEN REACHED
9. CLAIM AND AUTH TREATMENT TYPE NOT MATCHING	9. PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY
10. DENIED BY MEDICAL SERVICES	10. NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT

All claim payment figures are Q1 and Q2 2010

Indiana Health Coverage Programs

Update to Select Joint Commission on Medicaid Oversight

August 12, 2010

Indiana Health Coverage Programs

Volume Statistics, July 2006 through June 2010

	SFY 2007 Jul '06 – Jun '07	SFY 2008 Jul '07 – Jun '08	SFY 2009 Jul '08 – Jun '09	SFY 2010 Jul '09 – Jun '10
Dollars Paid [a]	$5,357,600,000	$6,427,600,000	$5,640,700,000	$6,136,400,000
Claims				
Risk Based Managed Care[b]	9,967,211	17,609,333	15,080,731	15,242,671
# Fee-for Svc Paid Claims [c]	28,369,602	28,591,064	29,590,516	35,474,838
# Fee-for Svc Denied Claims	15,244,816	15,231,873	13,978,353	15,684,009
% FFS Paid	65.0	65.2	67.9	69.3
FFS Adjudication Days [d]	2.6	2.5	2.3	2.4
Providers – MCO & FFS Enrolled [e]	50,561	51,610	52,456	46,669
Recipients at End of Period				
Enrolled (Medicaid)	866,387	892,058	965,853	1,028,746
Enrolled (HIP)	n/a	12,933	44,621	46,219
Total Enrolled	866,387	904,991	1,010,474	1,074,965

a. Increase from SFY 2007 to SFY 2008 due to disproportionate share and upper payment limit accelerated payment schedule for 2006, 2007, and 2008. SFY 2007 through SFY 2010 reflect adjusted auditor of state values.
b. Increase in RBMC claims from SFY07 to SFY08 is due to FSSA directive requiring MCOs to submit all encounter claim data to the MMIS.
c. Increase in fee for service claims from SFY 2009 to SFY 2010 is result of HP processing MCO pharmacy claims, beginning January 2010.
d. Adjudication is the number of days from submission to payment determination. Payment occurs in the next available weekly payment run.
e. Figures include all provider types who were enrolled at any time during the state fiscal year. Enrollment decrease from June '09 to June '10 is due to the October 09 implementation of automatic termination of providers who have not submitted claims for 18 months.

Indiana Health Coverage Programs

SFYTD 2010 Claim Statistics (July 2009 – June 2010)

Top 2 Hard Denial Reasons

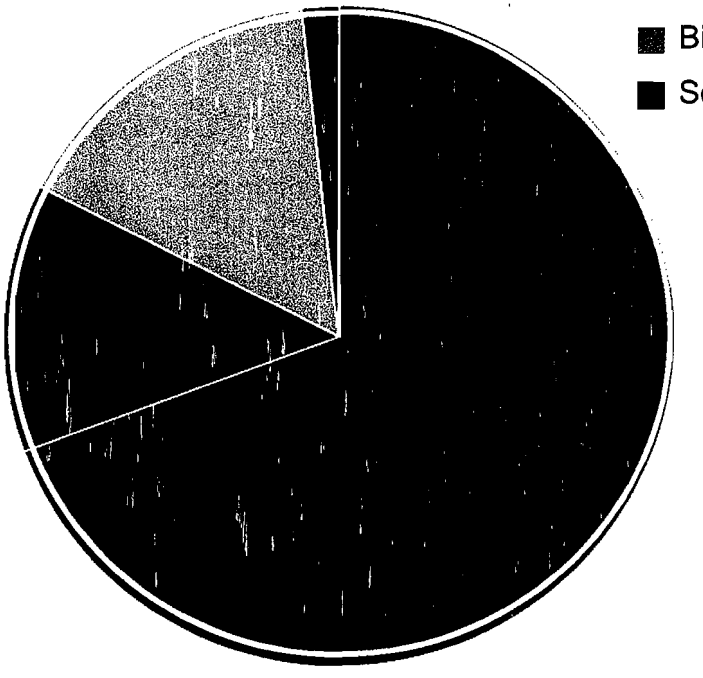
- Other insurance related denials
- Recipient eligibility related denials

Top 2 Billing Error Reasons

- Missing coinsurance and deductible
- Duplicate billing

Top 2 Service Verification Reasons

- Prospective Drug Utilization Review (ProDUR) related
- National Drug Code vs. days supply



Indiana Health Coverage Programs

Operational Statistics (April 2010 – June 2010)

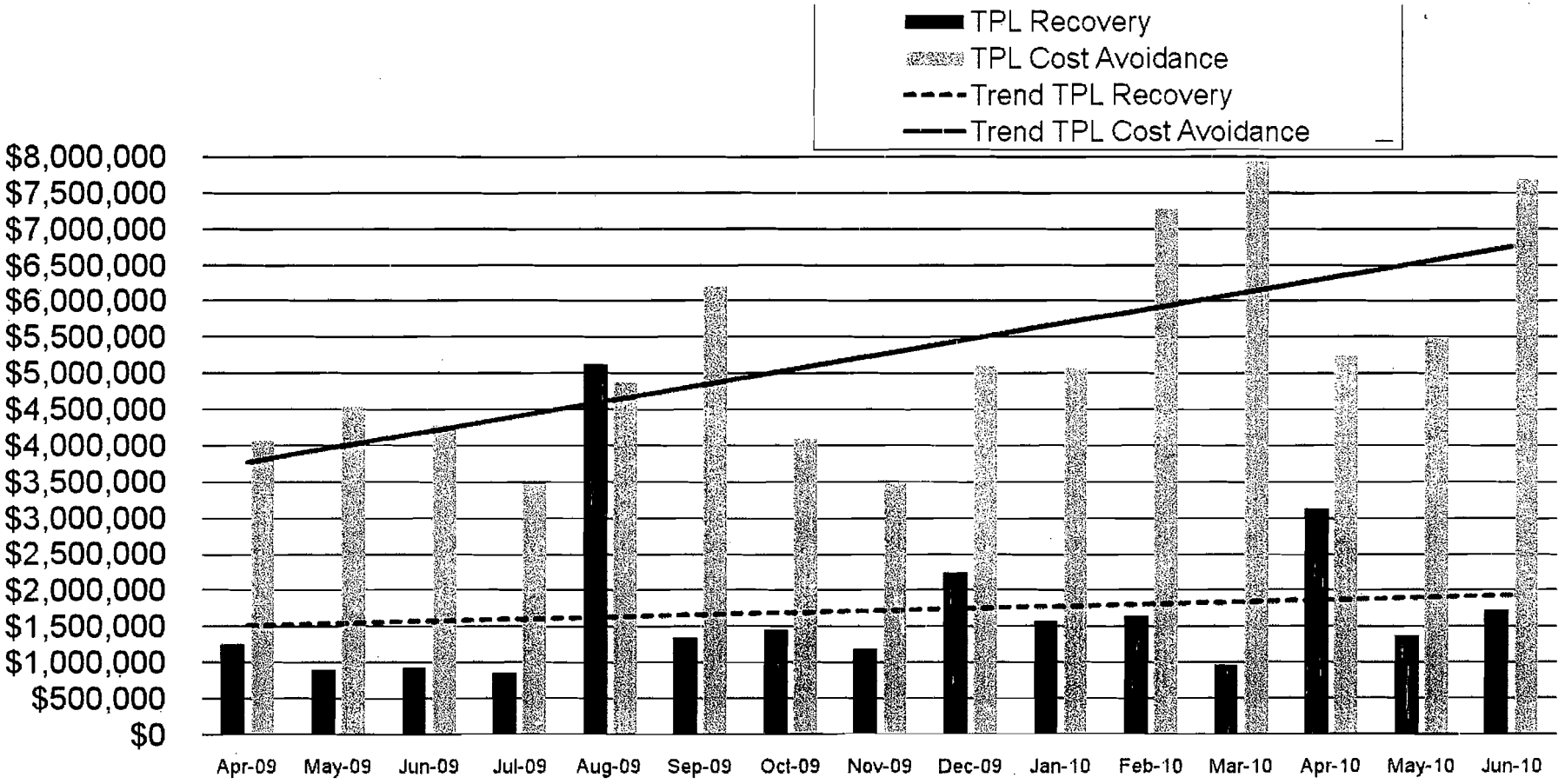
Operational Area	Apr-Jun 2010
Claims Volume	
Fee-for Service (FFS) Electronic	8,287,679
Fee-for Service (FFS) Paper	723,959
Pharmacy	5,736,851
Risk Based Managed Care (RBMC)	3,103,861
Total Claims	17,852,350
Web Claim Volume (included above)	858,091
Percent Electronic Claims	95.9%
Call Center	
Provider Calls	58,755
Recipient Calls	31,657
Total Calls	90,412
Automated Voice Response	148,971
Percent Automated Calls	62.2%
New FFS Provider Enrollments	1,395
Written Correspondence	1,829

Operational Area	Apr-Jun 2010
Claims Inventories: Jun '10 Month End	
Suspended for Manual Adjudication	14,944
Received, Awaiting Data Entry	23,444
Received, Awaiting Attachment	2,204
Total Claims in Inventory	40,592
Publications	
Bulletins	12
Banners	13
Newsletters	3
System Availability	
Indiana*AIM* (23 hours/day)	100.0%
Automated Voice Response (98%)	100.0%
OMNI – eligibility (23 hours/day)	100.0%
Response Time (Inquiry <= 3 sec)	0.01
Response Time (Update <= 3 sec)	0.09

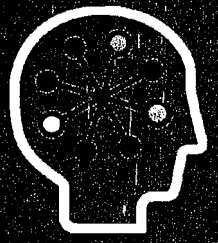
(Numbers in parentheses are contractual required minimums/maximums)

Indiana Health Coverage Programs

Third Party Liability Savings, April 2009 – June 2010)



- August 2009 higher than average recovery figure is due to Medicare A/B disallowance recoveries.
- February and March 2010 increased avoidance is the result of HP processing and cost avoiding MCO pharmacy claims, beginning January 2010.
- September 2009 and June 2010 were five weeks months, which resulted in more days with cost avoidance being counted.



Technology for better business outcomes

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May 21, 2010

Ms. Anne W. Murphy
Secretary
State of Indiana
Family and Social Services Administration
402 W. Washington Street
Indianapolis, IN 46204

RE: PATIENT PROTECTION AND AFFORDABLE CARE ACT WITH HOUSE RECONCILIATION – FINANCIAL ANALYSIS – BUDGET COMMITTEE REQUEST

Dear Secretary Murphy:

Milliman, Inc. (Milliman) has been retained by the State of Indiana, Family and Social Services Administration to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act (Act) as it relates to the provisions impacting the State's Medicaid program and budget. Milliman provided our initial analysis in a December 3, 2009 letter. Milliman's May 6, 2010 letter presented an update to the fiscal analysis to reflect the provisions of the House Reconciliation Bill (Bill) using a full participation assumption.

This letter has been prepared at the request of the state legislative budget committee to modify the May 6th analysis to include a range of fiscal results based on differing participation assumptions.

SUMMARY OF RESULTS

Milliman has developed an estimate of the enrollment and fiscal impact associated with the Medicaid expansion and other related provisions of the Patient Protection and Affordable Care Act and House Reconciliation Bill. We have updated our fiscal analysis to reflect the state impact for state fiscal years 2011 through 2020, as well as a range of results based on estimated participation rates.

Enclosures 1 and 2 provide the fiscal impact results of the Medicaid Assistance expansion under an alternate participation scenario (Enclosure 1) and a full participation scenario (Enclosure 2). The total fiscal impact to the State of Indiana budget during the next 10 years would be estimated to be in the range of approximately $2.9 billion to $3.6 billion. Table 1 illustrates the anticipated expenditure impacts to the State of Indiana budget for the period of SFY 2011 through SFY 2020. Note, we have modified the analysis period to coincide to State Fiscal Years rather than Federal Fiscal Years.

Table 1

State of Indiana
Family and Social Services Administration
Patient Protection and Affordable Care Act and House Reconciliation Bill

State Budget Fiscal Impact – SFY 2011 through SFY 2020

Item	Alternate Participation	Full Participation
Medicaid Assistance Expansion to 138%	$972.4 million	$1,330.3 million
Impact of Reduced FMAP on HIP Eligibles	482.5 million	482.5 million
Spend-down and SSI Eligible	575.8 million	575.8 million
Pharmacy Rebate Loss	298.0 million	298.0 million
Physician Fee Schedule Increase to 80% Medicare	600.1 million	831.8 million
Foster Children – Expansion to Age 26	14.8 million	14.8 million
Administrative Expenses	232.5 million	302.5 million
CHIP Program – Enhanced FMAP	(195.2) million	(195.2) million
Breast and Cervical Cancer Program	(14.2) million	(14.2) million
Pregnant Women > 138% FPL	(46.8) million	(46.8) million
Total	$2,919.8 million	$3,579.4 million

The results of our analysis are highlighted below, as well as additional detail information regarding enrollment and other key assumptions.

Current Medicaid and CHIP Enrollment – Projected SFY 2010 Average Monthly Enrollment

- Medicaid 930,000
- CHIP 79,000
- Healthy Indiana Plan 56,000
- Total 1,065,000

Estimated Medicaid Enrollment under Patient Protection and Affordable Care Act

- Alternate Participation Scenario - Increase in Medicaid enrollment reflecting 138% FPL limit:
  - 302,000 Adults: This reflects 195,000 Parents and Childless Adults that are uninsured and 107,000 that are currently insured through employer or other insurance.
  - 86,000 Children: This reflects 32,000 Children that are currently uninsured and 54,000 with insurance coverage.

- Full Participation Scenario - Increase in Medicaid enrollment reflecting 138% FPL limit:
  - 413,000 Adults: This reflects 237,000 Parents and Childless Adults that are uninsured and 176,000 that are currently insured through employer or other insurance.
  - 109,000 Children: This reflects 37,000 Children that are currently uninsured and 72,000 with insurance coverage.

The alternate participation scenario includes participation assumptions as noted below.

- Milliman assumed the following participation rates:
  - 75% for Insured Parents and Children
  - 85% for Uninsured Parents and Children
  - 50% for Insured Adults
  - 80% for Uninsured Adults

Participation rates for the uninsured are consistent with other independent analyses performed of the Medicaid Health Care Reform legislation. The participation rates for the insured were based on a review of the Children population participation and Parent and Childless Adult applications submitted for the Healthy Indiana Plan.

Additionally, the participation rates were reviewed for consistency with participation in the Medicare program which exceeds 95% and the Medicaid/CHIP programs for children which exceeds 85%. Actual participation in the Medicaid program after the expansion may exceed the participation rates noted in these other programs, since there will be an individual mandate for health insurance coverage under federal health care reform legislation.

- Increase Medicaid enrollment for the SSI eligible that are not currently eligible for Indiana Medicaid program by approximately 23,100 lives
- The Reconciliation Bill would maintain the CHIP program while receiving enhanced funding for October 2015 through September 2019
- Move 50,000 Healthy Indiana Plan enrollees to Medicaid (included in Adult assumptions identified above)
- Total Medicaid enrollment would increase to 1,420,100 under the alternate participation scenario or 1,554,100 under the full participation scenario

Percentage increase in Medicaid in relation to the total number of Hoosiers

- Calendar Year 2008 Indiana Census Estimate 6,377,000
- Increase would be approximately 5.6% (alternate participation) or 7.7% (full participation) more Hoosiers on Medicaid
- Increase from 16.7% to 22.3% (alternate participation) or 24.4% (full participation) - or nearly 1 in 4 Hoosiers
- Note, Milliman utilized population statistics prior to the full impact of the recession in the State of Indiana. While we have allowed for long-term growth rates in the population below the 138% FPL eligibility threshold, the actual population that will qualify due to the income threshold may be greater in 2014 depending on the impact of the economic recovery.

The remainder of this letter discusses each of the components shown in Table 1.

a. Medicaid Assistance Expansion to 138% FPL

The fiscal impact associated the Parent and Adult expansion to 138% includes both currently insured and uninsured individuals below the 138% FPL amount and children not currently covered under Medicaid, who are also below the 138% FPL. The 138% FPL reflects the 133% FPL indicated in the Act with the additional 5% allowance. The analysis presented in this report reflects modified participation assumptions.

Note, in prior analysis, the estimated fiscal impact reflected an offsetting savings associated with the current costs of the Healthy Indiana Plan. Under the scenario presented in this letter, the fiscal impact assumes that the Healthy Indiana Plan (HIP) will be terminated on December 31, 2012. Therefore, there are no savings associated with the termination of HIP.

The Bill reflects the following Federal Medical Assistance Percentages (FMAP) for the expansion populations.

- 100% FMAP in CY 2014, 2015, and 2016
- 95% FMAP in CY 2017
- 94% FMAP in CY 2018
- 93% FMAP in CY 2019
- 90% FMAP in CY 2020+

We have also illustrated the additional impact of the reduced FMAP on HIP eligibles. Although Indiana is not an early expansion state, CMS has informally indicated that the standard FMAP will apply to the first 36,500 expansion enrollees.

Milliman has not included any fiscal impact associated with the potential for some children to move from the higher enhanced federal match rate under CHIP to the standard federal match rate under Medicaid. Due to the new coverage provisions, movement between these populations may occur. This has not been included in our fiscal analysis.

b. Spend-down and SSI Eligible Populations

Currently, the State of Indiana performs the disability eligibility determination. In addition to the disability determination, Indiana provides eligibility on a spend-down basis. It is anticipated that Indiana would need to modify the eligibility provision for the disabled population and convert to SSI eligibility standards. Milliman has estimated an additional 23,100 lives would be enrolled in the program with this expansion. Additionally, approximately 75% of individuals currently classified as spend-down would convert to full Medicaid eligibility due to the increase to 138% FPL standard. The expenditures associated with the modification reflect an offset due to savings associated with the current spend-down eligible above 138% FPL.

c. Pharmacy Rebate Modifications

The Senate bill includes increasing the brand name and generic rebates. The bill indicates that the impact will be accrued 100% to the Federal government. The State of Indiana has estimated that this could reduce the State's rebates by up to 25% beginning on January 1, 2010. With the implementation timing

of the pharmacy consolidation program, it is anticipated that the rebate loss would be limited to 25% of the projected pharmacy rebates. This would include a loss on both fee-for-service enrollees and managed care enrollees. The revised fiscal impact of $298.0 million is below our prior analysis of $400 million due to the modification of the assumption related to HIP and other assumption modifications. The previous analysis included loss of rebates on the HIP program, as well. However, the updated analysis assumed termination of the HIP program as of January 1, 2013. This has reduced the fiscal associated with the pharmacy rebate loss.

d. Increase Physician Fee Schedule to 80% of Medicare Physician Fee Schedule

The current Indiana Medicaid fee schedule reimburses at approximately 60% to 65% of the Medicare fee schedule. It would be anticipated that OMPP would need to increase the physician fee schedule to assure access to physician care. We have estimated that the minimum increase for physicians would be to 80% of the current Medicare fee schedule. The House Reconciliation Bill includes 100% Federal funding to increase primary care physician reimbursement to 100% of Medicare for a limited set of primary and preventive care services. However, the 100% Federal funding is only available for 2013 and 2014. No additional funding is available for other physician specialists or the full set of physician services.

The increased cost would be an additional $300 to $350 million per year for the current Medicaid program and expansion populations. The increased cost would be estimated at $2.2 billion (State and Federal) or $0.6 billion (State only) for the period beginning on January 1, 2014.

As a point of further discussion with regard to access, physicians will be concerned with reimbursement due to the scheduled 21% reduction to the Medicare physician fee schedule beginning on June 1, 2010. With the significant reduction in the Medicare physician fee schedule, an increase in the Medicaid fee schedule will become even more important to assure access to care.

e. Foster Children Expansion to Age 26

Indiana currently provides Medicaid eligibility coverage to Foster Children to age 21. The Health Care Reform bill with House Reconciliation includes mandatory coverage for Foster Children to age 26 beginning on January 1, 2014. The annual cost has been estimated at $6.5 million per year (State and Federal) or $2.3 million per year (State only).

f. Administrative Expenditures

In addition to the expenditures associated with providing medical services, the State of Indiana will incur additional administrative expenditures. The expenditures for the initial modifications to the current administrative systems, as well as establishment of an Exchange, are estimated to be $80 million (State and Federal) or $40 million (State only). On-going costs for the coverage of the additional 388,000 enrollees are estimated to be $55 million per year (State and Federal) or $27.5 million per year (State only). The on-going costs were developed assuming approximately $150 per recipient per year or approximately 3.75% of total expected medical expenditures. Based on my experience with Medicaid programs, the state Medicaid administrative costs range from 3.5% to 6.0% of the total medical costs. The administrative expenses would be anticipated to be incurred in 2012 and 2013 for the initial administrative expenditures and in 2014 forward for the on-going expenditures.

g. CHIP Program Enhanced FMAP

Under the Health Care Reform bill with House Reconciliation, the CHIP program is required to continue to 2019. However, the legislation provides additional Federal matching rate of 23% beginning on October 1, 2015 and ending September 30, 2019. The additional 23% FMAP will increase the total FMAP for the CHIP program to approximately 99.57%. The enhanced FMAP will decrease expenditures for Indiana and increase expenditures for the Federal share.

h. Breast and Cervical Cancer Program

The State of Indiana currently provides eligibility under the Breast and Cervical Cancer program. The total annual expenditures under the program are approximately $7.0 million (State and Federal) or $1.7 million (State only). It is not anticipated that this program will be required to be continued with the expansion requirements below 138% FPL and insurance reforms for individuals above 138% FPL. Therefore, we have estimated that this program may be terminated beginning on January 1, 2014; although, some of these individuals will become eligible under the new Medicaid eligibility requirements.

i. Pregnant Women above 138% FPL

The State of Indiana currently provides eligibility for pregnant women up to 200% FPL. As with the Breast and Cervical Cancer Program, it would be anticipated that the pregnant women between 138% FPL and 200% FPL will have access to care through the insurance exchange. We have estimated that 9.5% of the current expenditures for the pregnant women population will no longer be incurred by the Indiana Medicaid program. We have estimated the annual savings to be approximately $18.5 million (State and Federal) per year or $6.2 million (State only) per year beginning on January 1, 2014.

j. Premium Assistance Program

The fiscal analysis did not consider the implementation of a premium assistance program which is required under Federal Health Care Reform. The implementation of a premium assistance program may be expected to increase the fiscal analysis results presented in this report.

KEY ASSUMPTIONS

- Medicaid Expansion up to 138% FPL including Adults, Parents, Children, and Disabled.
- Implementation of expansion on January 1, 2014.
- Assumed that Indiana would cover all individuals eligible for SSI disability at the standard FMAP.
- Healthy Indiana Plan would be discontinued on January 1, 2013.
- Assumed that the current spend-down population for the Aged, Blind and Disabled eligibility categories below 138% FPL would be converted to full benefit Medicaid. Assumed that the spend-down population above 138% FPL would be transferred to the insurance exchange.

LIMITATIONS

The information contained in this correspondence, including any enclosures, has been prepared for the State of Indiana, Family and Social Services Administration, related Divisions, and their advisors. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for FSSA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by FSSA and its vendors. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data. The data and information included in the report has been developed to assist in the analysis of the financial impact of Indiana Medicaid Assistance expenditures. The data and information presented may not be appropriate for any other purpose. It should be emphasized that the results presented in this correspondence are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter.

If you have any questions or comments regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures

Milliman

ENCLOSURE 1

STATE OF INDIANA
Family and Social Services Administration
Health Care Reform Projection - Senate Bill with House Reconciliation
Alternate Participation Scenario
(Values in Millions)

5/21/2010
10:22 AM

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY2020
Medicaid											
Total (State and Federal)	$6,723.8	$7,024.6	$7,341.1	$7,674.2	$8,025.0	$8,394.5	$8,783.7	$9,193.9	$9,626.2	$10,082.1	$82,869.2
Federal Funds	$4,463.3	$4,673.4	$4,884.0	$5,105.7	$5,339.1	$5,584.9	$5,843.8	$6,116.7	$6,404.3	$6,707.6	$55,122.8
State Funds	$2,260.5	$2,351.1	$2,457.1	$2,568.6	$2,686.0	$2,809.6	$2,939.9	$3,077.2	$3,221.9	$3,374.5	$27,746.4
CHIP											
Total (State and Federal)	$142.8	$151.4	$160.5	$170.1	$180.3	$191.1	$202.6	$214.8	$227.7	$241.3	$1,882.6
Federal Funds	$109.2	$115.9	$122.9	$130.3	$138.1	$146.4	$155.1	$164.4	$174.3	$184.8	$1,441.4
State Funds	$33.6	$35.5	$37.6	$39.9	$42.2	$44.8	$47.5	$50.3	$53.3	$56.5	$441.2
Healthy Indiana Plan											
Total (State and Federal)	$314.3	$355.5	$195.7	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$865.5
Federal Funds	$208.7	$236.5	$130.2	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$575.3
State Funds	$105.7	$119.0	$65.5	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$290.2
All Programs											
Total (State and Federal)	$7,180.9	$7,531.4	$7,697.2	$7,844.4	$8,205.4	$8,585.6	$8,986.3	$9,408.7	$9,853.9	$10,323.4	$85,617.3
Federal Funds	$4,781.1	$5,025.9	$5,137.1	$5,235.9	$5,477.1	$5,731.2	$5,999.0	$6,281.1	$6,578.6	$6,892.4	$57,139.5
State Funds	$2,399.8	$2,505.6	$2,560.2	$2,608.4	$2,728.2	$2,854.4	$2,987.4	$3,127.5	$3,275.2	$3,431.0	$28,477.8
Parents / Adults Expansion (< 138% FPL)											
Total (State and Federal) - Children	$0.0	$0.0	$0.0	$103.4	$219.1	$232.3	$246.2	$261.0	$276.6	$293.2	$1,631.8
Total (State and Federal) - Parents / Adults	$0.0	$0.0	$0.0	$744.4	$1,578.1	$1,672.8	$1,773.2	$1,879.6	$1,992.3	$2,111.9	$11,752.2
Federal Funds	$0.0	$0.0	$0.0	$780.8	$1,655.2	$1,754.5	$1,821.2	$1,881.5	$1,977.0	$2,058.9	$11,929.2
State Funds - Full Population Enhanced FMAP	$0.0	$0.0	$0.0	$32.4	$68.7	$72.8	$121.9	$186.1	$217.4	$273.0	$972.4
State Funds - Impact of Reduced FMAP on HIP Eligible	$0.0	$0.0	$0.0	$34.6	$73.3	$77.7	$76.2	$73.0	$74.6	$73.2	$482.5
Spend-down and SSI Eligible											
Total (State and Federal)	$0.0	$0.0	$0.0	$107.2	$228.4	$243.2	$259.0	$275.8	$293.8	$312.9	$1,720.3
Federal Funds	$0.0	$0.0	$0.0	$71.3	$151.9	$161.8	$172.3	$183.5	$195.5	$208.2	$1,144.5
State Funds	$0.0	$0.0	$0.0	$35.9	$76.4	$81.4	$86.7	$92.3	$98.3	$104.7	$575.8

STATE OF INDIANA
Family and Social Services Administration
Health Care Reform Projection - Senate Bill with House Reconciliation
Alternate Participation Scenario
(Values in Millions)

5/21/2010
10:22 AM

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY2020
Loss of Pharmacy Rebates (State only)											
Total Impact (State and Federal)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	($22.8)	($24.6)	($25.0)	($25.3)	($27.3)	($29.5)	($31.8)	($34.4)	($37.1)	($40.1)	($298.0)
State Funds	$22.8	$24.6	$25.0	$25.3	$27.3	$29.5	$31.8	$34.4	$37.1	$40.1	$298.0
CHIP Program (Enhanced FMAP)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$33.0	$46.6	$49.4	$52.4	$13.9	$195.2
State Funds	$0.0	$0.0	$0.0	$0.0	$0.0	($33.0)	($46.6)	($49.4)	($52.4)	($13.9)	($195.2)
Breast & Cervical Cancer	$0.0	$0.0	$0.0	($4.0)	($8.4)	($8.8)	($9.2)	($9.6)	($10.1)	($10.6)	($60.8)
Federal Funds	$0.0	$0.0	$0.0	($3.1)	($6.4)	($6.7)	($7.1)	($7.4)	($7.7)	($8.1)	($46.6)
State Funds	$0.0	$0.0	$0.0	($0.9)	($2.0)	($2.1)	($2.2)	($2.3)	($2.4)	($2.5)	($14.2)
Pregnant Women (>138%)	$0.0	$0.0	$0.0	($9.3)	($19.4)	($20.3)	($21.2)	($22.2)	($23.2)	($24.3)	($139.8)
Federal Funds	$0.0	$0.0	$0.0	($6.2)	($12.9)	($13.5)	($14.1)	($14.8)	($15.5)	($16.2)	($93.0)
State Funds	$0.0	$0.0	$0.0	($3.1)	($6.5)	($6.8)	($7.1)	($7.4)	($7.8)	($8.1)	($46.8)
Phys Fee Schedule Inc (80% Medicare)	$0.0	$0.0	$0.0	$144.3	$301.8	$315.7	$330.4	$345.8	$362.0	$379.2	$2,179.3
Federal Funds	$0.0	$0.0	$0.0	$105.7	$221.0	$231.2	$240.3	$249.4	$260.4	$271.2	$1,579.1
State Funds	$0.0	$0.0	$0.0	$38.6	$80.8	$84.5	$90.1	$96.4	$101.6	$108.0	$600.1
Foster Children Increase	$0.0	$0.0	$0.0	$3.3	$6.5	$6.5	$6.5	$6.5	$6.5	$6.5	$42.3
Federal Funds	$0.0	$0.0	$0.0	$2.1	$4.2	$4.2	$4.2	$4.2	$4.2	$4.2	$27.5
State Funds	$0.0	$0.0	$0.0	$1.1	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$14.8
Administrative Expenses	$0.0	$40.0	$40.0	$55.0	$55.0	$55.0	$55.0	$55.0	$55.0	$55.0	$465.0
Federal Funds	$0.0	$20.0	$20.0	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$232.5
State Funds	$0.0	$20.0	$20.0	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$27.5	$232.5
All Programs - After Expansion											
Total (State and Federal)	$7,180.9	$7,571.4	$7,737.2	$8,988.6	$10,566.5	$11,082.1	$11,626.2	$12,200.5	$12,806.9	$13,447.1	$103,207.5
Federal Funds	$4,758.4	$5,021.3	$5,132.1	$6,188.8	$7,490.4	$7,893.7	$8,258.1	$8,620.1	$9,035.3	$9,411.8	$71,809.9
State Funds	$2,422.6	$2,550.2	$2,605.2	$2,799.8	$3,076.1	$3,188.3	$3,368.1	$3,580.4	$3,771.6	$4,035.3	$31,397.6
All Programs - Fiscal Impact											
Total (State and Federal)	$0.0	$40.0	$40.0	$1,144.2	$2,361.1	$2,496.4	$2,639.8	$2,791.8	$2,953.0	$3,123.8	$17,590.2
Federal Funds	($22.8)	($4.6)	($5.0)	$952.9	$2,013.3	$2,162.5	$2,259.1	$2,339.0	$2,456.6	$2,519.5	$14,670.4
State Funds	$22.8	$44.6	$45.0	$191.4	$347.9	$333.9	$380.7	$452.9	$496.3	$604.3	$2,919.8

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ENCLOSURE 2

STATE OF INDIANA
Family and Social Services Administration
Health Care Reform Projection - Senate Bill with House Reconciliation
Full Participation Scenario
(Values in Millions)

5/21/2010
10:22 AM

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY2020
Medicaid											
Total (State and Federal)	$6,723.8	$7,024.6	$7,341.1	$7,674.2	$8,025.0	$8,394.5	$8,783.7	$9,193.9	$9,626.2	$10,082.1	$82,869.2
Federal Funds	$4,463.3	$4,673.4	$4,884.0	$5,105.7	$5,339.1	$5,584.9	$5,843.8	$6,116.7	$6,404.3	$6,707.6	$55,122.8
State Funds	$2,260.5	$2,351.1	$2,457.1	$2,568.6	$2,686.0	$2,809.6	$2,939.9	$3,077.2	$3,221.9	$3,374.5	$27,746.4
CHIP											
Total (State and Federal)	$142.8	$151.4	$160.5	$170.1	$180.3	$191.1	$202.6	$214.8	$227.7	$241.3	$1,882.6
Federal Funds	$109.2	$115.9	$122.9	$130.3	$138.1	$146.4	$155.1	$164.4	$174.3	$184.8	$1,441.4
State Funds	$33.6	$35.5	$37.6	$39.9	$42.2	$44.8	$47.5	$50.3	$53.3	$56.5	$441.2
Healthy Indiana Plan											
Total (State and Federal)	$314.3	$355.5	$195.7	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$865.5
Federal Funds	$208.7	$236.5	$130.2	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$575.3
State Funds	$105.7	$119.0	$65.5	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$290.2
All Programs											
Total (State and Federal)	$7,180.9	$7,531.4	$7,697.2	$7,844.4	$8,205.4	$8,585.6	$8,986.3	$9,408.7	$9,853.9	$10,323.4	$85,617.3
Federal Funds	$4,781.1	$5,025.9	$5,137.1	$5,235.9	$5,477.1	$5,731.2	$5,999.0	$6,281.1	$6,578.6	$6,892.4	$57,139.5
State Funds	$2,399.8	$2,505.6	$2,560.2	$2,608.4	$2,728.2	$2,854.4	$2,987.4	$3,127.5	$3,275.2	$3,431.0	$28,477.8
Parents / Adults Expansion (< 138% FPL)											
Total (State and Federal) - Children	$0.0	$0.0	$0.0	$131.8	$279.4	$296.2	$314.0	$332.8	$352.8	$373.9	$2,081.0
Total (State and Federal) - Parents / Adults	$0.0	$0.0	$0.0	$1,033.0	$2,190.0	$2,321.4	$2,460.6	$2,608.3	$2,764.8	$2,930.7	$16,308.7
Federal Funds	$0.0	$0.0	$0.0	$1,086.1	$2,302.6	$2,440.7	$2,531.8	$2,613.3	$2,745.2	$2,857.2	$16,576.9
State Funds - Full Population Enhanced FMAP	$0.0	$0.0	$0.0	$44.1	$93.5	$99.1	$166.6	$254.8	$297.8	$374.3	$1,330.3
State Funds - Impact of Reduced FMAP on HIP Eligible	$0.0	$0.0	$0.0	$34.6	$73.3	$77.7	$76.2	$73.0	$74.6	$73.2	$482.5
Spend-down and SSI Eligible											
Total (State and Federal)	$0.0	$0.0	$0.0	$107.2	$228.4	$243.2	$259.0	$275.8	$293.8	$312.9	$1,720.3
Federal Funds	$0.0	$0.0	$0.0	$71.3	$151.9	$161.8	$172.3	$183.5	$195.5	$208.2	$1,144.5
State Funds	$0.0	$0.0	$0.0	$35.9	$76.4	$81.4	$86.7	$92.3	$98.3	$104.7	$575.8

STATE OF INDIANA
Family and Social Services Administration
Health Care Reform Projection - Senate Bill with House Reconciliation
Full Participation Scenario
(Values in Millions)

5/21/2010
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EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY2020
Loss of Pharmacy Rebates (State only)											
Total Impact (State and Federal)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	($22.8)	($24.6)	($25.0)	($25.3)	($27.3)	($29.5)	($31.8)	($34.4)	($37.1)	($40.1)	($298.0)
State Funds	$22.8	$24.6	$25.0	$25.3	$27.3	$29.5	$31.8	$34.4	$37.1	$40.1	$298.0
CHIP Program (Enhanced FMAP)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$33.0	$46.6	$49.4	$52.4	$13.9	$195.2
State Funds	$0.0	$0.0	$0.0	$0.0	$0.0	($33.0)	($46.6)	($49.4)	($52.4)	($13.9)	($195.2)
Breast & Cervical Cancer	$0.0	$0.0	$0.0	($4.0)	($8.4)	($8.8)	($9.2)	($9.6)	($10.1)	($10.6)	($60.8)
Federal Funds	$0.0	$0.0	$0.0	($3.1)	($6.4)	($6.7)	($7.1)	($7.4)	($7.7)	($8.1)	($46.6)
State Funds	$0.0	$0.0	$0.0	($0.9)	($2.0)	($2.1)	($2.2)	($2.3)	($2.4)	($2.5)	($14.2)
Pregnant Women (>138%)	$0.0	$0.0	$0.0	($9.3)	($19.4)	($20.3)	($21.2)	($22.2)	($23.2)	($24.3)	($139.8)
Federal Funds	$0.0	$0.0	$0.0	($6.2)	($12.9)	($13.5)	($14.1)	($14.8)	($15.5)	($16.2)	($93.0)
State Funds	$0.0	$0.0	$0.0	($3.1)	($6.5)	($6.8)	($7.1)	($7.4)	($7.8)	($8.1)	($46.8)
Phys Fee Schedule Inc (80% Medicare)	$0.0	$0.0	$0.0	$164.6	$344.2	$360.0	$376.7	$394.3	$412.9	$432.4	$2,485.1
Federal Funds	$0.0	$0.0	$0.0	$109.5	$229.0	$239.5	$250.6	$262.3	$274.7	$287.7	$1,653.4
State Funds	$0.0	$0.0	$0.0	$55.1	$115.2	$120.5	$126.1	$132.0	$138.2	$144.7	$831.8
Foster Children Increase	$0.0	$0.0	$0.0	$3.3	$6.5	$6.5	$6.5	$6.5	$6.5	$6.5	$42.3
Federal Funds	$0.0	$0.0	$0.0	$2.1	$4.2	$4.2	$4.2	$4.2	$4.2	$4.2	$27.5
State Funds	$0.0	$0.0	$0.0	$1.1	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$14.8
Administrative Expenses	$0.0	$40.0	$40.0	$75.0	$75.0	$75.0	$75.0	$75.0	$75.0	$75.0	$605.0
Federal Funds	$0.0	$20.0	$20.0	$37.5	$37.5	$37.5	$37.5	$37.5	$37.5	$37.5	$302.5
State Funds	$0.0	$20.0	$20.0	$37.5	$37.5	$37.5	$37.5	$37.5	$37.5	$37.5	$302.5
All Programs - After Expansion											
Total (State and Federal)	$7,180.9	$7,571.4	$7,737.2	$9,345.9	$11,301.0	$11,858.9	$12,447.8	$13,069.6	$13,726.3	$14,419.9	$108,659.0
Federal Funds	$4,758.4	$5,021.3	$5,132.1	$6,508.0	$8,155.7	$8,598.3	$8,989.0	$9,374.9	$9,827.7	$10,236.6	$76,601.9
State Funds	$2,422.6	$2,550.2	$2,605.2	$2,838.0	$3,145.3	$3,260.6	$3,458.8	$3,694.7	$3,898.5	$4,183.3	$32,057.2
All Programs - Fiscal Impact											
Total (State and Federal)	$0.0	$40.0	$40.0	$1,501.6	$3,095.7	$3,273.2	$3,461.5	$3,660.9	$3,872.4	$4,096.5	$23,041.7
Federal Funds	($22.8)	($4.6)	($5.0)	$1,272.0	$2,678.6	$2,867.1	$2,990.1	$3,093.7	$3,249.1	$3,344.2	$19,462.4
State Funds	$22.8	$44.6	$45.0	$229.5	$417.1	$406.2	$471.4	$567.2	$623.3	$752.3	$3,579.4

STATE OF INDIANA
HOUSE OF REPRESENTATIVES
THIRD FLOOR STATE HOUSE
INDIANAPOLIS, INDIANA 46204

WILLIAM A. CRAWFORD
P.O. BOX 18446
INDIANAPOLIS, IN 46218
COMMITTEE:
WAYS AND MEANS, CHAIR

TO: The Honorable Richard Lugar, United States Senate
The Honorable Evan Bayh, United States Senate
The Honorable Pete Visclosky, United States House of Representatives
The Honorable Joe Donnelly, United States House of Representatives
The Honorable Mark Souder, United States House of Representatives
The Honorable Steve Buyer, United States House of Representatives
The Honorable Dan Burton, United States House of Representatives
The Honorable Mike Pence, United States House of Representatives
The Honorable Andre Carson, United States House of Representatives
The Honorable Brad Ellsworth, United States House of Representatives
The Honorable Baron Hill, United States House of Representatives

FROM: William Crawford, Chairman, Ways and Means Committee
Indiana House of Representatives

DATE: April 29, 2010

RE: The Impact of the Health Care Bill on Indiana

I am jointly writing to you as the members of Indiana's Congressional delegation in order to seek your input and advice on how best to obtain Indiana specific information on how the recently enacted provisions of Health Care Reform substantively found in the Patient Protection & Affordable Care Act (P.L. 111-148) and the Health Care & Education Reconciliation Act of 2010 (P.L. 111-152) will impact the Hoosier State and it's residents as it is implemented over the course of the next few years.

Unfortunately, a swirl of tendentious misinformation and vastly divergent opinions are quickly coming to the fore by numerous parties when it comes to interpreting what was actually enacted into law as part of Health Care Reform and how that legislation will impact Indiana.

Sadly, when it comes to Indiana, inaccurate portrayals and assertions of what is actually contained in Health Care Reform are already having a materially adverse impact on Hoosier's when it comes to health care coverage.

Case in point being the near immediate "suspension" of enrollments in Indiana's innovative Healthy Indiana Plan (HIP) consumer driven health coverage plan for those with incomes below 200% of the Federal Poverty Level (FPL).

Exhibit C
Select Joint Commission
on Medicaid Oversight
August 12, 2010

This "suspension" of the HIP program coupled with the concomitant probable early "orderly termination" of the entire HIP program, was recently undertaken by our Indiana State Government in response to the passage of Health Care Reform even though the Medicaid coverage expansion which purportedly conflicts (although not substantiated in any way) with the HIP program is not set to even commence until January 14th, 2014 a full year after the pre-determined legal "sunset" of the Medicaid Waiver for the HIP program which is set to occur on December 31st, 2012.

In order, to forestall further precipitous actions when it comes to the provision of services to those assisted by Indiana health care programs, I am respectively seeking your assistance on the following items which I hope will help seek to facilitate a more accurate understanding of what really has and will transpire as Health Care Reform is implemented:

First, I am seeking contact information for an individuals or individuals at the Department of Health & Human Services that can specifically and directly respond to any and all inquiries I or other Members of the Indiana General Assembly have related to the interpretation and implementation of any and all attributes of Health Care Reform especially as Federal Register Rules and policy guidance documents are being promulgated and formulated.

Secondly, I am presumably set to become Chairmen of the State Medicaid Oversight Committee this Summer. The State Medicaid Oversight Committee is tasked by the Indiana General Assembly with monitoring any and all activities related to the operation of Indiana's Medicaid program and the advent of Health Care Reform has added an additional layer of complexity to the Committee's typical role.

Thus, as part of my role as Chairman of the Medicaid Oversight Committee, I am contemplating exploring how various aspects of Health Care Reform impacts Indiana at all of the plenary Sessions of the Committee. In active contemplation, of those hearings, I am extending an open invitation for you and/or your staff to attend any and all of those hearings if your schedule permits, to provide any insight you may have as a Member of Congress as it relates to the implementation the Health Care Reform legislation in Indiana.

Once the date of hearings for the Medicaid Oversight Committee have been definitively determined I will send you a notice of the schedules and proposed agendas for the Hearings

In closing, as always, I remain appreciative of the role you play in tirelessly representing Indiana in the United States Congress.

I believe your collective knowledge and insight will assist us as policymakers here in the General Assembly when it comes to garnering a more accurate and complete understanding of what is specifically contained in the Health Care Reform laws which will in turn help us as policymakers avoid making decisions that are based on fits of pique or that are imprudently undertaken without due regard to the facts.

Cc. The Honorable Mitch Daniels, Governor, The State of Indiana
Members of the Indiana General Assembly

Congress of the United States
Washington, DC 20515

May 28, 2010

The Honorable William Crawford
Chairman, Ways and Means Committee
Indiana House of Representatives
Indianapolis, IN 46204

Dear Chairman Crawford;

Thank you for your correspondence to the entire Indiana congressional delegation regarding the implementation and cost of the Patient Protection & Affordable Care Act (PPACA). As you know, many Members of Congress are still unclear about the full effects of this legislation, and we are not surprised that state officials such as yourself are asking questions about how the federal government will implement its many provisions. In these difficult budgetary times, we are certain your position is more challenging than ever before. You should be very concerned about the financial impact this legislation will have on the State budget and in turn Hoosier taxpayers.

State budgets across the nation have been in deep red territory for some time. Governor Mitch Daniels, working with the Indiana General Assembly, has held the line on spending, reformed government to serve more efficiently and made cuts in education as only the very last resort. We applaud and are proud of the Indiana public officials who have made difficult choices to streamline our state government while still providing core services.

It is our clear understanding from the report of independent actuaries hired in 2000 by Governor Frank O'Bannon and retained still today, that the State's cost of the expansion of Medicaid will be between $2.9 billion and $3.6 billion depending on the rate of participation by those who will be newly eligible for Medicaid benefits. As you are aware, Medicaid is a partnership between the federal and state government but administered by each state with specific rules for service and coverage determined by the states. Under the PPACA, the federal government has overridden eligibility levels set by the states and mandated many new and increased service levels as well as provider payment levels.

The economic burden the PPACA places on state governments is just one reason why we voted against this 2400-page bill that impacts one quarter of our economy at a time in our history when we can least afford another massive government entitlement program. We will watch closely in January when the Indiana General Assembly begins the biannual budget session to learn how PPACA will be integrated into the already stretched Indiana State budget. We sincerely hope state tax increases are not necessary to balance the budget.

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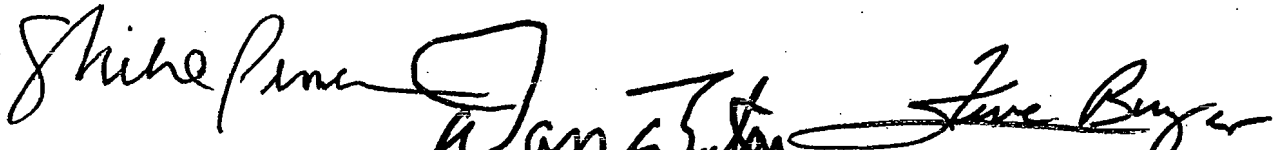
We agree, however, that a consumer-driven health insurance program, like the Healthy Indiana Plan (HIP), is an excellent vehicle to cover those who now lack health insurance but will become eligible for government-funded health insurance through the PPACA. We hope the federal government will explore the benefits of consumer driven health plans like the Healthy Indiana Plan and encourage their use in Indiana and across the country.

We count on and believe the Indiana Department of Family and Social Services is well equipped to answer your technical questions regarding implementation of the Medicaid program and the new requirements under PPACA. However, our offices are always pleased to provide constituents, including members of the Indiana General Assembly, with assistance.

Again, thank you for contacting our offices as we enjoy a productive working relationship with all levels of state and local government.

Sincerely,



Mike Pence
Member of Congress

Dan Burton
Member of Congress

Steve Buyer
Member of Congress

RICHARD G. LUGAR
INDIANA

RICHARD G. LUGAR OFFICE BUILDING
WASHINGTON, DC 20510
202-224-4814

rlugar@lugar.senate.gov

RANKING MINORITY MEMBER
FOREIGN RELATIONS, RANKING MINORITY
AGRICULTURE, NUTRITION, AND FORESTRY

United States Senate

WASHINGTON, DC 20510–1401

May 21, 2010

The Honorable William A. Crawford
Indiana House of Representatives
P.O. Box 18446
Indianapolis, Indiana 46218

Dear Representative Crawford:

Thank you for your recent letter. I appreciate knowing your frustrations regarding the continued uncertainty of what in accurate and practicable terms implementation of the Patient Protection and Affordable Care Act (PPACA)—and the ancillary Reconciliation measure—will mean for the State of Indiana's Medicaid program, including the Healthy Indiana Plan. I share these frustrations. Implementation of the PPACA has raised a number of unanswered questions, including its fiscal impact on individual states.

A number of Medicaid relevant provisions in the new law are subject to interpretation and rulemaking by federal agencies, which of course will require a certain amount of time in their study, public disclosure, and final promulgation. I am following this ongoing process closely and remain especially mindful of the impact decision-making at the Department of Health and Human Services, broadly, and the Centers for Medicare and Medicaid Services (CMS), more specifically, will have on our nation's health care system, the State of Indiana, and Hoosier taxpayers and beneficiaries. In your letter you requested, "contact information for an individual or individuals at the Department of Health and Human Services that can specifically and directly respond to any and all inquires I or other Members of the Indiana General Assembly have related to the interpretation and implementation of any and all attributes of Health care Reform especially as Federal Register Rules and policy guidance documents are being promulgated and formulated." I asked my staff to contact CMS officials to inquire as to who should be that contact. We were informed that the primary CMS contact for the State of Indiana is Winnie Pizzano, Director, Intergovernmental Relations Group. You or your staff can reach Ms. Pizzano at 202-260-2357 or winifred.pizzano@cms.hhs.gov.

While CMS has a considerable role in implementation of the PPACA, I would also note that given the massive scope of the new law and the complexity involved, I suspect that you may need to contact other agencies depending on the specific subject of your inquiry.

I congratulate you on your upcoming service as Chairman of the State Medicaid Oversight Committee beginning this summer. I look forward to reviewing reports from the

PRINTED ON RECYCLED PAPER

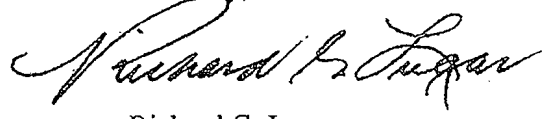
Committee and your suggestions on how to improve our health care delivery systems, especially with regard to Medicaid.

With respect to Medicaid expansion and its cost to Indiana, I understand that the accuracy of any one particular projection or forecast is subject to assumptions that may or may not come into reality. However, I also believe that it is abundantly clear that the envisioned expansion of Medicaid represents a sizeable unfunded mandate to the states at a time when many face historic levels of budgetary stress and the prospect of painful cuts in areas as vital as education and public safety. As additional studies are generated and compared, a more complete understanding of the challenges ahead will be available for the review of policy makers. In the meantime, it is my sincere hope that the PPACA's ten year estimate of a $2.9 to $3.6 billion fiscal impact to Indiana is overestimated. But even if this analysis is wrong and enrollment in an expanded Medicaid program is lower than many expect, there will still be a real, sizeable cost to the State. Your Committee's effort to address this issue will be critical in ensuring both patient access to needed health care and the long-term fiscal solvency of our State.

While the immediate health care reform debate is over in Congress, I anticipate there will be further opportunities in the U.S. Senate to discuss the merits of the new law and to consider legislation addressing its flaws and shortcomings. Your perspective will be important and welcome as those discussions proceed.

Thank you, again, for contacting me.

Sincerely,



Richard G. Lugar
United States Senator

RGL/aca

STATE OF INDIANA
HOUSE OF REPRESENTATIVES
THIRD FLOOR STATE HOUSE
INDIANAPOLIS, INDIANA 46204

WILLIAM A. CRAWFORD
P.O. BOX [illegible]
INDIANAPOLIS, IN 46[illegible]
COMMITTEE
WAYS AND MEANS, [illegible]

TO: The Honorable Richard Lugar, United States Senate
The Honorable Evan Bayh, United States Senate
The Honorable Pete Visclosky, United States House of Representatives
The Honorable Joe Donnelly, United States House of Representatives
The Honorable Mark Souder, United States House of Representatives
The Honorable Steve Buyer, United States House of Representatives
The Honorable Dan Burton, United States House of Representatives
The Honorable Mike Pence, United States House of Representatives
The Honorable Andre Carson, United States House of Representatives
The Honorable Brad Ellsworth, United States House of Representatives
The Honorable Baron Hill, United States House of Representatives

FROM: William Crawford, Chairman, Ways and Means Committee BC
Indiana House of Representatives

DATE: April 29, 2010

RE: The Impact of the Health Care Bill on Indiana

I am jointly writing to you as the members of Indiana's Congressional delegation in order to seek your input and advice on how best to obtain Indiana specific information on how the recently enacted provisions of Health Care Reform substantively found in the Patient Protection & Affordable Care Act (P.L. 111-148) and the Health Care & Education Reconciliation Act of 2010 (P.L. 111-152) will impact the Hoosier State and it's residents as it is implemented over the course of the next few years.

Unfortunately, a swirl of tendentious misinformation and vastly divergent opinions are quickly coming to the fore by numerous parties when it comes to interpreting what was actually enacted into law as part of Health Care Reform and how that legislation will impact Indiana.

Sadly, when it comes to Indiana, inaccurate portrayals and assertions of what is actually contained in Health Care Reform are already having a materially adverse impact on Hoosier's when it comes to health care coverage.

Case in point being the near immediate "suspension" of enrollments in Indiana's innovative Healthy Indiana Plan (HIP) consumer driven health coverage plan for those with incomes below 200% of the Federal Poverty Level (FPL).

This "suspension" of the HIP program coupled with the concomitant probable early "orderly termination" of the entire HIP program, was recently undertaken by our Indiana State Government in response to the passage of Health Care Reform even though the Medicaid coverage expansion which purportedly conflicts (although not substantiated in any way) with the HIP program is not set to even commence until January 14th, 2014 a full year after the pre-determined legal "sunset" of the Medicaid Waiver for the HIP program which is set to occur on December 31st, 2012.

In order, to forestall further precipitous actions when it comes to the provision of services to those assisted by Indiana health care programs, I am respectively seeking your assistance on the following items which I hope will help seek to facilitate a more accurate understanding of what really has and will transpire as Health Care Reform is implemented:

First, I am seeking contact information for an individuals or individuals at the Department of Health & Human Services that can specifically and directly respond to any and all inquiries I or other Members of the Indiana General Assembly have related to the interpretation and implementation of any and all attributes of Health Care Reform especially as Federal Register Rules and policy guidance documents are being promulgated and formulated.

Secondly, I am presumably set to become Chairmen of the State Medicaid Oversight Committee this Summer. The State Medicaid Oversight Committee is tasked by the Indiana General Assembly with monitoring any and all activities related to the operation of Indiana's Medicaid program and the advent of Health Care Reform has added an additional layer of complexity to the Committee's typical role.

Thus, as part of my role as Chairman of the Medicaid Oversight Committee, I am contemplating exploring how various aspects of Health Care Reform impacts Indiana at all of the plenary Sessions of the Committee. In active contemplation, of those hearings, I am extending an open invitation for you and/or your staff to attend any and all of those hearings if your schedule permits, to provide any insight you may have as a Member of Congress as it relates to the implementation the Health Care Reform legislation in Indiana.

Once the date of hearings for the Medicaid Oversight Committee have been definitively determined I will send you a notice of the schedules and proposed agendas for the Hearings

In closing, as always, I remain appreciative of the role you play in tirelessly representing Indiana in the United States Congress.

I believe your collective knowledge and insight will assist us as policymakers here in the General Assembly when it comes to garnering a more accurate and complete understanding of what is specifically contained in the Health Care Reform laws which will in turn help us as policymakers avoid making decisions that are based on fits of pique or that are imprudently undertaken without due regard to the facts.

Cc. The Honorable Mitch Daniels, Governor, The State of Indiana
Members of the Indiana General Assembly

STATE OF INDIANA
HOUSE OF REPRESENTATIVES
THIRD FLOOR STATE HOUSE
INDIANAPOLIS, INDIANA 46204

WILLIAM A. CRAWFORD
P.O. BOX 18446
INDIANAPOLIS, IN 46218
COMMITTEE:
WAYS AND MEANS, CHAIR

August 3, 2010

Dear Member of the Indiana Congressional Delegation:

As mentioned in my previous correspondence to you a few months ago, I am going to begin my tenure as Chair of the Indiana Select Joint Medicaid Oversight Committee. Our first hearing is set for Thursday, August 12th at 10:00 a.m. (Indianapolis time). One of the topics for consideration and review is Health Care Reform and how it is going to be implemented in Indiana in the next couple of years.

Please advise if you or your staff is interested in attending and we will gladly accommodate any request you may have to attend or actually address the Select Joint Committee on Medicaid Oversight on the topic of Health Care Reform and the potential impact on Indiana in terms of coverage opportunities and/or cost. If you or any of your staff would like to attend, please call my office at 232-9875 by Tuesday, August 10th if possible. Thanks as always for your valued service to the State of Indiana.

Sincerely,

Bill

Representative William Crawford
Chairman, Ways and Means Committee

Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

August 6, 2010

STATE-BY-STATE NUMBERS: CRITICAL FISCAL RELIEF AT STAKE IN TUESDAY'S HOUSE VOTE

By Michael Leachman, Matt Broaddus and Erica Williams

States stand to lose significant amounts of fiscal relief if legislation that the Senate approved yesterday, and the House is due to take up next week, fails to become law. The level of losses is shown on a state-by-state basis in the table below.

Because of the long and deep recession, states have begun their third consecutive year of cutting deeply into their funding for schools, health care, and other basic public services (most state fiscal years begin July 1). Last year's Recovery Act provided two forms of relief for states: additional federal funding to support state Medicaid programs and additional federal support for state education systems. The additional Medicaid support expires at the end of this year, right in the middle of the current fiscal year for most states. The additional education support is also rapidly disappearing.

The jobs legislation the Senate passed August 5 extends a phased-down version of the Medicaid support for another six months, worth about $15 billion to states, and extends $10 billion in additional education support to save teachers' jobs.[1]

Failure to extend the relief would force states to lay off more workers, cut more services, and raise taxes more than they would otherwise to balance their budgets. These actions will slow an economy that already is growing too slowly to lower the 9.5 percent unemployment rate and that economists fear is already likely to slow more in the months ahead.

Specifically, here's the amount of fiscal relief that each state will receive if the Senate legislation is enacted — and lose if it is not.

Exhibit D
Select Joint Commission on Medicaid Oversight
August 12, 2010

[1] CBPP's estimate for the additional Medicaid assistance differs somewhat from estimates conducted by the Congressional Budget Office (which estimates a total of $16.1 billion under the extension rather than $15 billion) because of modest differences in the methodology employed.

Estimated Distribution of Fiscal Relief to States in Senate Jobs Bill, in Millions

	Medicaid	Education	Total		Medicaid	Education	Total
TOTAL TO STATES	**$14,981**	**$9,989**	**$24,970**	Missouri	$292	$190	$482
Alabama	$133	$149	$282	Montana	$38	$31	$69
Alaska	$64	$24	$88	Nebraska	$69	$59	$128
Arizona	$351	$212	$563	Nevada	$79	$83	$162
Arkansas	$125	$91	$216	New Hampshire	$54	$41	$95
California	$1,869	$1,201	$3,070	New Jersey	$399	$268	$667
Colorado	$159	$159	$318	New Mexico	$126	$65	$191
Connecticut	$199	$110	$309	New York	$2,228	$607	$2,835
Delaware	$48	$27	$75	North Carolina	$343	$298	$641
District of Columbia	$54	$18	$72	North Dakota	$29	$22	$51
Florida	$784	$555	$1,339	Ohio	$492	$361	$853
Georgia	$228	$322	$550	Oklahoma	$188	$119	$307
Hawaii	$86	$39	$125	Oregon	$156	$118	$274
Idaho	$51	$52	$103	Pennsylvania	$667	$388	$1,055
Illinois	$545	$415	$960	Rhode Island	$72	$33	$105
Indiana	$227	$207	$434	South Carolina	$138	$144	$282
Iowa	$128	$96	$224	South Dakota	$27	$26	$53
Kansas	$100	$92	$192	Tennessee	$240	$196	$436
Kentucky	$155	$135	$290	Texas	$858	$830	$1,688
Louisiana	$375	$147	$522	Utah	$57	$101	$158
Maine	$86	$39	$125	Vermont	$47	$19	$66
Maryland	$273	$179	$452	Virginia	$289	$249	$538
Massachusetts	$506	$204	$710	Washington	$338	$208	$546
Michigan	$380	$318	$698	West Virginia	$81	$55	$136
Minnesota	$346	$167	$513	Wisconsin	$229	$180	$409
Mississippi	$151	$98	$249	Wyoming	$22	$18	$40

Sources: FMAP allocations reflect Center on Budget and Policy Priorities' estimates using Medicaid spending projections from February 2010 and unemployment rate projections from February 2010. Expenditures for childless adults shifting from CHIP to Medicaid also would qualify for the higher matching rate. ARRA would be modified so that the base FMAP increase would be lowered from 6.2 percentage points to 3.2 percentage points in the second quarter of federal fiscal year 2011 and to 1.2 percentage points in the third quarter. Figures are rounded.

Notes: Education total excludes shares for administration and the U.S. territories. CBPP's FMAP estimates may differ somewhat from estimates issued by the Congressional Budget Office (which estimates a total of $16.1 billion under the extension, rather than $15 billion) as well as state-specific estimates generated by state officials, because of differences in the methodology or in the underlying data related to Medicaid spending and projected state unemployment rates.

Health Care Reform Questions

❑ Is Milliman aware of any other creditable research entities (think tanks) that have prepared an analysis of Health Care Reform utiling a 133% of FPL threshold instead of a 138% FPL threshold when looking at the Medicaid expansion population (as found on page 2)? Please clarify why the 138% threshold was used and if there is any legitimate potential to use another % of FPL when undertaking these calculations)?

❑A formal decision (as far as I am aware) regarding the "newly eligible" status determination for HIP eligibles (as found on page 2) HAS NOT YET been made by CMS. Yet, the Milliman Analysis definitively portrays for reporting purposes (even though Milliman acknowledges that CMS has only made an "informal" decision found at page4) the HIP cohort population as not being able to be counted as "newly eligible" thus resulting in a purported $482.5 million dollar cost to the State.

If I am understanding things correctly if CMS determines that HIP recipients are "newly eligible" the $482.5 million dollar "State cost" would not be operative and should not be included.

Could you please confirm that this is the case when it comes to including or excluding HIP in the analysis?

❑ The increase of the physician fee schedule to 80% of the Medicare Fee schedule (as found on page 5 of the Report) is not a statutory requirement of the Health Care

Exhibit E
Select Joint Commission
on Medicaid Oversight
August 12, 2010

Reform legislation ,yet it is posited in the Milliman Analysis as a definite cost to the State for the purposes of the analysis even though no State law or Rule has been enacted providing for this specific rate of increase.

What data driven evidence was utilized by Milliman to come up with the 80% number? Is this information available to the public? Could the threshold number not be 70%, 75% or some other rate? Was the analysis disagreggated to take into account the difference between Managed Care and Fee for Service. How were the various specialist increases determined (i.e., by each type of sector or holistically)?

Also, at it relates to physician reimbursement should not the statement found on page 5 of the document related to a 21% reduction in the Medicare physician fee schedule be excised from the document since it is no longer relevant (Congress prevented this reduction from occurring)?

Was the non-realized physician fee schedule reduction tangibly factored in anyway whatsoever into this analysis?

In addition, the Milliman analysis states that the increased cost in would be $300 to $350 million for the State for NOT ONLY the expansion population but also existing Medicaid recipients (as found on page 5). Milliman does not differentiate between current and future recipients. Could disagregated numbers be provided when it comes to existing and expansion

populations?

❑ Spend Down/SSI Eligibility (found on page 4)- A "key assumption" in the Report is that Indiana would cover all disability eligible populations at the Standard FMAP. However, when presented this data is co-mingled with the Spend Down population. What is the separate stand-alone cost assumptions for each of the populations (i.e. the Disabled and the Spend down)?

Also, since it seems that the State would still retain some flexibility (since the wording in the Report on page 4 says it "is *antcipated")* in how they can conceivably categorize the disabled population should the cost estimate for the disabled be modified to potentially show the impact if the SSI standard is not eventually adopted for whatever reason?

❑ Since Indiana was not anticipating the FMAP increase, what impact will the receipt of these dollars have on the assumptions in the Study especially if the net effect of the new FMAP dollars (even indirectly) is the replenishment of the Medicaid Reserve which was depleted at "Close-Out"?

What are the positive impacts of savings to the State that will arise from diminished utilization of emergency rooms and other critical care services. Why were these

savings not entered into the analysis as was the case in other entities that have undertaken a State centric impact analysis of Health Care Reform?

Does Milliman have the capacity to do a revised analysis that looks at and incorporates these substantively important positive offsets?

❑ Administrative Costs (as found on page 5)-When portraying the Administrative Costs the percentage cost of administering the expansion population and the establishment of the new Exchanges were seemingly blended in a unitary manner at 3.75%. What were the individualized (stand-alone) assumptions for the administrative costs for the Medicaid Expansion population in one instance and the establishment of the Exchanges in the other?

❑Why does the Milliman Report not contemplate or credit any funding whatsoever for grants or other funding that will be forthcoming (such as the grants to States to help offset the costs of the implementation of the Exchanges)?

Exhibit F
Select Joint Commission
on Medicaid Oversight
August 12, 2010

State Opportunities as Federal Health Law is Implemented

Select Joint Commission on Medicaid Oversight
August 12, 2010

JoAnn Lamphere, DrPH
Director, State Government Relations
Health & Long-term Care Issues
AARP

Presentation Overview

> Leading the Way in the Midwest

> An Evolving Landscape

> Driving Efficiencies & Value through Medicaid Improvements

> Medicaid Link to a Pro-Consumer Health Exchange

> Using Medicaid to Transform Health Care

> Federal Grant Opportunities

> Emerging Policy Challenges

> Qs & As

Leading the Way in the Midwest

> Tradition of civic commitment to social well-being

> Long-standing bi-partisan state health policy engagement and experimentation, with resulting collective expertise

> Stable, thoughtful, and respected public health and private sector leadership, with stakeholder involvement

> Indiana ahead of the curve on many key health indicators

> A state grounded in Midwestern values and sensibilities

An Evolving Landscape -- Favorable Policy Elements

Large Bipartisan Majorities Favor Specific Policy Elements of New Health Law

Favor Reform Policy	Republicans	Democrats	Independents
Tax credits for small businesses	84	91	85
Make it harder for insurers to drop coverage when individual has major health problems	79	85	80
Requiring plans to offer preventive care with no cost-sharing	71	92	78
Rebate for seniors in the Medicare doughnut hole	66	90	74
Children on parents' plan until 26	64	86	71
No coverage denials for children	61	79	68
Temporary high-risk pools	60	88	73
Ban on lifetime spending limits	56	75	63
Rebate for overspending on admin costs/profits	52	78	66

SOURCE: Kaiser Family Foundation, 4/9-14/10

Driving Efficiencies and Value Through Medicaid Improvements

- Medicaid expansions for adults by 2014 will reduce uninsured by 215,000 or more in IN
- Barriers to receiving prompt necessary medical care will be reduced
- State administrative systems will be challenged
  - Simplify eligibility rules & processes to conform to federal law
  - Simplify enrollment to achieve efficiencies
  - Design effective outreach
  - Harmonize Medicaid, CHIP, HIP -- "no wrong door"
- Assess IT infrastructure within state policy guidelines and Exchange requirements
- Investments can foster delivery system improvements and individual behavior change

Medicaid Link to a Pro-Consumer Exchange

> Consider Medicaid policy development within context of larger health policy objectives for Exchange: benefit design, negotiated prices, consumer service, quality, etc.

> Must assure seamless transition between Medicaid and Exchange

- Assess eligibility processes, technical capabilities, IT infrastructure
- Streamline and harmonize approaches
- Make specific plans for addressing service risks of outdated systems

> Overarching leadership across divisions can maximize effective program design and minimize risk and costs

Policies to Assure a Pro-Consumer Health Exchange

	Weak Exchange	Strong Exchange
Governance	Consumers & businesses not majority Wasteful spending	Fully transparent Stakeholder & public input Strong relationships with employers Frugal spending
Oversight	Takes prices set by insurers No standards for benefit design, call centers, quality, & costs	Negotiates rates & benefits Sets high & realistic standards that improve value
Usefulness	Exchange is invisible Too many options & few tools for comparison Customer service limited & underfunded Awkward eligibility mechanisms	Robust outreach to consumers/business Manageable number of meaningful choices for consumers Culture of problem solving & quality service Seamless, as personal circumstances change
Integration	Connection across Medicaid, plans, and subsidies is cumbersome/confusing IT system and business processes antiquated	Provides consistency & stability in coverage as individuals' circumstances change Links seamlessly to Medicaid and subsidies IT platform enables communication
Sustainability	Allows outside market to offer products on favorable terms Fails to keep up with market & clinical change	Protects against adverse selection Adjusts to Medicaid breakthroughs of health transactions Cuts waste & raises efficiency
Size	Too small to drive significant value improvements in market or achieve cost savings	Large enough to enable quality improvements & cut costs Large enough to assure risk pool stability & economies of scale

Note: Chart builds on *Delivering the Promise,* by CALPIRG Education Fund, June 2010

Using Medicaid to Transform Health Care Delivery

> Health Homes – States taking up option get 90% FMAP for two years (1/1/2011)
> Incentives for Healthy Lifestyles
> Bundled Payments – demonstration to reward quality care
> Health Care Workforce – training, residencies, physician payment

Considerations:

> Keep eyes open for funding opportunities
> Use leadership positions to foster delivery system improvements

Current State Grant Opportunities

> Planning Grants for State Health Insurance Exchanges (submit by 9/1/2010)

> Grants to Extend Money Follows the Person Rebalancing Demonstration programs (submit by 1/2011)

> Community Health Center Grants for Expansion (early Aug announcement)

Emerging Policy Challenges to State Implementation

> The economy as it affects federal and state policymaking and priorities

> Public anxiety about level of mandatory and discretionary federal spending

> State budget shortfalls and program sustainability

> Health and insurance expertise leaving state service

> Aging IT infrastructure

> Caution about the impact of lawsuits and nullification

> Uncertain leadership and will

Qs & As

JoAnn Lamphere, DrPH
AARP
Director, State Government Relations & Advocacy
Health & Long-Term Care

JoAnn Lamphere, DrPH, Director, State Government Relations & Advocacy, Health & Long-term Care, leads a team of legislative experts and serves as a main strategy advisor to AARP's fifty-three state offices. Dr. Lamphere provides political and analytic guidance to support enactment of national and state legislative priorities in areas of health care reform; long-term services and supports; effective, quality health care; and prescription drug affordability. Since passage of national health care reform, her priority is to assure the successful implementation of the Affordable Care Act across the states.

Dr. Lamphere rejoined AARP in 2006 after serving six years as a senior consultant with The Lewin Group, where her areas of expertise included public sector financing, state health reform, long-term care policy, and tax credits for health coverage. From 1997 to 2000, she was Senior Policy Advisor for AARP's Public Policy Institute. Her professional experience also includes Senior Associate, Alpha Center, Washington, DC; Research Associate and Lecturer, Department of Health Policy and Management, University of North Carolina at Chapel Hill; Administrative Manager, New England Medical Center, Boston; and Health Policy Analyst and Program Director, New York State Department of Health.

She earned her doctorate in Health Policy and Management from Columbia University and is an Adjunct Associate Professor at the University of Maryland. In addition to being a noted author and frequent lecturer, she is a founding member of the Campaign for Effective Patient Care.

DSH/UPL

-Explain how the DSH Funding Formula has been changed and updated this year? Have new recipient entities been added to the funding mix? Have any existing or prior recipients been dropped from Funding?

-Has the "supplemental" DSH payments that the State received as part of the Stimulus been totally resolved to CMS's satisfaction since there was apparently a dispute between the State and CMS on how the proceeds could be applied?

-Passage of the Federal Health Care Reform will have impacts on the DSH program. Has FSSA done a pro-active analysis of how the changes at the Federal level (relative to DSH) will impact the Medicaid Program?

-How was DSH/UPL treated in the Millman Report on Health Care Reform, since DSH/UPL is about 1/7th of the funding in the Medicaid Program and changes at the Federal level in this program will have impacts on Medicaid especially in latter years as changes to DSH become more manifested?

Exhibit G
Select Joint Commission
on Medicaid Oversight
August 12, 2010

-Page 19-20 of the LSA LEOPS report on Supplemental Payments makes mention of the fact that there are several disconnects between what is in State statute related to Supplemental payments and what has actually been done as it relates to the actual distribution methodology. Is FSSA working on draft legislation to harmonize these inconsitencies in State Statute and the Indiana State Medicaid Plan?

-How has the elimination of the HCI levy impacted Medicaid leveraging? Are the prior amounts of HCI monies being fulling applied to Medicaid leveraging or are the now State funded dollars (i.e., that replaced property tax dollars) for HCI being utilized in a different manner?

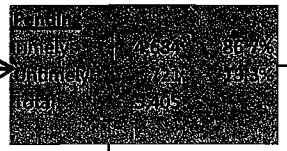
-

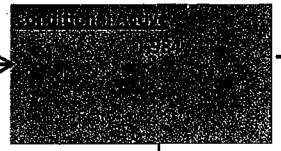
HIP MONTHLY DASHBOARD

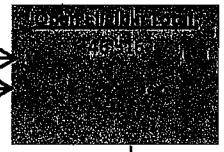
COB: Saturday, July 31, 2010 | Year: 3 Day 212 | Day 943 of project

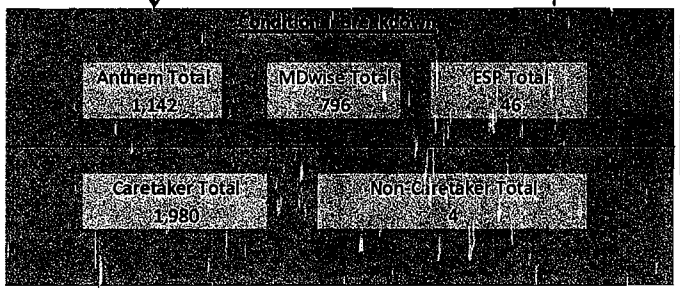
HEALTHY INDIANA PLAN

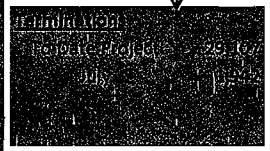
Submitted Applications









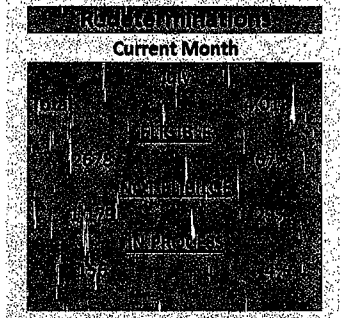


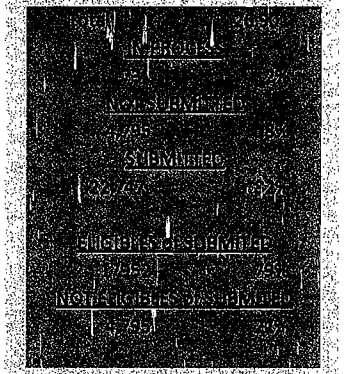
Applications

Invalid	14,877
Duplicates	10,473

(provided by multiple resources)

Benefit Period Details





* Waitlist Opened: 5,000 waitlist applicants were issued an invitation to reapply to HIP 11/2009.

Denials

Top 5 - July 2010

1. Non-Caretaker Cap reached
2. Did not verify income
3. No proof of Citizenship
4. Failure to provide ins info
5. Failure to make PAC payment

Top 5 - Year to Date 2010

1. Non-Caretaker Cap reached
2. Did not verify income
3. No proof of Citizenship
4. Failure to make PAC payment
5. Ins in prev 6 months

*PAC=POWER Account Contribution

Enrollee Details (Data provided by HP)

Total Enrolled

Total:	45,658	
Anthem:	30,040	65.8%
Mdwise:	14,625	32.0%
ESP:	993	2.2%

FPL Description

<=100	31,489	69.0%
101-125	5,586	12.2%
126-150	3,865	8.5%
>150	4,711	10.3%

Zero Contributions

21.5% of total fully eligibles

July	9,814
<=100% FPL:	9,697
101-125% FPL:	62
126-150% FPL:	21
>150% FPL:	34

Employer Contributions

Anthem:	$511
MDwise:	$234
ESP:	$0

Age:

<20:	22	0.0%
20-29:	7,367	16.1%
30-39:	12,983	28.4%
40-49:	13,127	28.8%
50-59:	9,284	20.3%
60+	2,874	6.3%

Sex

M:	15,728	34.4%
F:	29,929	65.6%

Race

Asian:	590	1.3%
Black:	4,884	10.7%
Hispanic:	1,376	3.0%
Indian:	28	0.1%
Other:	709	1.6%
White:	38,070	83.4%

Caretaker Adult

Yes:	27,373	60.0%
No:	18,284	40.0%

Enrollee Detail Data Will Differ From Open Eligible Data

Terminations

Top 5 - July 2010

1. Hip packet not returned
2. Other current health insurance
3. Medicare Part A or B currently
4. Employer offers health ins.
5. Closure System determined close

Top 5 - Year to Date 2010

1. Hip packet not returned
2. Failure to make PAC payment
3. Other current health insurance
4. Open MA - Applied HIP
5. Employer offers health ins.

For Questions / Concerns / Comments please contact : Darren Klingler (Darren.Klingler@FSSA.IN.GOV)
Dashboard Updated : 8/10/2010 by Loreyne Hunter

Exhibit H
Select Joint Commission on Medicaid Oversight
August 12, 2010

Healthy Indiana Plan (HIP) Questions

-Can you please "clear the air" on what the ACTUAL status of the Healthy Indiana Plan is? In March, shortly after the passage of Health Care Reform the Governor made the statement at a press availability that he was asking Sec. Murphy to immediately suspend the HIP program (i.e., future admisissions for Non-Caretaker Adults) *and also* to look into an "orderly termination" of the HIP program. However, in May, Sec. Murphy sent a letter to CMS (as reported by the AP) asking about the possibility of extending the program passed the expiration date of the Waiver? What is the official status of the program?

-Why was/has the HIP Website still not been updated to reflect the fact that Non-Caretaker Adults are no longer eligible for the program? Have other promotional materials also not been updated to reflect the material change to this program?

-Could you please provide a copy (for the next meeting) of the correspondence/notification that FSSA sent to CMS regarding the suspension of the HIP program for Caretaker adults that was contemporaneous with the Governor's announcement that he was suspending the HIP program?

- Is CMS even aware of this suspension? how does it impact that Waiver since the extension of HIP coverage of Non-Caretaker adults was one of the cardinal tenets of the initial Waiver request.

Exhibit I
Select Joint Commission
on Medicaid Oversight
August 12, 2010

-In light, of the apparent financial difficulties that the HIP program is allegedly now facing, will FSSA advocate changing the law this upcoming Session so that interest proceeds from the Indiana Check-up Plan Trust Fund stay with the Trust fund? Thus far, I believe the program has lost at least $4 million in dedicated funding (not to mention the leveraged amount lost) due the fact that interest from the Trust Fund has not stayed with the Trust Fund because of a drafting error in 2007 when HIP was enacted.

-As I am sure you are aware, the HIP program permits payments for medical services to out of State providers (DSH does not). How much HIP program dollars are being expended outside the State of Indiana for out-of-state hospital, doctor and other health care expenses? Is this particular nuance of the HIP financial structure a further unrecognized loss associated with the foregoing of DSH dollars?

-Many policymakers knowledgeable about the funding intricacies of the HIP program thought that the State was going to "forego" $50 million dollars a year in DSH monies in order to be able to participate in DSH. However, the LSA LEOPS report details a Foregone Allotment of $59 million for 2009 and 2010? Will the amounts also be $59 for the successive final two years (2011 and 2012) of the Waiver? In the final analysis will the Foregone dollars be tens of millions dollars higher than originally estimated or portrayed?

-Please describe how the State is going to "demonstrate" additional savings of $15 million dollars after 5 years in other areas of the HIP program that is found in the Special Terms and Conditions of the Waiver? These reductions are above and beyond the general agreement to forego the agreed amount of State entitled DSH dollars?

-With less than two and a half years to go in the HIP Waiver enrollment seems to be stuck at around 45,000 individuals. With Non- Caretaker Adult enrollments "suspended" (with no potential for growth) what is FSSA doing pro-actively in marketing and or outreach to further the enrollment of the Caretaker Adults where there is considerable capacity for growth since the program was project to accommodate and fully fund with the resources availalble an anticipated 130,000 member programmatic enrollment?

-Has FSSA taken any steps to appropriately place disabled individuals in traditional Medicaid instead of the HIP program since this population costs relatively more than was anticipated by actuaries?

Medicaid Waivers Questions

-Were any members of the General Assembly or public consulted relative to the material changes that have been made to the DD Waiver? Was their input sought since ? How was their input facilitated?

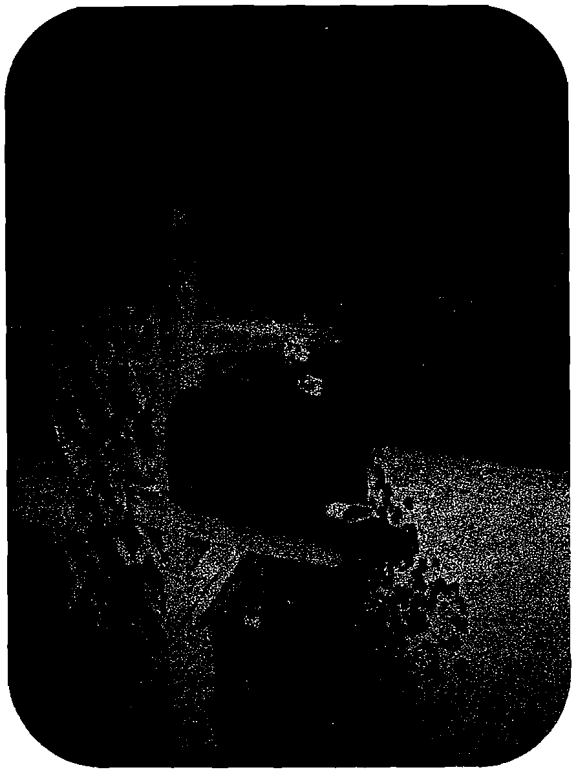
-What measures are being utilized by FSSA to alert current DD Waiver recipients that some of them will start becoming ineligible for services starting October 1st, 2010?

-With the reduction in the service coverage in the SEFA Waiver from an average of 4.5 years to a maximum of 18 months will the Indiana Medicaid program have to provide alternative support (ostensibly at an increased, unmatched cost to the State)?

-However, it is my understanding that there may be some mitigatory measures the State could pursue if FSSA would consider amending the DD Waiver as (22 states have done) to allow States to receive Day Service be allowed to permit paid work activity.

Exhibit J
Select Joint Commission
on Medicaid Oversight
August 12, 2010

Exhibit K
Select Joint Commission
on Medicaid Oversight
August 12, 2010



Lessons from Home
Applied

The Recommendations of the Round Table Education Series on Home and Community Based Services in Indiana

June 2010
THE GENERATIONS PROJECT

The Generations Project, Inc. is a non-profit organization established in 2001 to educate citizens and private and public leaders about the opportunities to implement a balanced and responsible long term care system in our state. The Project is a collaborative effort of leading civic organizations. Those organizations represent the majority of Indiana's citizens.

Collectively, we believe Indiana can and must do better for senior citizens and persons with disabilities that need home and community based care.

The Generations Project believes this report will assist citizens and policy makers in building a long term care system for Indiana that is defined and driven by the humanity and common sense needs of Hoosiers.

www.generationsproject.org

A Message of Thanks

Dear Reader,

On behalf of The Generations Project and its Board of Governors thank you for reading this report regarding home and community based services (HCBS) in Indiana.

For many years, Indiana has lagged behind the nation in developing a system of long term care that is driven first and always by the needs of individuals and families. Our state continues to rely far too much on nursing homes as the primary means for delivering long term care services. We dramatically under utilize HCBS among the mix of publicly funded long term care choices.

That harms all Hoosiers. Too many people want to leave or avoid Indiana due to the state's lack of home care, assisted living, adult day services, adult family care, self directed care and other HCBS options.

While Indiana remains an unattractive option for many people that need HCBS, efforts are underway to change that. Realizing those changes is at the heart of the report and recommendations that follow. So please join us in considering and acting on the recommendations in *Lessons from Home Applied.*

Sincerely yours,

Elmer Blankenship, Board President	Michelle Niemier, Board Vice President	John Cardwell, TGP Director

John J. Thomas...
beloved Hoosier and father of the CHOICE Program

This report is dedicated to the memory of John J. Thomas of Brazil, who served in the Indiana House of Representatives for twenty four years. John was the author of the 1987 CHOICE home care act. To this day the CHOICE program remains the cornerstone of Indiana's system of home and community based services and is still considered one of the best state funded HCBS programs in the nation. As a legislator, Representative Thomas was known for taking on tough issues and turning them into bipartisan triumphs. In addition to the CHOICE program Thomas was also credited with the passage of other pieces of historic legislation regarding public education, farm finance and legal services, mental health services, and much more. In June of 2007, John Thomas came back from his retirement home in Arizona to join many of his legislative colleagues and citizens from around the state to celebrate the 20th anniversary of the CHOICE program at the University of Indianapolis. The above picture was taken at that celebration. An Army Air Corps veteran of World War II, a successful attorney, church and Boy Scout leader, and a proud father, John Thomas died at age 86 on July 22, 2010 back home in his beloved Indiana.

Lessons from Home *Applied*

The Recommendations of the Round Table Education Series on Long Term Care in Indiana.

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Introduction

Nearly four decades ago there was an explosion in the number of nursing homes in Indiana following the enactment in the mid 1960s of the federal Medicaid act. That law made nursing home care a legal entitlement for persons who qualified based on their impairment levels and income. No other form of long term care (LTC) was granted entitlement status. The result has been a tragedy. Soon people who only needed home care and other community based services were being forced into nursing homes because they lacked the means to pay for non-institutional LTC. As a result of the entitlement, taxpayers picked up the tab for expensive institutional care when less expensive, more effective, humane and preferred home care and related community based services, such as assisted living, adult foster care in true family settings, adult day and night care, variations on self-directed care, and many other options, should have been used.

In 1986, in response to growing public concerns regarding the limited long term care choices of senior citizens and other persons with disabilities, the Indiana Home Care Task Force was founded. A voluntary alliance of senior citizens, persons with disabilities, families, professionals and other interested parties, the Task Force achieved many specific policy victories working in concert with the Indiana General Assembly.

Citizens and legislators rallying at the Indiana State House in 2007 in support of home and community based services.

The victories included the passage of new laws, such as CHOICE, the Community and Home Options to Institutional Care for the Elderly and Disabled Act of 1987. The triumphs also included the implementation of new Medicaid waivers to further expand the availability of home and community based services (HCBS) in the 1990s, which allowed Medicaid dollars to be spent for defined populations of consumers for specified HCBS. Nonetheless, the Task Force was unable to convince legislators and state administrators to establish and fund a fully comprehensive system of long term care services based *first and foremost* on HCBS. The ironic result continues to be waiting lists for critically needed HCBS and after 2006 a greater reliance on Medicaid funded nursing home care.

Since 2001, The Generations Project has assisted the member organizations of the Indiana Home Care Task Force in developing comprehensive solutions for re-balancing the state's long term care system. Senate Enrolled Act 493, the state's first attempt at a comprehensive HCBS reform law, was passed in 2003 based on concepts developed by the Project for the Task Force.

In 2005 The Generations Project published *Moving Forward*, an in-depth analysis of SEA 493 that provided guidance to people seeking a better long term care system in Indiana.

In 2007 The Generations Project initiated the Round Table Education Series. Meetings were held throughout the state with HCBS consumers, family caregivers, advocates, long term care professionals, providers, community leaders, and leaders from organizations representing senior citizen, persons with disabilities, and minorities. That process produced *Lessons from Home* in 2008, a report that described 45 separate recommendations that were crafted by the Round Table participants. The recommendations were intended to provide guidance to all Hoosiers who want to establish a consumer-driven LTC system in the state.

Guidance alone does not mean change. In 2008 and 2009 The Generations Project and the Task Force continued to meet with citizens frustrated by the failure of the state to fully re-balance its LTC system. Finally, on November 18, 2009 the Round Table series ended in Indianapolis. On that day, citizens from across the state crafted the findings for a second report, **Lessons from Home *Applied*.**

LFH *Applied* presents the components of a comprehensive long term care policy reform model based first and foremost on HCBS and the honoring of the human rights of the citizens that must use the system. The report is presented here for your consideration. You will find what many people believe are the missing pieces in Indiana's long term care system: building blocks to truly re-balance LTC so Hoosiers will finally have a complete and first rate system of home and community based services.

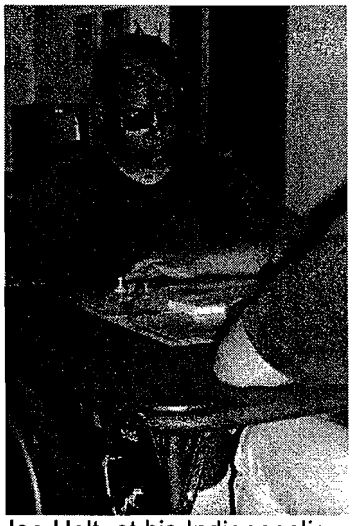
This report is intended to be shared with other citizens. Readers are urged to discuss the report and their own ideas regarding the need for HCBS with family, friends, neighbors and public officials. The Generations Project believes the *lessons from home* that follow, if they are applied, will make Indiana a better place for all Hoosiers.

Citizens at the 2007 Round Table Education Series conference at the Indiana Interchurch Center, Indianapolis.

Executive Summary

The report that follows contains the recommendations for transforming, or re-balancing, Indiana's system of long term care. The recommendations come from citizens that participated in the Round Table Education Series, a series of local, regional and state level meetings from 2007 through 2009 hosted by The Generations Project in cooperation with the Indiana Home Care Task Force. The participants in the series included Hoosiers who use home and community based series, such as home health care, their family caregivers, long term care professionals, leaders from organizations representing senior citizens and persons with disabilities, and lawmakers. The report also contains additional recommendations developed by members of the Indiana Home Care Task Force in response to dramatic long term care policy and program developments since January 2010.

The findings, over sixty in all, are summarized in executive form under the eleven general points that follow.



Joe Holt, at his Indianapolis home in 2010, demonstrates that individuals with brain injuries can remain independent if they have access to therapy and support services.

One, Indiana continues to vastly over utilize nursing home care among the total mix of long term care services. The result has been tragic for senior citizens, persons with disabilities and their families. Some 14,500 Hoosiers are residing each day in nursing homes in Indiana, funded by the Medicaid program, who should be receiving low cost, better and more humane home and community based services. These Hoosiers have been forced to use the Medicaid legal entitlement for nursing home care because affordable publicly assisted home care options have not been available that could have kept them in their own homes.

Two, taxpayers are taking it on the chin due to the state's frequent failure to use home care and other community based services when those are the most appropriate long term care options for Hoosiers. Of the 28,500 Hoosiers in nursing homes under the taxpayer financed Medicaid program The Generations Project believes, based on comparative data from other states, some 14,500 have been inappropriately placed in those institutions. Those 14,500 people are costing the public $800,000,000 per year in state and federal taxes. They should be receiving far cheaper and better home and community based services. If properly used, those dollars could fund all of Indiana's home and community based care needs, substantially upgrade the quality of care for persons who must have nursing home care, and still have funds left over.

Three, to appropriately serve people without the means to provide for all of their home and community based care needs, the state should fully utilize its highly regarded CHOICE home care program and SEA 493, the long term care reform act passed in 2003 by the General Assembly. Upon its enactment, the latter law provided the state with all the legal tools needed to fully re-balance its system of long term care so people can get the home care services they need and avoid inappropriate nursing home placements.

Four, to effectively address the budget crisis facing the state of Indiana, Governor Daniels and the Indiana Family and Social Services Administration can invest in home and community based services by fully utilizing the CHOICE program and SEA 493, as described under points one through three above. They can also utilize the new home care opportunities that will become available under the provisions of the 2010 federal Patient Protection and Affordable Care Act.

Five, lift the 15 percent cut in the CHOICE home care program that the state will begin on July 1, 2010 and the continued freeze on serving new clients through the Medicaid aged and disabled home and community based services waiver. Cutting CHOICE services and maintaining the freeze on the Medicaid aged and disabled waiver will only deepen the state's fiscal crisis by driving more Hoosiers into nursing homes. To address its budget crisis the neighboring state of Ohio is expanding the availability of publicly funded home care in order to reduce the use of legally entitled nursing home care through the Medicaid program. In Indiana, Medicaid funded nursing home care costs $55,000 per person per year, Medicaid funded home and community based services through its Aged and Disabled Waiver costs nearly $33,000 per person per year, and the CHOICE home care program costs $5,000 per person per year.

Six, to effectively re-balance Indiana's system of long term care the state should take direction from long term care consumers, their family caregivers, HCBS advocacy organizations, and area agencies on aging. The state should also work with private employers, minority and other demographic groups, local units of government, senior citizen organizations, groups representing persons with disabilities, the faith community, unions, human services organizations, schools, all state agencies, transportation services, builders, health care providers, and long term care providers to promote the growth and smart utilization of home and community based services in all regions of the state. This inclusive approach could substantially improve consumer awareness of home care options, the availability of high quality home care services in poor urban and rural communities, help prevent unintended consequences for persons needing home and community based care (such as insensitivity to ethnic, cultural, religious, family and neighborhood values), improve the ability of employers to support employees that have family caregiver duties, improve the economic vitality of the state, and raise the quality of life.

Dennis Frick, co-director of the Senior Law Project of Indiana Legal Services, and Karen Vaughn, HCBS consumer and advocate, chatting at a 2008 session of the Round Table Education Series.

Seven, stop the multiple efforts by state agencies to degrade and under utilize the CHOICE program. Making the CHOICE program more like Medicaid is self-defeating. It takes away the preventative care benefits of the program and its ability to uniquely save taxpayers and the state money while giving Hoosiers flexible and high quality services. A special section of eight recommendations regarding the CHOICE program is contained in this report.

Eight, end the state's radical experiment with the privatization, modernization, and, most recently, hybridization of the Medicaid, Supplemental Nutrition Assistance Program (SNAP or food stamps), and

the Temporary Assistance for Needy Families program (TANF). These experiments are not working. The citizens in need of these services are being harmed, the state's economy is being impacted, and the ability of senior citizens and persons with disabilities to get the long term care services they need in a timely manner is being affected. The Generations Project, in cooperation with the Indiana Home Care Task Force, has developed a model for a new public benefits program that is citizen/user friendly, high tech, cost effective, and based on what has worked in other states.

Nine, develop a comprehensive system of brain injury services and new models of nursing home care as endorsed in resolutions that passed the 2010 Indiana General Assembly. Brain injury services are hit and miss in Indiana. Comprehensive acute, post acute, life span and HCBS brain injury services are needed and should be accessible to persons regardless of income and locality. Nursing home care services, as commonly practiced in Indiana, constitute a failed model of long term care. The state should join consumers, professionals and providers in developing completely new approaches to nursing home care that are based on models desired and defined by consumers.

Ten, insure Indiana's expanded and new HCBS are truly comprehensive. Truly comprehensive HCBS must include traditional home care, assisted living, adult family care (in which each resident moves in with a true family in the actual home of that family), adult day and night, independent provider services, self-directed care, transportation, family caregiver supports including respite and employer programs to help family caregivers, and any other service that is necessary to prevent inappropriate institutional placements. These and other recommendations are found in *Lessons from Home,* published by The Generations Project, February 2008 and in this report.

Eleven, insure Indiana's expanded and new HCBS are cost effective, of high quality, and available when needed. This means establishing effective consumer review mechanisms in conjunction with the CHOICE advisory board, and giving the area agencies on aging the following tools with the mandate to use them: case managers with the authority to presumptively determine the eligibility of consumers thought to be eligible for publicly funded HCBS, more case managers, using self-funding mechanisms for growing HCBS (meaning, retaining the savings whenever people use publicly funded HCBS instead of Medicaid nursing home care to grow additional HCBS), dramatically expanding the use of self-directed care for HCBS clients, and establishing a viable independent provider network. This also means establishing a LTC pre-admission screening program with real authority, ending conflicts of interest between medical providers and nursing homes, administering the federal "money follows the person" grant in a manner that actually transfers people from nursing homes to HCBS, and ending the state's various welfare privatization experiments that are harming seniors and persons with disabilities.

Lessons from Home *Applied*

Goals

The Generations Project is proud to share with all Hoosiers the recommendations of a dedicated group of their follow citizens to improve Indiana's system of long term care. We call these recommendations *Lessons from Home Applied* to establish a direct link with the HCBS consumers and the family caregivers who were directly involved in crafting them through the Round Table Education Series and the Indiana Home Care Task Force.

When adopted and placed in practice these recommendations will make Indiana a better place to live by producing the following general outcomes. The outcomes will include publicly funded home and community based services for qualified senior citizens and persons with disabilities who otherwise would be at risk of forced placements in nursing homes. The outcomes will include support for the family members and friends who have attempted to care for loved ones who need, but cannot afford, home care and related services. Life simply will be easier and kinder for senior citizens, persons with disabilities and their families. The improved quality of life will translate into positive economic opportunities for many people. Businesses, academic institutions, and communities will be able to promote the state as a desirable place to work and live. If fully optimized, these changes can be transformative for Indiana.

These goals are inclusive of many of the basic qualities of life to which we all aspire. The estimated 700 citizens who participated in community, regional and statewide meetings sponsored and hosted by The Generations Project since early 2007 endeavored to identify the actions that are needed to make our state a place of opportunity, safety and support for senior citizens, persons with disabilities, and their family caregivers. This report is an attempt to reflect their combined recommendations.

A History

The Generations Project was founded in 2001 with the mission of re-balancing Indiana's system of long term care. As envisioned by the Project, re-balancing would be achieved by raising the public investment in home and community based services (HCBS) for senior citizens and persons with disabilities of all ages. Concurrently, re-balancing would lead to a reduction in nursing home care by giving people complete and uninhibited market access to the long term care services they prefer and which are most appropriate for them. To achieve the re-balancing of the state's long term care (LTC) system the Project determined the citizens who need home and community based services, and their families, had to be empowered to change the system through education and their own advocacy efforts.

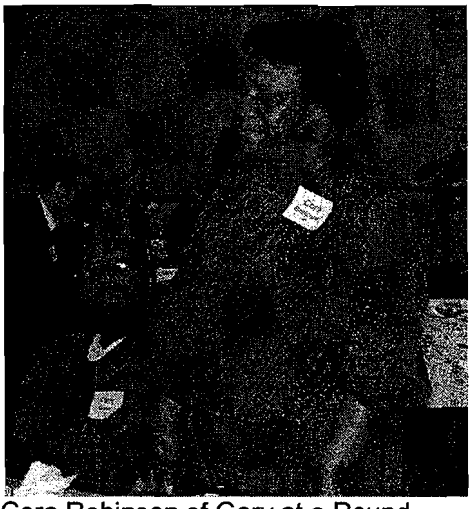
The Generations Project worked to achieve these ends in partnership with the Indiana Home Care Task Force, a voluntary alliance of consumers, their families, community leaders, long term care providers and professionals, and organizations representing senior citizens and persons with disabilities.

By late 2002 the Project's citizen-led education and advocacy activities gave the organization a statewide presence and produced its first HCBS reform model. The Project's advocacy education

activities were dramatically enhanced by working in partnership with the Indiana Home Care Task Force. The Task Force and citizen volunteers working through the Project soon got the attention of the General Assembly. Leading state lawmakers showed a keen interest in the Project's reform model. Using that model the 2003 General Assembly passed Senate Enrolled Act 493 and Governor Frank O'Bannon signed the measure into law.

SEA 493 created the necessary overall legal framework to re-balance Indiana's long term care system. Nonetheless, entrenched institutional and political interests in and out of state government have stifled the popular will that drove the passage of SEA 493. Seven years later the general authority of the act to re-balance Indiana's long term care system has been used only partially.

Despite their strenuous efforts the interests arrayed against the re-balancing of the state's long term care system have succeeded only in delaying the inevitable. The continuing advocacy and policy education activities by the Project, and similar activities by the member organization of the Task Force, is moving Indiana closer to a re-balanced LTC system. For example, the Task Force used analyses by the Project to convince the General Assembly to enact targeted laws in 2004, 2005 and 2006 intended to compel the executive branch to implement SEA 493. Those laws and the expanding base of citizens involved in the Project's advocacy education efforts did lead to steps to implement the act. In fact, for a time Medicaid funded nursing home enrollments actually declined.


Cora Robinson of Gary at a Round Table Education Series forum in Indianapolis speaking to the community needs of people with disabilities.

The combination of steps toward re-balancing and concurrent actions to block the process has produced public policy that is contradictory. State administrators and legislators have lauded SEA 493 and the CHOICE home care program while cooperating with nursing home interests to increase the public dollars invested in institutional care. Lawmakers and state administrators also have cooperated with licensed home health industry interests to limit the ability of qualified individual caregivers to provide publicly funded HCBS. At various times, state officials have interfered with the timely distribution of public funds for HCBS to the area agencies on aging (AAAs), the not for profit corporations that administer Indiana's single point of entry long term care system. Officials have also interfered with the ability of AAAs to consistently enroll persons into the CHOICE program and Medicaid waivers. In the 2010 state fiscal year, enrollments in the aged and disabled HCBS Medicaid waiver were suspended by the state, CHOICE dollars were withheld while waiting lists for services grew, and plans announced for cutting CHOICE by 15 percent in SFY 2011.

Perhaps, the contradictory long term care policies of the state would have already been resolved if it were not for another and completely unanticipated development: the contracting out of the administration of Indiana's public benefit programs to over twenty for-profit corporations beginning in early 2007. When the state handed IBM, ACS and other companies the administration of eligibility and benefits for Medicaid, food stamps, and Temporary Assistance for Needy Families (TANF) the result was catastrophic for clients.

Within months of the start of privatization, senior citizens and persons with disabilities were being forced off of Medicaid and food stamps throughout the state. That dynamic was exacerbated when the state also "modernized" selected counties after November 2007. "Modernization" proved to be a euphemism for forcing impoverished seniors, persons with disabilities, single moms, and families to self determine their Medicaid, food stamp and TANF eligibility and eligibility re-determinations on-line and through a regional calling center with telephones, fax machines, and computers. A very large percentage of these citizens could not afford access to telephonic technology and computers. They were also denied access to case workers in local offices. In a matter of months, modernization denied access to vital medical and nutrition services to tens of thousands of impoverished people.

By the spring of 2008, 59 of 92 Indiana counties had been "modernized" while all 92 counties had been privatized. The result was a documented crash in food stamp utilization and area agencies on aging had to step in to get Medicaid services restored for persons using waiver services. AAA case managers reported cases in counties across the state of seniors dying from complications linked to the denial of food stamps. AAA case managers in modernized counties reported using 60 to 90 percent of their regular working hours getting Medicaid and food stamp services restored to clients in order to keep them eligible for Medicaid waiver services. A review of IBM documents revealed over 247,000 denials for Medicaid, food stamp and TANF services were issued in SFY 2009 for "failure to cooperate" even though denying benefits for that reason is illegal under federal law.

The Generations Project and the Task Force were forced to respond to the privatization and modernization crisis because of its immediate negative impact on citizens needing LTC. These entities responded even though their limited resources were fully committed to LTC re-balancing and related citizen education activities. Fortunately, the Project's advocacy education activities provided access to informed and skilled volunteers. In 2008, Project volunteers that included retired and active social workers, leaders of senior citizen and disability advocacy organizations, elder law and ACLU attorneys, former farmers, a township trustee, and a former banker, logged over 11,000 hours helping to restore Medicaid and food stamp services for hundreds of impoverished seniors and persons with disabilities. The Project also assisted the Indiana Home Care Task Force, township trustees, local social services agencies, food pantries, unions, and community organizations in organizing large public meetings and media coverage of the public benefits crisis.

(L to R) Dan Skinner, Jim Wallihan, and Glenn Cardwell, volunteer members of the Indiana Home Care Task Force Committee of Welfare Privatization Issues, speaking at an October 2009 press conference regarding Indiana's Medicaid and food stamp privatization crisis.

Without a doubt the privatization and modernization of the state's public benefits system dramatically contributed to the increase in nursing home usage across the state. Long term care re-balancing objectives were also set back and are still being affected since most of the ills of welfare privatization and modernization continue to plague the state's public benefits system.

In the past decade there have certainly been policy and public funding triumphs driven by the growing number of Hoosiers who are knowledgeable regarding the benefits of HCBS. The notable victories include winning funding for the state's CHOICE home care program and the passage of SEA 493. In recent months the General Assembly has also shown an interest in studying the need for comprehensive

brain injury services including HCBS and life span components and, to a lesser extent, new models for nursing home care.

Sadly, the successes have also been off-set by the state's growing investment in institutional care, the limited availability of CHOICE and waiver services, and the persistent, purposeful roadblocks by the state and provider interests to pivotal HCBS elements. The list of blocked and or only partially used *critical* components includes the state's poor implementation of its federal "money follows the person" grant: a $21 million fund to transition people from nursing homes to home care that has only moved a few score people in five years. The list of blocked and or only partially used *critical* components includes retaining savings in publicly funded LTC when HCBS are used instead of nursing home services to purchase and grow HCBS for additional persons in need. This self-funding mechanism, which was a part of SEA 493 when it was enacted by the General Assembly in 2003, has never been used by the state.

The list of *critical* components that have been blocked or only partially used includes legislated or administratively adopted targets for transitioning people into HCBS, a LTC pre-admission screening process that really works, and expanded case management resources for area agencies on aging. The blocked or only partially used *critical* components have also included unlimited access to publicly financed self-directed care, a large individual provider network, Medicaid waiver presumptive eligibility authority for area agency on aging case managers, ending the self-dealing of patients-to-residents between medical providers and nursing homes that have fiduciary ties, adult foster care in which individuals truly live with real families in their own homes, assisted living, adult day and night care, home modifications, and transportation services. When welfare privatization and modernization is added to these factors the negative impact on long term care re-balancing has been considerable.

The results have also been predictable. The downturn in nursing home utilization leveled off and since 2007 Medicaid nursing home enrollments have been rising. In May 2006 the state's aging director reported the Medicaid nursing home resident daily census as 25,000 people. Four years later the current aging director reported a daily census for Medicaid nursing homes residents of over 28,500 people. Seven years since the passage of SEA 493, followed by numerous public commitments by state officials to implement SEA 493 and to grow HCBS, a rising nursing home daily census is unacceptable.

In early 2007, The Generations Project launched the Round Table Education Series. Scores of community, regional and statewide meetings were held over a three year period. More than 700 people were involved in the process. When the series ended on November 18, 2009, HCBS consumers, professionals and advocates had identified many of the remaining necessary steps to re-balance Indiana's long term care system. The Project published the participants wide ranging recommendations in February 2008 under the title of *Lessons from Home*. In this report the final recommendations of the citizens who participated in the Education Series have been compiled. They include proposed changes in Indiana's system of long term care for senior citizens and persons with disabilities, fundamental change in the state's public benefits system, and parallel private sector actions that can improve the state's economy and quality of life.

The report also includes recommendations crafted by persons in the Indiana Home Care Task Force, who also participated in the Round Table process, in response to dramatic HCBS public policy and

program developments since January 2010. The additional recommendations are directly related to the original Round Table findings.

Attached to the report are exhibits that include model proposals regarding long term care and public benefit programs including Medicaid and the Supplemental Nutrition Assistance Program. The model proposals demonstrate the changes that are recommended in the report are feasible. The exhibits also include resolutions that were passed by the 2010 Indiana State Senate, based on ideas drafted by the Project for the Task Force, regarding brain injury services and new approaches to nursing home care.

Lessons from Home *Applied:* The Recommendations

The recommendations that follow are intended to provide the missing elements from SEA 493, Indiana's sweeping 2003 HCBS reform law. The recommendations also consolidate and enhance the previous recommendations made by the consumer participants in the Round Table Education Series from 2007 through 2009, and include the findings of the Indiana Home Care Task Force since January 2010.. The Generations Project believes the implementation of these, or similar recommendations, is critical if Indiana is to re-balance its long term care system.

One, implement the recommendations made by participants in the Round Table Education Series and contained in the February 2008 report *Lessons from Home* published by The Generations Project. Those recommendations are attached to this report as *Exhibit A*. Many of those earlier recommendations include elements of the recommendations that follow below.

Two, throughout the Round Table process the Community and Home Options to Institutional Care for the Elderly and Disabled Program, or CHOICE, continued to receive highly positive and intense support from the participants even though the program is now over twenty-three years old. People uniformly believe the CHOICE program is uniquely valuable to the wellbeing of Hoosiers who need HCBS. Despite the continuing success and demand for CHOICE services that program is under siege as a result of a series of recent actions by the state administration to curtail its funding, availability and services to clients. Participants in the Round Table process have been expressing their deep concern for the future of the CHOICE program. For these reasons a special set of recommendations will be presented in this report regarding the CHOICE program and the Medicaid aged and disabled HCBS waiver.

State senators Robert Meeks (R-La Grange) and Richard Young (D-Milltown) signing an enlarged copy of House Enrolled Act 1094, the original CHOICE home care law, at the 2007 20th birthday celebration of the CHOICE program.

Three, Indiana should use any savings incurred by giving qualified senior citizens and persons with disabilities the option of using publicly funded home and community based services instead of nursing home care to purchase HCBS for other qualified senior citizens and persons with disabilities who are also at risk of going into a nursing home. This *self-funding* approach is now used by a large number of states across the nation as a means for pulling down the over utilization of nursing homes while growing publicly funded HCBS. The average Indiana public cost of nursing home care through Medicaid per persons per year is over $55,000 while the like cost on the Medicaid HCBS waiver is just short of $33,000. The per person per year costs for the CHOICE home care program is just over $5,000. If Indiana has 14,500 people on Medicaid in nursing homes who should be receiving HCBS it is easy to see why the self-funding mechanism described above has great potential.

Four, establish a network of independent providers (individuals who are qualified to provide a variety of home care services) in addition to the HCBS provided through licensed home health agencies. Independent provider (IP) networks are used in at least twenty-two states because they provide quality care, expand the availability of qualified and vetted HCBS workers, enhance the ability of consumers

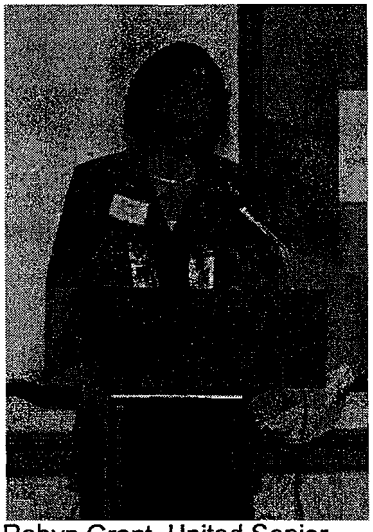
who are able to self direct their caregivers, expand the labor pool from which licensed HCBS agencies recruit employees, lower government cost, and save tax dollars.

Five, give the area agencies on aging the authority to presumptively determine the eligibility of persons who need HCBS funded through a Medicaid waiver. Other states do this in order to enroll people into lower cost home care services before they are at risk of being placed in more expensive nursing home settings. The results also include lower institutional care costs for those states, greater HCBS cost effectiveness, more preventative care, and taxpayer savings.

Six, fully utilize the administrative mechanisms, methods, programs and services identified as *critical* components on page 7 of this report. Presently, these necessary tools for re-balancing Indiana's LTC system suffer from neglect, under use, partially use, or are not used at all in our state. As a result, Indiana cannot fully and properly establish the home and community based services that will serve the best health, family and economic interests of its citizens. This means taxpayers will continue to underwrite the nursing home industry for services that are not needed and not wanted.

Seven, monies appropriated by the legislature for the CHOICE home care program, and federal funding for home and community based services, should not be withheld by the state from the area agencies on aging that administer these programs locally. This only results in delays in services, fiscal uncertainties for the AAAs, more people being forced into nursing homes, and the loss of the fiscal and health outcomes benefits described under point five above. More will be said regarding this recommendation in the special section on the CHOICE HCBS program.

Eight, establish a comprehensive system of services for persons with brain injuries (BI) in Indiana. The system should insure the immediate availability and full access to acute, post-acute and lifespan treatment and therapy. The system should also include viable education, employment and family support assistance. At best, current brain injury services in Indiana are spotty. Estimates range from $14 million to $18 million each year in taxpayer dollars that are spent by the state caring for Hoosiers who must be treated in Illinois, Michigan and elsewhere because the services are not available here. With appropriate and ongoing therapy people with brain injuries continue to recover throughout their lives. Among the Hoosiers who need BI services many are receiving improper long term care because they have been misdiagnosed. Too many Hoosiers with brain injuries are wrongly sent to nursing homes that have no capacity to provide them with adequate treatment other than housing and food. Others end up in the state's prisons and county jails. Many more lead lives where their productivity and economic opportunities are significantly limited due to the lack of brain injury services.


Robyn Grant, United Senior Action, addressing a session of the Round Table Education Series in 2008 regarding the needs of nursing home residents.

Nine, new models and strategies for long term care in nursing homes and other institutions should be explored and, over time, established. They might include so-called "small" house with emphasis placed on highly individualized care that closely mirrors the resident's actual home. These models should emphasize the protection of the human rights of the residents. These models should also maximize the opportunities for

residents to maintain their involvement in family life, community affairs, and economic activities as they see fit and are able.

Ten, a new model for Indiana's public benefits (welfare) program is desperately needed. The state's experiment with the privatization and so-called modernization of Medicaid, food stamps (the Supplemental Nutrition Assistance Program, or SNAP), and temporary assistance for needy families (TANF) has failed badly. Local human service professionals believe persons in frail health have died for lack of appropriate nutrition and medical care. Recent field interviews suggest the state's latest experiment, the hybridized version of privatization in SW Indiana, also is failing. Separately and together the three forms of welfare privatization currently use by the Indiana Family and Social Services Administration have added a confusing layer of private for-profit bureaucracy that has brought no net value and no net efficiency to the system while harming clients and increasing costs for taxpayers. A new system based on a uniform system administered by mission driven state employees with a focus on timely and quality services, face to face contact, caseworkers helping seniors and persons with disabilities in their own homes, and new, smart consumer friendly technology in local/county offices is needed. As of the publication date of this report, the continuing failure of private for-profit contractors that work for Division of Family Resources to properly process Medicaid, SNAP and TANF applications places senior citizens and persons with disabilities in danger.

Eleven, provide public support for employees who are also family caregivers, and support for employers that help their employees with their family caregiver obligations. The state should also proactively work with unions, non-profit organizations, senior citizen organizations, organizations that represent persons with disabilities, minority organizations, and the federal government to support family caregivers, small businesses, and corporations. Eli Lilly & Company, the largest employer in Indianapolis, is an example of a corporation that recognizes the wisdom of supporting valuable employees who are also family caregivers.

Twelve, review and develop transportation and housing initiatives in communities throughout the state where the lack of these services are placing senior citizens and persons with disabilities at risk. The risks include medical and physical jeopardy, isolation, lack of employment opportunities, and exclusion from social and civic affairs. The lack of public transportation also keeps low income home care workers from reaching potential HCBS clients. The transportation initiatives should cover the local, regional and statewide transportation needs of seniors and persons with disabilities of all ages.

Thirteen, reviewing racial, ethnic, cultural, religious, geographic, economic and other demographic factors to insure that all people have equal access to HCBS, and taking action to address disparities and unintended consequences that any segment of the population may be experiencing per the delivery of HCBS. The solutions must include public and private institutions and agencies.

Fourteen, defining quality in the long term care system from the perspective of the human rights of the persons receiving publicly funded services. Short of defining quality in this context, citizens who use HCBS and other LTC services that are critical to their health and well-being are always subject to having those services curtailed or altered per the convenience of other people including case managers, providers and public officials.

Fifteen, none of the aforementioned recommendations are viable if the state fails or refuses to *fully* invest in a comprehensive and inclusive system of HCBS with the intention of re-balancing Indiana's LTC. For example, preventing unintended consequences and addressing health care disparities between racial, ethnic, and other demographic groups becomes virtually impossible without a viable state investment in CHOICE and the full and aggressive use of services funded through the Medicaid aged and disabled waiver.

Sixteen, establish a consumer review and advisory process for working directly with the CHOICE Advisory Board and the Division of Aging per the implementation of the reforms advocated in this report. This new process should be entirely consumer driven and should enhance the statutory review and advisory authority of the CHOICE board.

Seventeen, review and prepare to act on the various provisions of the 2010 federal Patient Protection and Affordable Care Act, including utilizing the CLASS (Community Living Assistance Services and Support) Act section of the new law, to increase the federal resources available to Indiana to grow HCBS.

Special Recommendations Regarding the CHOICE Program and the Medicaid Aged and Disabled Waiver

The CHOICE program is the cornerstone to Indiana's system of HCBS. Since the act's original passage in 1987, the General Assembly has enacted a long series of laws that have extended the reach of the CHOICE program. These have included expanding the following: the rights of the citizens that use CHOICE services, the scope of the program's client cost share formula, and Senate Enrolled Act 493.

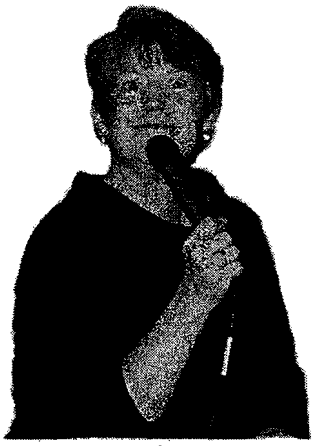
SEA 493, passed in 2003, requires the services provided under the Medicaid aged and disabled waiver, and the rights of the clients receiving those services, to be brought up to the standards established by the CHOICE program. It is also important to note that eligibility for the CHOICE program is inclusive of everyone that is eligible for services through a Medicaid waiver. CHOICE requires a person to be unable to perform two (2) or more activities of daily living, while the Medicaid aged and disabled waiver requires the inability to perform three (3) or more ADLs. Income eligibility for CHOICE starts at zero and has no upper limit in contrast to specific income limits under Medicaid including the aged and disabled waiver. However, because of the cost share formula, persons on CHOICE must pay for 1 percent of their services for every two points their income rises above 150 percent of the federal poverty level after deducting the applicant's ongoing medical expenses that were existent prior to applying for CHOICE services.

John Thomas, center, author of the 1987 CHOICE home care act, posing in 2007 with members of the Indiana General Assembly to celebrate the 20th birthday of the CHOICE program.

When the CHOICE program was originally passed by the General Assembly, lawmakers had

specified goals in mind and designed the program to meet those objectives. CHOICE was intended to keep people from being forced into poverty because lawmakers correctly believed that poor folks were far more likely to be forced into Medicaid funded nursing home care. CHOICE was intended to provide preventative home health care services in order to keep senior citizens and persons with disabilities from prematurely deteriorating physically, medically and psychologically. CHOICE has done that. CHOICE was intended to provide enough help to adequately support family caregivers but not to displace them. The program has succeeded in doing that. CHOICE was intended to keep people from being inappropriately placed in nursing homes and similar institutions. CHOICE has certainly done that. Finally, CHOICE was intended to save the state money. Many state officials and the annual reports issued by the Division of Aging have always confirmed that CHOICE saves the state and taxpayers significant amounts of funding. (See data from the most recent CHOICE annual report attached to this report as *Exhibit C.*)

Inexplicably, since 2005 certain state officials have failed to value what CHOICE was successfully designed to do. These same officials have essentially criticized CHOICE for not being a Medicaid program and have subsequently attempted to force the program to act as a funding stream for Medicaid waiver match.



Nancy Griffin, HCBS consumer and advocate, addressing the CHOICE 20th birthday celebration at the University of Indianapolis.

The latter strategy has failed to recognize the total public costs associated with the Medicaid aged and disabled waiver, which are thought to average $32,772 per person per year based on comments made by a Division of Aging official at the June 17, 2010 meeting of the CHOICE advisory board. That's over six times the average annual cost for a person to be on the CHOICE in total public funding. When the federal tax portion of the aged and disabled waiver is factored out the state's tax share ($8,193) is still substantially higher than the cost to the state for the CHOICE program ($5,086 per person per year).

The Medicaid aged and disabled waiver costs substantially more than CHOICE because persons on the waiver also qualify for all Medicaid state plan medical services in addition to home and community based services. Citizens participating in the Round Table Education Series correctly noted that if a person only needs home care then CHOICE makes the most sense for that person. It also makes the most sense for the state and taxpayers. However, if a person also needs the medical care that is available for persons who qualify for Medicaid or a Medicaid waiver then the aged and disabled waiver may be the best option for all concerned.

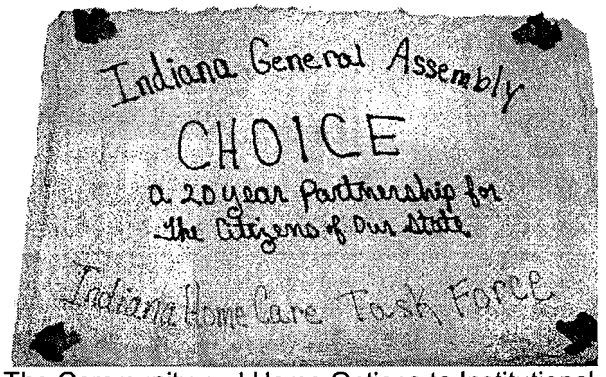
Furthermore, the CHOICE program is more versatile and administratively easier to use than waivers. Under CHOICE a person needing home care can qualify for whatever HCBS service that is needed as long as the funds are available from the state to cover the services.

Ironically, state officials have succeeded in making CHOICE operate more like the Medicaid waiver even though SEA 493, enacted into law in 2003, calls for just the opposite. Under pressure from the state administration the General Assembly has designated more and more money from the CHOICE program as the state's share of the Medicaid aged and disabled waiver. Presently, that total is now up to

$13.1 million per year. Since December 2009 the state has also frozen new enrollments in the waiver. During this time the state has done nothing to bring the rights of Medicaid HCBS clients up to those enjoyed by Hoosiers using the CHOICE program. The state is also requiring persons applying for CHOICE to apply for and be rejected for Medicaid waiver eligibility first, thus delaying, sometimes by many months, enrollments in either the waiver or the CHOICE program.

Area agencies on aging, which administer CHOICE and the waiver locally, can temporarily enroll people in CHOICE if they have CHOICE funds available, but the distribution of CHOICE appropriations by the state has been erratic. Persons who are only CHOICE eligible are harmed by this process as dwindling CHOICE dollars are used for persons who ultimately are eligible for the waiver. Assigning or using CHOICE dollars for Medicaid waiver match also reduces the total dollars available for HCBS. The net effect of that is to drive up the utilization of Medicaid funded nursing home care, which is a legal entitlement that cannot be denied to clients by state budget cutters.

As of July 1, 2010, which is the start of the state's new fiscal year, there will be a 15 percent cut in CHOICE services issued by the Indiana Family and Social Services Administration. However, some observers believe that is not a cut that will be spread evenly across the entire annual appropriation for the CHOICE program, which is $48.675 million. They contend the 15 percent is being taken from the dollars that remain for direct CHOICE services after dollars for administrative costs and the Medicaid aged and disabled waiver have been subtracted. If true, the real cut in CHOICE services would be much higher. The state needs to clarify its intentions regarding the planned cut in the CHOICE program.



The Community and Home Options to Institutional Care for the Elderly and Persons with Disabilities Program (CHOICE) 20th birthday cake.

The actions taken by the state administration against funding and fully utilizing HCBS, especially in the past year, are dumbfounding given what is happening to the state's Medicaid funded nursing home population. The Medicaid nursing home daily census in Indiana has now jumped to over 28,500, up by approximately 3,500 people in just the past four years according to statements made by Division of Aging officials. When compared to other states, such as Washington and Oregon that have successfully pulled down the inappropriate and highly expensive use of publicly financed nursing home care, Indiana is a radical failure. Most states complete the bulk of the long term care rebalancing process in 5 to 7 years once they put in place the legal and administrative means to do so. Indiana passed SEA 493 in 2003 but has done very little to implement that comprehensive long term care re-balancing law.

If Indiana had acted over the past seven years like Washington or Oregon, our Medicaid nursing home population daily census could be under 14,000 people - less than half the current census of just over 28,500. One can calculate the costs that are incurred when serving an extra 14,500 people in nursing homes by multiplying that number by $55,000, the average cost to serve a Hoosier for one year in a nursing home funded by Medicaid. That produces a total cost of $797,500,000.00 in one year. That is an astonishing number by any measure. In a real world context, this means Indiana is now spending nearly $800 million per year in state and federal taxes for the wrong care through the Medicaid program.

If used appropriately, those dollars could be purchasing home and community based services at a much lower cost for far better outcomes, the persons remaining in nursing homes could receive better care, and citizens could probably see a reduction in their taxes.

Given the above factors, and the concerns shared by citizens that participated in the Round Table Education Series, special recommendations regarding the CHOICE home care program and the Medicaid aged and disabled HCBS waiver are presented below.

One, attempts to bring the CHOICE program down to the level of the Medicaid aged and disabled waiver should be halted and reversed. Trying to turn the CHOICE program into a conduit for Medicaid funding and standards violates the letter and intent of SEA 493, as enacted by the 2003 Indiana General Assembly.

Two, the fiscal integrity of the CHOICE program should be restored by ending the practice of arbitrarily holding back the distribution of CHOICE dollars, including $2.2 million that was appropriated for state fiscal year 2010. The state just recently agreed to release those dollars for the 2011 fiscal year which begins on July 1. No one should ever go on a waiting list for services if CHOICE dollars are available. During the 2010 fiscal year the waiting list for CHOICE services was allowed to grow past 3,200 individuals. Growing the waiting list for any HCBS services (see point three below) merely drives people to use expensive Medicaid funded nursing home care, to which they are legally entitled under federal law.

Three, stop the freeze on Medicaid aged and disabled waiver service slots. Lift the December 2009 ban on new enrollments in the waiver and petition the federal government for permission to add new waiver slots if all current slots are filled. The United States Department of Health and Human Services, through its Centers for Medicare and Medicaid Services (CMS), has been actively promoting the growth of state administered HCBS programs in order to reign in the over use of Medicaid funded nursing home care. The odds are very high that CMS will approve a request for new waiver slots if properly documented by Indiana. It has been proven in other states that growing HCBS reduces Medicaid costs by pulling down the inappropriate use of far more expensive nursing home care.

Four, stop misapplying the service eligibility standards of the CHOICE program. When people cannot get services through the Medicaid aged and disabled waiver or by private means, individuals who are legally qualified should be enrolled in CHOICE. Insofar that the funds are available, under the CHOICE statute these individuals should get the full array of home services that they need. These individuals should not be restricted to limited case management services if other HCBS services are needed. According to the Division of Aging, a full sixty percent of the clients served by CHOICE are now being limited to case management.

Five, stop the arbitrary assignment of the maximum number of CHOICE dollars available for the Medicaid waiver under the provisions of the state budget act. This practice guarantees that people needing CHOICE services will be pushed aside, and the total number of dollars spent on HCBS reduced, as CHOICE simply becomes the state's funding source for matching the federal dollars in the Medicaid waiver. Indiana is serving an estimated 14,500 people in nursing homes through Medicaid who should be receiving HCBS. Consequently, the practice of raiding CHOICE dollars for Medicaid match, even

though it is legal under the provisions of the 2009 state budget act, is actually making the state's budget crisis worse since Medicaid nursing home care is eleven times more expensive than CHOICE.

Six, ***stop immediately the 15 percent cut in CHOICE funding.*** Why cut an estimated $7.3 million in funding when every dollar that is available should be used for HCBS? The cut in CHOICE funds will actually contribute to the state's budget crisis by growing the use of Medicaid funded nursing home care.

Conclusions

What can we conclude regarding CHOICE and Medicaid waivers?

If the CHOICE program was allowed to function as designed more people would receive high quality home care and related community based services. Medicaid funded nursing home care could also be pulled down at a dramatic savings for taxpayers.

If the Medicaid aged and disabled waiver was used appropriately, low income Hoosiers could get much needed HCBS and medical services while also contributing to the reduction in nursing home care spending.

IF both of these programs were fully utilized our nursing home daily census would be substantially dropping, home care substantially expanded, the quality of nursing home care raised for those Hoosiers who truly need that form of care, taxes potentially lowered, and the quality of life improved in Indiana.

Presently, Indiana is spending an estimated $800 million per year for the wrong form of long term care for 14,500 of its citizens. This is happening because those citizens are not being given the option of more appropriate, better and less expensive home and community based services. It is time to treat Hoosiers right by spending our tax dollars on the home and community based services that people want and need but cannot otherwise afford. It is time to invest in a better quality of life for all Hoosiers.

What can we conclude regarding Indiana's system of long term care?

By definition long term care includes care provided in a nursing home and care provided to persons in their own homes and the community who can no longer perform the common activities of daily living, such as walking or feeding or toileting or bathing or communicating, or other such activities, without some form of assistance. Most people will experience a decline in their physical and cognitive skills during the course of their lives but may never need assistance from another person. However, many people do need that assistance. For those who do they may be at risk of losing their independence without the help of family members, friends or long term care professionals. In some cases, people simply do not have the financial means to pay for long term care services. Consequently, those individuals may need publicly financed home and community based services, such as home care or assisted living, and in some cases nursing home care depending upon their level of impairment and the support they have from family and friends.

Al Tolbert speaking for the Paralyzed Hoosier Veterans at a Round Table Education Series forum.

In this report, much has been said about the ability of people who need long term care services to continue to live at home, to be engaged with their families and in community life, and even to keep working, ***if*** they have access to affordable, workable and reliable home and community based services.

Presently, Indiana simply does not have in place the full array of

home and community based services to keep all Hoosiers at home who should remain with their families and friends, and remain contributors to their communities. This failure fractures families, hurts businesses when employees who are also family caregivers have no help in providing care for a loved one, and hurts the overall quality of life in our state.

This need not be the case. In this report, the means have been identified to resolve and to solve the needs of citizens in Indiana who need help with long term care services and expenses. In this report the tools to put in place the home and community based services that Hoosiers need and want have been identified. The means to pay for those services and the benefits to be derived by all Hoosiers have also been identified.

Who has the power to act to give Hoosiers the long term care system they need?

The bottom-line question is this: will our policy makers in the form of elected lawmakers and appointed state administrators have the will to put the long term care system in place that Hoosiers need? The CHOICE program, Indiana's Senate Enrolled Act 493 of 2003, Medicaid waivers for home and community based services, and the new federal Patient Protection and Affordable Care Act provide most of the legal, administrative and financial means are needed to give Indiana the long term care system that its citizens so badly need.

Elmer Blankenship, President of the Indiana Alliance for Retired Americans, speaking at the 2009 Round Table Education series state conference regarding the importance of citizen involvement in rebalancing long term care.

Given these facts it is up to our elected lawmakers and appointed public officials to make the decisions to focus the above resources on the availability and delivery of quality home and community based services.

That brings the focus of this report and these conclusions back to you. As a citizen of Indiana you must step forward and implore your public leaders to do these things. You have the power to do that. You have the power, acting in concert with your friends, neighbors and other Hoosiers to give Indiana the long term care system that will serve and protect our most vulnerable senior citizens, persons with disabilities, and their family caregivers. Please step forward and act. Please contact us and other citizen advocacy organizations. As citizens we will be proud to work with you to achieve this worthy end. Thank you.

Exhibits

To fully appreciate the information and commentary contained in **Lessons from Home *Applied*** please review the exhibits that follow. The exhibits contain valuable insights and information regarding Indiana's long term care system. The exhibits also include tangible models for re-balancing long term care and establishing a fair and practical public benefits program in Indiana.

Exhibit A, pages 20 to 31, ***Lessons from Home***, The Generations Project, February 2008. Forty-five recommendations for HCBS reform developed by long term care consumers, their family caregivers, professionals, leaders of organizations representing senior citizens and persons with disabilities, and advocates that participated in the community, regional and statewide meetings of the Round Table Education Series sponsored by The Generations Project in 2007. These recommendations are at the heart of the LTC reforms contained in this report and were intended to provide the pieces that were missing from SEA 493, Indiana's 2003 HCBS reform and LTC re-balancing act.

Exhibit B-1 and **B-2**, pages 32 to 50, findings from the community forums and HCBS reform surveys conducted by The Generations Project, fall, 2009. The information contained in Exhibits B-1 and B-2 is highly insightful. B-1 is a summary of the discussions that took place in twelve community/regional forums on HCBS issues held across the state. 200 people took part in these discussions. B-2 is a summary of the written answers that 109 people gave to questions regarding HCBS reforms following the fall 2009 community meetings.

Exhibit C, pages 51 to 55, data from the **CHOICE Annual Report**, Division of Aging, Indiana Family and Social Services Administration, July 1, 2008 through June 30, 2009. The data from the CHOICE annual report demonstrates the distinct savings generated by the CHOICE home care program in comparison with like Medicaid data per the cost of nursing home care. The data is from state fiscal year 2009 and is from the most recent annual report published by the division.

Exhibit D, page 56, **Senate Concurrent Resolution 31**, 2010 Indiana General Assembly. "A concurrent resolution requesting that the Health Finance Commission review innovations in nursing home services and housing." Authored by Senators Vaneta Becker and Patricia Miller, and based on a model crafted by The Generations Project for the Indiana Home Care Task Force, the resolution passed but implementation remains uncertain.

Exhibit E, page 57, **Senate Concurrent Resolution 32**, 2010 Indiana General Assembly. "A concurrent resolution requesting that the Health Finance Commission review the prevalence of brain injury, the scope of brain injury services, and financing for those services in Indiana." Authored by Senators Patricia Miller and Vaneta Becker, and based on a model crafted by The Generations Project for the Indiana Home Care Task Force, the resolution passed and initial action is expected in the fall of 2010.

Exhibit F, pages 58 to 64, ***A New Long Term Care Model***, The Generations Project, 2010. Written to represent the views expressed by HCBS consumers, their family caretakers, and representatives of the Indiana Home Care Task Force throughout the Round Table Education Series process from 2007 through 2009, and during the spring of 2010. The model demonstrates it is possible to re-balance

Indiana's long term care system based on consumer defined and driven home and community based services.

Exhibit G, pages 65 to 72, ***A New Model for Public Benefit Programs in Indiana***, The Generations Project, 2009. The model was written to represent the needs expressed by citizens involved in the Round Table Education Series, the Indiana Home Care Task Force Committee on Welfare Privatization Issues, and by over 1,000 citizens who participated in public meetings in Anderson, Muncie, Terre Haute, Bloomington and Kokomo in 2008. The model demonstrates it is possible to establish a system of eligibility services for public benefits (the Medicaid, Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families Program) that is driven by the rights and needs of clients. The model makes it clear that clients can and should receive public benefit services in safe and accessible locations, at home whenever necessary, in a timely manner, and of high quality. The model demonstrates that senior citizens and persons with disabilities should not have their home and community based services for long term care jeopardized by a poorly conceived and administered system of public benefits.

The Round Table Recommendations

The human stories from the Round Table sessions provided compelling real life evidence regarding the urgency of rebalancing of the state's system of long term care by fully investing in HCBS. The stories played a direct role in building consensus among the participants. The Project believes these consensus recommendations are solutions that can be used by citizens, businesses and the state to dramatically improve our system of long term care. These recommendations represent an opportunity to elevate the quality of life for all Hoosiers. The Round Table process is also a model that can be applied in other states.

Under the topical headlines that follow, please read the recommendations from the citizen participants in the Round Table Education Series.

Fund CHOICE and Medicaid waiver services as made possible and intended by the Indiana General Assembly.

- *Make CHOICE and Medicaid waivers work as intended by releasing the dollars appropriated for those programs according to the schedule set by the General Assembly in the state budget act, HEA 1001.* It is now apparent that many, if not most, area agencies on aging had their CHOICE dollars held back by the Division of Aging and the Family and Social Services Administration at least through the first quarter of the present state fiscal year, SFY 2008 beginning July 1, 2007. On the disability side of the ledger, centers for independent living (CILs) are still in a struggle with FSSA to have their funds released. In both cases, persons served by these agencies have been placed at great risk, employees of the agencies harmed, CILs placed in jeopardy, and precious funds will go unspent because of the delays while vulnerable Hoosiers go without service.

- *Stop cuts in funding, services and hours of service for CHOICE consumers.* Recently, reports have popped up all over Indiana of area agencies on aging (AAAs) being forced to cut services and hours of service for established CHOICE clients. These cuts cannot be justified given the level of funding provided by the General Assembly for CHOICE in the 2007 budget act and the concurrent migration of persons from CHOICE to Medicaid waivers under the provisions of SEA 493.

Fully implement CHOICE, SEA 493 and related consumer driven HCBS programs.

- ***Fully implement SEA 493 and properly implement the CHOICE program*** because the services through these programs are vital to the health and well being of persons with disabilities, senior citizens, and their families. These programs are the law!

- ***The primary emphasis should be on home care among the services provided through the CHOICE and Medicaid waiver programs (under SEA 493).*** All HCBS services are important but plain old home care can serve more people faster and cheaper than other program s and keep

people in their homes. It is the best deal for taxpayers and the quickest and most reliable way to reduce the need for expensive Medicaid funded nursing home care.

- *Aggressively implement the Money Follows the Person (MFP) provisions of SEA 493 and properly implement the $21 million federal MFP grant* the state received over a year ago. MFP is a huge opportunity to move people from institutions back into their homes or into community based care settings. As a recipient of a five year federal grant for that purpose, Indiana has a great opportunity. Unfortunately, the implementation of services under that grant has still not happened and the state is already into the second grant year. Federal law requires a person to be in a nursing home six months before the MFP grant dollars can be used. However, under the provisions of SEA 493 there is no six month restriction. In the situations where MFP grant dollars cannot be used the state could apply other dollars to meet the provisions of SEA 493 for persons using services via a Medicaid HCBS waiver. Finally, there are no restrictions on placing NF residents who meet CHOICE eligibility criteria in community services funded by that program except for the availability of appropriated dollars.

Mike Sullivan, Alzheimer's Association, presenting at the November 7, 2007 Round Table at the Indiana Interchurch center, Indianapolis.

- *Explore using Medicare funds for home care on a temporary basis until a person can utilize CHOICE services.* In the early days of the CHOICE program there was more attention given to the limited service window for home care provided by Medicare. For persons coming out of hospitals reviewing that option could be an important short term home care funding source. Additionally, the state and the area agencies on aging should dramatically increase the rate of transitioning people out of nursing facilities, and diverting folks from facilities, by working in close partnership with organizations that represent senior citizens, persons with disabilities, and community based groups.

- *Implement the Private Hire Act and optimize the use of self-directed care.* Self directed care not only keeps people in their homes but it dramatically engages consumers in the nuts and bolts of their own care. It is radically under-utilized in Indiana and should be a major feature of CHOICE and Medicaid waivers.

- *Let the market develop naturally for CHOICE and Medicaid waiver services under SEA 493 by not limiting the service slots available to consumers for these programs.* SEA 493 required the state to have 20,000 slots available for Medicaid waiver services, but that provision was never utilized. This recommendation is important for two critical reasons. First, nursing home care is a legal entitlement so anyone who is denied HCBS can always go into a NH. Second, the limiting of slots or access to needed services drives people away from the best health outcomes and

most cost effective forms of LTC. Such outcomes are bad for taxpayers and the overall quality of life in our state.

- *Establish provider rates that truly work for CHOICE* by re-establishing the local rate negotiation authority for that program that was successfully and cost effectively utilized by the area agencies on aging from 1988 until 2006.

- *Set year by year targets for the number of people to be served* in HCBS and for reductions in the number of people using Medicaid certified nursing home beds. The targets should be linked with a nursing home resident diversion and conversion program that is effective for all consumers who need HCBS. When the market is not artificially manipulated this approach has proven to be effective in other states.

- *Select the membership of the CHOICE board as required by state law.* If the statutory process was followed the CHOICE board membership would include senior citizens, persons with disabilities, and other advocates with real standing among the constituencies they are legally charged to represent. This would enhance the effectiveness of the body per its dual policy oversight and advisory functions regarding publicly funded LTC. It should be noted that in 1996 and 1998, when the CHOICE board had stronger consumer representation, it produced studies and recommendations that anticipated the content of SEA 493 in 2003.

State Senator Errington (D-Muncie) and State Representative Larry Buell (R-Indpls).

- *Publish data regarding the CHOICE program and Medicaid waivers that is accurate.* In 2007 the state counted people as active recipients of CHOICE services who had merely been assessed or reassessed per their HCBS eligibility and status. Inaccurate data and exaggerated claims regarding persons served jeopardize public confidence and place the proper funding of HCBS by the General Assembly at risk.

Level the playing field between HCBS and nursing home care.

- *Establish HCBS as an entitlement under Indiana law.* This would solve the problem of access to HCBS and resolve the parity issue with nursing homes. Given the low cost and high effectiveness of CHOICE and Medicaid waivers, if entitlement status was established, long term care consumers, taxpayers and the state would all be better served.

- *Place state employees in hospitals to review and screen every discharge to make sure no one is inappropriately sent to a nursing home.* It is common practice for persons to go directly to nursing homes from hospitals. This dramatically increases the risk of permanent institutional placement. The state of Washington has used state employees in hospitals since the early

1990s to direct patients to appropriate LTC services. Washington and Indiana have virtually the same size population and very similar demographics. Washington has a daily Medicaid nursing home resident population of about 11,000. The same number for Indiana is over 25,000. In Indiana, AAA case managers could stationed in hospitals as an alternative to state employees.

- *Establish a Pre-Admission Screening (PAS) system and a Medicaid eligibility determination process that really works.* PAS, the administrative mechanism administered by the AAAs to route persons to the appropriate form of long term care, fails all too often. As suggested above, placing state employees or AAA case managers in hospitals (and even nursing homes) would allow PAS to work as intended and needed. Many Hoosiers are also having their Medicaid applications for HCBS waivers delayed for months by the state. These failures waste taxpayer dollars and place the health and independence of long term care consumers at risk.. Giving AAAs presumptive eligibility authority would be an effective way to avoid these problems.

Changes in state policies and programs must resolve any unintended consequences that harm HCBS consumers.

- *The serious problems for senior citizens, persons with disabilities, and minorities that are being caused by welfare modernization must be addressed.* Welfare modernization (privatization) is jeopardizing access to HCBS because it is stopping people from entering the Medicaid system. This will increase the pressure on vulnerable individuals to turn to nursing homes for care. Stripped down county Division of Family Resources (DFR) offices are telling persons they are not taking Medicaid applications at the present time, or that they will have to wait for several months to apply. If true, this is clearly a violation of federal law. The problems may get worse as the new telecommunications based eligibility system is not likely to work for many individuals with cognitive and physical impairments. Additionally, most of the experienced case workers have been transferred to the private contractor or they have simply quit. The Generations Project has even received reports of county DFR employees coming to local AAA offices for instructions on how to process Medicaid applications.

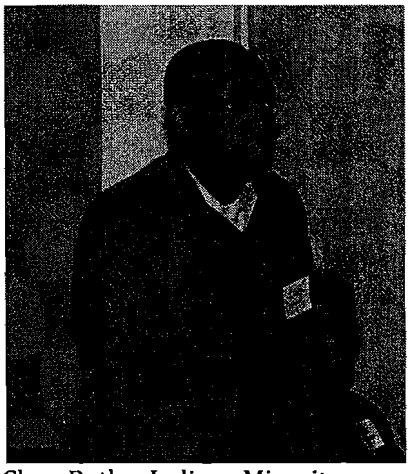
- *Changes in home medical services that place the lives of consumers in jeopardy must be reversed immediately.* Citizens in the Round Table hearings and during other outreach activities by the Project identified planned changes by FSSA and private vendors that are threatening to end the home delivery of medical supplies and services that literally keep persons with significant disabilities alive. These planned changes need to be reviewed immediately and stopped, if consumers are at risk.

- *The interpretation and/or application of Medicaid rules that irrationally blocks needed HCBS services should be changed.* Reports are coming in from across the state of persons who are being denied Medicaid waiver services who were already Medicaid eligible. In many cases, state Medicaid officials appear to be issuing arbitrary denials of home health equipment purchases, home modifications, and services even when these denials jeopardize the provision of needed home care or make it harder for family members to continue as caregivers. Moreover, consumers and family members are often stonewalled for extensive periods of time when

attempting to get answers from the state. The entire Medicaid HCBS review and decision making process needs to be reviewed with consumers, their advocates, area agencies on aging, and the centers for independent living.

- *Any universal health care proposal considered by the General Assembly should include all forms of long term care.* Universal health care proposals are receiving increasing attention in every state in the nation. In the 1960s, home and community based services were not a part of the Medicare and Medicaid debate. The same mistake should not be repeated if universal health care becomes politically viable.

Address the HCBS needs of minorities and special demographic groups.

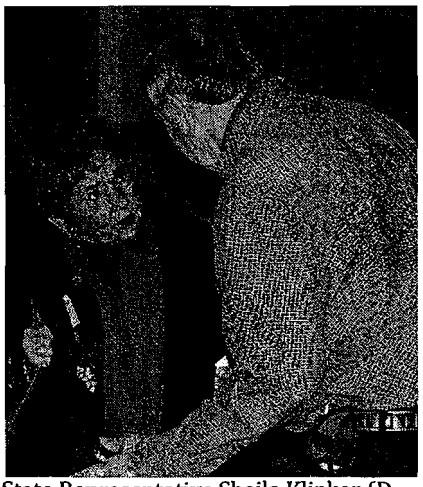


Clary Butler, Indiana Minority Health Coalition, leading a session regarding the risk of unintended consequences for minorities and other demographic groups in the application of HCBS at the December 12th Round Table.

♦ *Examine the data regarding the distribution of publicly funded HCBS and the unmet need for those services among minorities and persons in unique demographic and geographic areas.* This should include research regarding variations in HCBS services among demographic groups and working with the Indiana Minority Health Coalition, area agencies on aging, and centers for independent living to identify the services needed by those populations.

♦ *Direct involvement of minority populations in the HCBS policy and program decision making process.* This should include re-examining the composition of the CHOICE board and adding a minority services component to the Division of Aging.

♦ *Establish training and education programs for area agencies on aging and centers for independent living per the needs of African Americans, Hispanic Americans, Native Americans, and other populations with significant HCBS needs.* Such training and education would be highly consistent with the total service mission of the new *aging and disability resource centers* that are being developed by every AAA in the state. The training and education would also help fill long standing and lapses in service received by minority populations.



State Representative Sheila Klinker (D-Lafayette) and A.G. Clyne, family caregiver, discussing the lack of comprehensive services in Indiana for persons with brain injuries.

- *Act to serve populations with profound and unique LTC needs, including HCBS. Persons with brain injuries* and other populations with profound and unique needs often have lifelong and highly individualized care requirements. The state should proactively address the immediate and life span needs of these individuals with the objective of helping them achieve as much independence and self-reliance as possible. Developing and establishing supports for persons with lifelong needs enhances the possibility that these individuals can become partially, if not fully independent. Such support can reduce or eliminate the stress on aging parents that often places their health and financial well being at risk. For years Indiana has been sending persons with brain injuries to out of state facilities for services. These services have been paid entirely with Hoosier taxpayer dollars without the benefit of federal Medicaid matching funds. It is long past time for the state to establish those services in Indiana. That will allow families to remain whole and better protect the interests of taxpayers.

Grow consumer empowerment, rights and protections.

- *Establish consumer-directed (or self-directed) HCBS as a priority for the state and the area agencies on aging (AAAs).* Many states successfully employ consumer-directed care on a large scale. It has been proven to save money and to sustain the independence of consumers for whom it is appropriate. This option is being grossly underutilized in Indiana.

- *Extend the consumer-driven features of CHOICE to Medicaid waivers as required by SEA 493.* In reality, this feature of SEA 493 was never implemented. Consumer driven principles should be applied to all features of current and future HCBS including all Medicaid waivers, and to all transportation services (local, intercommunity, and statewide).

- *Significantly increase the number of AAA case managers that arrange and broker HCBS services for consumers, and who troubleshoot and intervene for consumers when there are problems with those services and/or providers.* For CHOICE and Medicaid waivers to work as intended and established in state law there must be an extensive AAA case management system in place to work with and to protect vulnerable consumers.

- ***Full and timely funding of HCBS.*** The failure to properly fund services and to provide adequate levels of care when needed is probably the primary threat to the health and well being of all Hoosiers who need home and community based services: seniors, persons with disabilities, and family caregivers. Since the mid-1980s, this has been the leading concern and complaint stated by long term care consumers and their families in Indiana.

- *Improve the status, pay, training and working conditions of home care workers in order to improve the quality of HCBS in Indiana.* This should be a priority for the state. The Generations Project believes innovative programs between unions, such as SEIU, and Ivy Tech Community College could be put in place that would dramatically improve the home care work force, directly boost the state's economy, and raise the quality of services rendered to consumers. Indiana would also benefit from having an independent provider network (IPN) to facilitate the development of a large pool of home care workers. The state of Illinois presently has an IPN in place. The state could also explore with the federal Centers for Medicare and Medicaid Services the establishment of a Medicaid waiver to fund a health insurance benefit for home care workers. It is a sad irony that the lack of health insurance for home care workers continues to be one of the major blocks to sustaining a quality HCBS work force.

Kathy Tartar, a home care worker and member of the Service employee International Union, commenting on the risks and working conditions endured by members of her profession.

- *Establish extensive programs by the Division of Aging (DoA), FSSA, AAAs, and CILs to educate in detail HCBS/LTC consumers and their families regarding their rights and responsibilities.* Equally extensive consumer rights education programs for state DoA staff, AAAs, CILs, and the general public should be established. The Generations Project believes there is a strong link between consumers well-versed about their rights, responsible behavior, and quality assurance. The Project has concluded there is a strong link between the ignorance of the public and some professionals that leads to the overutilization of nursing home care.

Karen Vaughn, advocate and HCBS consumer, discussing risks faced by HCBS consumers.

- *Implement adequate and effective regulations to protect all HCBS consumers with swift and substantial fines against providers whenever necessary.* The services needing beefed-up regulation include, but are not limited to, home care, assisted living, adult family or foster care, and adult day or night care.

- *Pursue swift, certain and significant punishment for providers and professionals who personally, mentally or physically harm HCBS consumers.* During the Round Table process firsthand accounts of inexcusable abuse by providers were heard. In one instance, the identified perpetrator of a sexual assault against an HCBS consumer was not prosecuted and was believed to still be employed by a home health agency. The Division of Aging should develop protocols with the area agencies on aging for immediately engaging local police, prosecutors, and Adult Protective Services in such situations. Citations and fines, or so called "paper enforcement", by the Indiana State Department of Health is failing to protect consumers in far too many cases.

- *Establish appropriate levels of funding for the state and local ombudsman services, guardianship services, and adult protective services.* Ombudsman services are grossly underfunded for nursing home residents, and are essentially nonexistent for HCBS. Ombudsmen are charged with advocating on behalf of consumers, particularly those who cannot speak for themselves, in order to address concerns regarding the delivery and quality of services. Strengthening ombudsman, guardianship and adult protective services is an important step toward ensuring the protection of highly vulnerable persons.

- *Reform the guardianship system in order to stop abusive and inappropriate guardianships.* Consumers must be heavily involved in any reform process. Court appointed volunteer advocates from nonprofit organizations to monitor guardianships could be among the approaches used to guarantee independent oversight. The practice of appointing APS employees as guardians must stop.

- *Eliminate estate recovery for Medicaid waiver HCBS as long as family members are engaged in the overall provision of appropriate care.* This would provide a huge incentive for family members to continue in the care giving role. The fear of estate recovery continues to cause individuals and families who qualify for HCBS to refuse to participate in Medicaid. Ironically, this makes them more vulnerable for institutional placement at a future date.

- *Implement an extensive and comprehensive public education program on HCBS.* This might be the most powerful tool that is available to recalibrate the public's attitudes and behavior regarding HCBS and the positive possibilities for caring for loved ones. The education process needs to include the general public, businesses, unions, potential HCBS consumers, seniors, persons with disabilities, state officials, doctors, nurses, hospital administrators and discharge planners, and even AAAs and CILs. This recommendation could be combined with the aforementioned HCBS consumer rights education proposal.

- *Reestablish the Governor's Conference on Aging as a meaningful and consumer empowering event.* In the 1980s home care was extensively debated at the annual aging conference. The conference has been reduced to a non event in the last three years. During the Orr administration, the conference attracted nearly 1,000 participants and truly engaged seniors in the public policy process. Today, the Governor's Council for Persons with Disabilities still holds a powerful conference each fall for Hoosiers with disabilities. That conference consistently brings the disability community into the public policy process. The Commission on Aging could be given the same task for the senior community and, with help from the area agencies on aging and sponsors, stage an important conference each year at little or no cost to the state. The sponsors could include academic institutions, foundations, nonprofit entities, and for-profit corporations.

- *Establish and aggressively pursue affordable, accessible and safe housing for people coming out of nursing facilities with appropriate support services as part of the package.* Affordable, accessible and safe housing is empowering for persons with disabilities: it allows them to live and work in the community with dignity, and makes it much, much easier for family caregivers

to sustain their assistance. Universal design in housing for persons with disabilities could be a part of this process. Home modifications for seniors and persons with disabilities are also in this mix. Indiana desperately lags in doing home modifications, which places thousands of Hoosiers at risk who want to age in place at home.

- *Support creative housing initiatives for seniors and persons with disabilities.* Presently, there are active models in Indiana of creative housing initiatives that are designed to let people age in place and live in diverse communities. Two are in Indianapolis. The Jewish Community Center operates a NORC, or naturally occurring retirement community, that has received direct support from the Division of Aging. The local area agency on aging, CICOA Aging and In-Home Solutions, operates Lifelong Living Communities, an innovative program that is currently helping seniors in the Fountain Square neighborhood to rehab and retrofit their homes to be safe and accessible.

- *Establish a process for non-elderly persons with disabilities to review and shape HCBS public policies, and the local administration and delivery of services, from a consumer perspective.* The Division of Aging could work with advocacy groups, CILs, the CHOICE board, the Governor's Council for Persons with Disabilities, the Indiana Council for Independent Living, and AAAs to make this process a reality.

Develop the opportunities that HCBS represent for employers, their employees, and Indiana's economy.

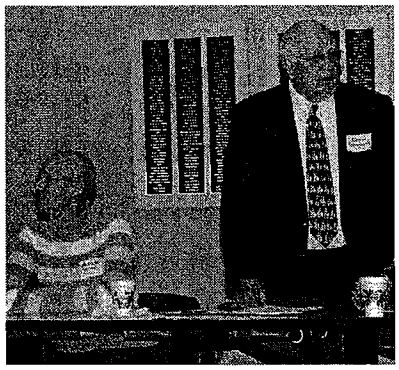
- Promote cooperative education programs between consumer groups, manufacturers, other businesses, unions, nonprofit agencies, and the state that can help employers to work with and assist employees who are trying to provide home care for loved ones. MetLife, university research, and secondary analyses done by The Generations Project all agree that HCBS is great for industries with aging work forces. In Indiana, Eli Lilly & Company has long worked with its employees who do double-duty as family caregivers. In fact, industries across the nation are increasingly looking to make investments in states that have well developed programs to support persons with disabilities of all ages.

Dennis Frick of the Senior Law Project in a discussion of Medicaid HCBS issues with other participants at the November 14th Round Table

- *The General Assembly and the state administration should explore with employers, unions, consumer groups, AAAs, CILs, and other nonprofit entities positive solutions to workplace issues for persons who are family caregivers.* Enhancing the state's Caretaker Support Program, established by SEA 493, should be an important part of this process.

Develop a smaller, but far better, nursing home industry that is defined by a high quality of direct care for consumers.

- *Take advantage of the savings that are generated by growing HCBS to improve the total LTC system including nursing home care.* Fully implementing SEA 493, properly implementing CHOICE, supporting employers who want to help employees who are also family caregivers, and taking the many steps described in this paper to help HCBS consumers and their families would dramatically lower the unnecessary utilization of nursing home care in Indiana. But simply reducing the number of nursing homes and Medicaid certified beds is not enough. The savings generated by reducing the use of nursing homes needs to be used in four ways: rapidly growing HCBS, educating the public regarding all LTC options, improving the HCBS work force, and improving the quality of care in nursing homes.


Elmer Blankenship, President of the Project's Board of Governors, opening the December 12th Round Table at the American Red Cross building in Indianapolis. He is joined by Michelle Niemier, Vice President.

- *Make high quality care the norm in a smaller nursing home industry.* Nursing home care is an important option in Indiana's LTC system. "High quality" should be the words that describe nursing home care in the future. To achieve high quality Indiana's grossly over built nursing home industry must become smaller over time in order to reduce the resource drain that is caused by that over investment. Paying for inappropriate care and unneeded buildings and beds reduces the quality of care throughout the LTC system. Nonetheless, as the nursing home industry gets smaller Indiana needs to invest more money on a per capita basis in the direct care of nursing home residents. This redirected investment means tougher and better standards for protecting residents, and better salaries, benefits, working conditions, and training for direct care workers. Steps must also be taken to enhance and strengthen the rights of residents, to improve their quality of life by increasing the personal needs allowance (PNA) and more opportunities for socialization. The PNA should be matched with the rate of inflation.

Innovative Division of Aging (DoA) programs should be continued, developed, and scrutinized for their viability.

- *Changes implemented by the Division of Aging must be thoroughly evaluated per their impact on consumers and vital public services.* In the past two years the DoA has promoted assisted living and adult foster care through Medicaid waivers, and has encouraged the development of NORCs, ADRCs, local transportation systems, and adult protective services. The agency has also forced changes in AAA senior meal programs, its internal fiscal management and operational structure, and tried to impose a merger between the CHOICE Advisory Board and the Commission on Aging. From a consumer and taxpayer perspective, these changes ranged from very good to very bad. Furthermore, close scrutiny of claims by the division in terms of the number of people served on Medicaid waivers and through CHOICE, and the cost of services

through these programs, is merited. For example, The Generations Project cannot verify recent claims by the division regarding enrollments and the average cost per CHOICE client.

- *The AAA authority to negotiate CHOICE rates should be re-established.* The forced changes by the Division of Aging and the Indiana Family and Social Services Administration in the provider reimbursement system for the CHOICE program continue to put pressure on providers, especially in rural areas, to leave the system. ¨ Attempts to privatize aspects of aging services need to be critically reviewed. Efforts by DoA and FSSA to privatize aspects of aging services, such as meals, and most recently the transition of persons from nursing homes to HCBS, have been and remain disruptive. The rationale for the privatization initiatives has been hard for many professionals and consumer advocates to understand since Indiana's single point of entry long term care system is locally administered by private nonprofit area agencies on aging.

During September and October of 2009, The Generations Project team traveled around the state to hold open discussions about the status of home and community based services (HCBS) in Indiana. The Project heard from nearly 200 consumers, advocates, providers, case managers, agency directors, elected officials, direct care workers and social workers. The discussions included a range of concerns expressed by the participants as well as ideas and suggestions on how to improve the delivery of HCBS. Participants spoke about food shortages, staffing, transportation, housing, administrative and cash flow issues, Medicaid, CHOICE, and other programs that fund home and community based services. They also discussed the failure of the privatized and modernized welfare eligibility process and how it has affected HCBS clients.

The following pages are a summary of these discussions.

The Dysfunctional Privatized and Modernized Public Benefits (Welfare) Eligibility System

On October 15, 2009 the governor announced the privatized and modernized welfare eligibility system was failing in many respects. He said the state was going to cancel the contract with IBM and develop, over time, a hybrid system to replace it. The announcement was dramatic but did not change the on the ground reality experienced by the participants in The Generations Project's regional meetings. For months and years to come, participants expect all 92 privatized counties, and the 59 counties that were also modernized, to struggle with the consequences brought on by the privatization of public benefits administered by the state's Division of Family Resources (DFR). Following the gubernatorial announcement people wondered if a "hybrid" system of state and private sector employees could correct the mistakes created by privatization and modernization experiment.

From local citizens and professionals that deal with DFR offices the following comments were received regarding the impact of welfare privatization and modernization on services for senior citizens, persons with disabilities, and other low income persons. Eligibility determinations and re-determinations continued to be a major problem in both privatized and modernized counties. Although their financial circumstances had not changed, an individual's food stamp benefits might vary widely from month to month. Approval or denial for food stamp benefits can take up to a year. Spend down requirements could materialize without warning or justification. Losing one's Medicaid QMB, Medicaid card, or other designation or document would trigger months of problems.

Seniors citizens, persons with disabilities, and professionals that must commonly use services coordinated through area agencies on aging (AAA) made the following observations regarding the impact of welfare privatization and modernization on them. Many aging agencies were forced to redirect resources to help qualified people obtain Medicaid and food stamps. Their care managers became de facto Medicaid caseworkers and were forced to work long hours, including weekends, to compensate for the lack of services from the local DFR offices. When working with a new client, aging care managers could spend 50% or more of their time dealing with eligibility issues caused by welfare privatization and modernization. It was reported some local area agency on aging staff were spending up to 90% of their time fixing client eligibility problems that were needlessly created by welfare privatization and modernization. The increased administrative time spent on these tasks is not billable. Aging agencies have hired full time employees to solve problems created by the privatized/modernized DFR system. The participants said privatizations and modernization also affected providers. Some

providers paid up to $150,000 for medications for their clients while the latter waited for DFR to confirm their eligibility. Nursing facilities began refusing Medicaid pending clients because of the delayed determination of Medicaid eligibility and the uncertainty of being paid for services already delivered.

Local citizens and professionals reported the privatized regional call center system simply did not work. Many people could not reach the Marion call center by phone. When they did, the center staff answered questions by reading a script and could not answer based on their knowledge of the system. Hoosiers lost eligibility for services due to "failure to cooperate", a claim used all too often by the center staff to hide their own mistakes. The call center lost countless documents and demanded that clients resubmit them or lose eligibility. Call center staff would inform clients of a two hour window scheduled for a telephone interview and then not call during the specified time period. The private company staff would later claim that the client failed to cooperate and then cancel or deny benefits. At times people who had an appointment at their local DFR office were sent home and later told by staff that they missed their appointment. People also lost eligibility when the private sub-contractor (often ACS) staff called their homes and got no answer. The staff would report that the person was not homebound and, therefore, not eligible for services. If a client complained, the staff told the client to start over with the eligibility process. People were not told about the appeals process and their right to appeal a denial. Privatized employees did not understand the duties and rights of a client's legal representative and often refused to work with them.

Local citizens and professionals also reported that the privatization of the DFR offices throughout the state caused many problems. All counties experienced poor service with privatization. DFR state employee staff cut in every county. Instead of reaching an individual when calling, clients were connected to an automatic answering system that did not specify the needed option. Many DFR offices no longer listed their phone numbers and some would not answer their phones at all.

If clients did manage to find and visit the local DFR office, they were directed to use computers which offered them no privacy. Some DFR offices relocated to inaccessible and dangerous locations. The DFR staff often looked to the local AAAs for answers. In some areas the DFR staff told clients that there was a "spend-down waiver" available at the AAA. These clients usually had too high an income and too low need to qualify for services through the Medicaid aged and disabled (A&D) waiver. Staff provided by private companies, under contract with the state to operate local DFR offices, did not have proper training and didn't understand the waiver categories or what services were available through the AAAs. In order to serve their HCBS clients, AAAs were forced to train local DFR office staff regarding eligibility standards and processes for Medicaid and food stamps. Staffing DFR offices with a Medicaid A&D waiver specialist, and a traumatic brain injury waiver specialist, may eliminate some of these problems. The public needs to be educated about what they should expect from DFR offices. The instruction should include the right of any citizen to appeal decisions.

Experienced and truly qualified caseworkers that are readily accessible to clients are needed now to make the eligibility process functional in the local DFR offices. Potential clients are frustrated, many have never used a computer, and some don't want to learn. The economic crisis has added to the trouble caused by the privatized and modernized system. Many people trying to access the system for the first time are shut out. Simplifying the required eligibility re-determinations of DFR clients, especially those

that have had no change in their eligibility status, would speed up the process and allow time for new and more complicated cases to be processed in a timely manner.

Discussion group attendees asked if anyone was tracking and reporting instances of fraud within the privatized and modernized eligibility system. They felt that the lack of personal contact and absence of a person responsible for a specific case was an invitation to fraud. They were also concerned about the lack of transparency of operations which should include how the privatized county offices were monitoring for fraud.

> *"A welfare system with no one responsible for or knowledgeable about a specific case, is ripe for fraud. Who is tracking fraud in the new system?"...a concerned citizen*

When commenting on the new hybridized system in southwest Indiana the participants hoped the state would establish an independent client appeals process for denial of eligibility for public benefits. The process should be outside the for-profit realm of influence. The appeals process could help equalize services throughout the state.

CHOICE, Medicaid and Medicaid Waivers

During the fall community discussions several participants shared concerns about problems in the CHOICE program caused by changes imposed by the state. Delayed disbursement of CHOICE funds and late or modified contracts prevented agencies from using these funds to serve eligible clients. Participants believed directives from the state to stop accepting people into the CHOICE program will leave CHOICE funds unspent. Freed up CHOICE funds due to unanticipated waiver growth (increased slots) are not being used even while the client waiting list grows for CHOICE services. The local citizens felt these methods left little time for area agencies on aging to budget and spend the funds in a responsible manner. People on the CHOICE waiting list are being placed in nursing facilities because they need immediate services. Additionally, limitations on the use of dollars allocated for Children's CHOICE keeps the funds from being used for adults even when there are no children in need of services. If the needs of children in the CHOICE program are being met, then using these funds to serve adults makes fiscal sense. Building a sustainable package of viable CHOICE services for clients is very difficult with the limited dollars that are currently available per client.

Citizens felt that requiring people to apply for Medicaid before they can get onto CHOICE is inefficient and unnecessary especially when case managers have the skills to determine whether a client will qualify for Medicaid or not. Presumptive eligibility for CHOICE and Medicaid Waivers is the solution to this problem. The process for qualifying children is also slow and inefficient, often taking 3 to 4 months to receive notification, not the 72 hours promised by the state. As a temporary solution to these problems, some areas have been assigned a "special outreach" Medicaid staff person only available to AAA staff. Citizens said Indiana needs a permanent solution to these problems.

People commonly said it is taking months to get onto a Medicaid waiver, which is much longer than in the past. Once papers are submitted to the state, there is no ability to predict when approval will be granted. Clients who need services are left waiting. Needless time is wasted by the process that requires the state waiver unit to notify the AAA of approval, only for the AAA to have to then notify OMPP to get services started.

The transition to waiver services from regular Medicaid creates spend down problems for many clients. Shifting one's spend down threshold from 150% of SSI to 300% of SSI is often difficult to achieve and delays payments to providers. It can take 5 or 6 months to get spend down problems solved in the modernized counties. Meanwhile the client is billed for services and providers are not paid. Although CHOICE funds can sometimes be used to resolve this problem, *using CHOICE funds in this manner prevents their use for CHOICE clients*. In addition to the slow transition into a different threshold of spend down, clients are acquiring spend down obligations they should not have. Solving this problem takes up to eight months per client. Vendors and AAAs assume the cost of spend down which puts further strain on their budgets. Adult day care facilities and foster care homes are also having trouble with spend down for their clients. Indiana needs a simple and accurate process to track spend down and changes in spend down levels. Determining spend down just once a year would be easier and far less expensive. Indiana should look to other states that accurately determine spend down on an annual basis. Taking this action would significantly reduce the state's administrative costs.

> *"Determining Medicaid spend down just once a year would be easier for everyone, just as accurate, and far cheaper for the state," ...an HCBS advocate.*

Inadequate reimbursement rates and delayed reimbursements are squeezing providers out of the system. A three month delay in receiving payments is too long. Many providers no longer offer homemaker services because reimbursement rates do not cover expenses. The level of care needed by folks receiving services varies widely which affects the level of skill needed by the home care worker. Reimbursements based only on staff hours are inadequate when higher skilled workers are required. Agencies who want quality, highly skilled staff must pay wages higher than the minimum wage. Mileage payments and other benefits would allow them to increase the quality and skill of their employees. Paying mileage to serve people in rural areas can make the difference in being able to provide staff or doing without services. The Generations Project team was told providers want to offer training, raises, and benefits, but can't afford it.

Not only are reimbursement rates often inadequate for direct care services, rates often don't cover the cost of meals for clients in some locations. Different sources of funding, CHOICE, Title III, and Medicaid, reimburse for the same meals at different rates. Separate contracts with the same provider must be negotiated for each funding source. Standardized reimbursement rates and one contract for meals per provider would streamline this part of the system and save money.

There was general agreement that Indiana needs to bring everyone to the table to discuss solutions that allow quality care and services for clients with adequate reimbursements for providers and fair wages and benefits for workers. Discussion participants should include the state, licensed agencies and independent providers, AAAs, consumers, Home Care Task Force members, other advocates, unions, and lawmakers. These discussions should also consider re-evaluation of the number of hours needed for the delivery of HCBS appropriate for the needs of each individual in the system.

Distribution of Allocated Money and Other Financing Issues

FSSA has not released budgeted money to the AAAs in a timely manner. During the community forums citizens repeatedly told The Generations Project the state owed huge sums of money to the area

agencies on aging and to providers. Citizens said agencies have been forced to extend their line of credit to pay providers and to scramble to find other ways to retain providers and services. Some agencies were borrowing against their organization's assets.

FSSA has established a 35-day rule for CHOICE reimbursements. Citizens were unclear whether the rule counts calendar or business days; but regardless of which it is the agency is not meeting its own deadline. This new procedure requires submission and rejection of CHOICE claims by batch instead of individually. If one claim in the batch contains an error, the entire batch is returned. This process delays payments for many providers instead of just one. Batch claims and approvals do not serve the needs of clients, agencies or providers.

> *"Will I lose CHOICE services because the state refuses to release appropriated dollars?"... a citizen with disabilities.*

Issuing a percentage of CHOICE funds to agencies in advance of services would allow more efficient and effective use of agency funds. Funding for Community Action agencies is distributed this way and serves as a good model. Decreases in other sources of money [a 25% cut in Title IIIe (caregiver) funding and a 30% cut in Social Services Block Grant (SSBG) allocations on October 1, 2009], has added to the strain on AAA budgets. SSBG funds are commonly the largest source of funding for AAA case management. A midyear correction (March, 2010) which may reinstate some SSBG funds will be too late for budget-responsible agencies to spend by the end of the fiscal year. Withholding funds impacts the AAA's ability to build capacity and fulfill their mission. Participants did not understand why the state is holding these funds when the 9:1 federal match is available.

Citizens thought that a resourceful way to help contracted agencies (AAAs) use their budgets more effectively would be to allow them to keep money saved when they can obtain services from providers below the unit rate established by the state. Having to pay back this money is a deterrent for the efficient use of funds. If allowed to keep these funds agencies could provide more services or augment services that cost more than the established reimbursement rate pays. The excess money received from private payers for some pre-admission screenings (PAS) could also be used to augment services when the costs are greater.

Mismanagement/Micromanagement by State

The Generations Project was emphatically and frequently told that a well-trained, experienced, knowledgeable state level staff who have a depth of understanding of the programs and processes they oversee is a requirement for effective government administration. Indiana no longer has such a staff. Experienced staff work cooperatively to solve problems and to create collaboration. The Generations Project was told by ordinary citizens that DFR staff and contractors who lack professional qualifications and experience make poor decisions, have an insufficient understanding of common management obligations, engage in retaliation for the problems they have created, waste money, and create over time hostile relationships between themselves, providers, local agencies, local communities and clients. High staff turnover makes matters worse. The state should return to the practice of hiring proven, professionally qualified persons in key staff roles.

The Older Americans Act maintains that planning for community services be a community responsibility. FSSA's inappropriate forcing of standardization on community level planning and innovation is counter-productive. Viable local planning needs to be restored, and FSSA staff needs to understand that such activities are an opportunity to improve the administration of programs and the application of policy.

Local citizens believe FSSA's auditing and monitoring of local personnel and finances is less about good administration and more about marginally-competent micro managing by inexperienced and under-trained state staff. The state is requiring reports that are redundant. Increased restrictions caused by micro-management make no sense. For example, listing billable and non-billable hours for care managers and providers does not change the work load nor improve services. Non-billable hours are essential to the delivery of quality services. The state is requiring AAAs to follow state employee rules when sending case managers to conferences. Examples of this include the restrictions that reimbursements for educational purposes cannot be higher than the state reimburses and case managers are not allowed to attend out-of-state conferences. AAA employees are not state employees. AAAs must anticipate what will be required next by FSSA, and are constantly fearful of having to pay back the state for inaccuracies caused by the numerous new requirements.

The two companies that approve Medicaid "prior approval" (PA) requests are often hostile to providers when they inquire about the progress of their requests. The Medicaid and Medicaid waiver staff seem to fight about who will fund the services. This not only delays service approval but is also unprofessional.

Housing and Deinstitutionalization

The community forums generated extensive and passionate discussions regarding the housing needs of senior citizens, persons with disabilities, and low income families that need HCBS. HCBS cannot be provided if safe, accessible and affordable housing is not available to people who need care. Bringing people out of a nursing facility after an extended time is difficult. Local citizen and professionals feel the Money Follows the Person (MFP) grant, the means being promoted by the state to place NF residents in HCBS, is not working. Once in a nursing facility many residents quickly lose their ability to care for themselves. Their increased level-of-care needs make it more unlikely that they will ever go home to receive services. Many people who are in facilities no longer have a home to return to, don't have the ability to complete the enormous amount of paper work required to qualify for subsidized housing and have no credit to qualify for adequate housing on the open market. Assisted living is still out of the reach of many if the facilities do not accept Medicaid payment.

CHOICE and the Medicaid A&D waiver can pay for some home modifications. However, like many other vendors, home modification contractors are not being paid in a timely manner (less than 30 days), and cannot afford to provide these services and stay in business.

"Safe, affordable, accessible housing near community amenities is needed to properly serve the frail elderly and disabled populations. This can only happen if we get all the stakeholders together to create a comprehensive plan of action."... an HCBS professional.

People strongly felt we must find more ways to blend housing with services at an affordable price for both publically funded individuals and those who pay privately. The need for subsidized Section 8 housing is enormous. The current six year wait for housing voucher slots is unacceptable for people in need of home care as well as a place to live. Younger people in nursing facilities could live with more freedom in communities if housing became available. Care should be taken to not develop ghettos for persons with disabilities that are neither safe nor integrated into the community at large. Persons with felony convictions are another cohort of people that are not accepted for low income housing. What will happen as they age or if they become disabled and need care? Many participants wanted to know if Indiana is preparing for the Baby Boomer cohort and for their needs for accessible housing in the future.

People commonly said an overall assessment of available housing and housing needs, especially for special populations, is needed. Indiana should explore all types of community housing that would support individuals based on their specific needs. Funding for home modifications needs to be established or expanded. Builders of accessible housing should be recruited. Building and fire codes need to be reviewed and possibly changed. Landlords need to be aware of these needs and encouraged to meet them. The state may want to establish a housing rehab pool and an investment credit for landlords to do housing modifications.

Often the community discussions included suggested solutions to help alleviate the housing problem. One such suggestion was for AAAs to share their stories on what they do to increase the housing supply in their regions. The discussion should embrace all types of housing including "small house" nursing homes, adult foster care, assisted living, shared housing, as well as independent living. Participants agreed that the future of long term care options would include small houses. They thought this was an exciting area to explore for growth in Indiana. The New Albany area has a few small houses in operation already. These innovative new generation replacements for traditional nursing homes operate in more of a family-style manner. For example, small houses allow residents to do their own cooking and arrange their living spaces in ways to emulate their former homes. The state and the nursing home industry should be encouraged to develop this promising model of long term care.

The Generations Project learned that discussion participants want more information about the Life Long Living Community project in Indianapolis. Builders and housing remodelers need to learn how to create accessible living spaces. Incentives need to be established that encourage landlords to modify living quarters to be accessible. Rehabilitating existing senior housing is a real need that could be satisfied at a low cost. Tax credits could be established to encourage growth in accessible housing.

Transportation

Transportation services for the frail elderly and disabled populations vary widely throughout the state. Some county councils on aging offer adequate services while other counties have a dearth of services or

none. Home care workers are allowed to transport clients to medical appointments but there is no funding source for mileage reimbursements.

Many discussion participants pointed out that acquiring transportation services for seniors and persons with disabilities in their communities have become more complicated. In the past Medicaid paid for most transportation services, but now there are many different sources of funding with different contracts required for each source. The excessive rules and bureaucratic hoops created in this area by the state inhibit the ability of local AAAs and others to serve these citizens. People with the greatest needs seem to have the most restrictions. This is an ineffective use of time and confuses providers as well as clients. Control and standardization of contracts and payment rates at the local level would streamline the system. Federal regulations and rules are straight forward and simple, but state rules and regulations are not. This issue can be resolved by balancing the state's concerns with proper local oversight and common sense.

Food Pantries and Food Services

The Generations Project learned that two events, the national economic recession and Indiana's self inflicted Medicaid and food stamps eligibility crisis, have increased demand for provisions at food pantries by more than 30% in the past year. Food pantries need help to identify people who need food and to find more food to distribute. An improved system would enable food pantries to have adequate amounts of the kinds of food people need, and to deliver all food before its expiration date. A check-off list given to clients to choose what they want would result in less wasted food because clients would be getting food they like. This system would be even more helpful to people on special, medically ordered diets.

Food pantry personnel understand that many people requesting food do not qualify for welfare services and therefore don't receive services from AAA or DFR offices. However, pantries would welcome help from these agencies through the establishment of nutrition advisory councils which would assist food pantries to expand outreach services. AAA and DFR case managers already identify people who might need food when they evaluate them for other services; however it is not a standard part of the intake process to refer them to food pantries. Assessments of all service applicants would identify many who need nutrition assistance, especially people in outlying areas of the state. A nutrition advisory council could coordinate with the established volunteer food distribution networks already in place. The 211 system could also assist in identifying people who need help.

Gleaners Food Bank supplies the food pantries with food, but not enough. Local communities need to be made aware of this situation. Restoring the former USDA subsidy would also help.

However, the biggest problem facing people locally who are in need of nutrition services is timely access to food stamps. The Generations Project has been told that everywhere in the state there is a large negative impact on food stamp distribution caused by welfare privatization and modernization. Long term care professionals reported cases of senior citizens dying from common medical conditions as a direct result of reduced nutrition following cuts in their food stamp allocations.

Long term care ombudsman

Participants thought that an adequately funded ombudsman system with independent authority could make good changes happen for clients. Referring cases to the Indiana Department of Health or the

Attorney General's Office for action takes too long and often produces inconclusive results. Presently, Indiana has no working HCBS ombudsman program or services. Indiana can look to other states like Wisconsin to build an effective ombudsman program for all types of long term care. This is especially

important as HCBS continue to grow. A worried parent asked, "Can an ombudsman correct the unresponsiveness of a Bureau of Developmental Disability Services (BDDS) office to clients?"

Technology

Indiana should proactively seek technology solutions to solve long term care issues. Technology can change the quality of life for seniors and persons with disabilities. Wireless ERS can strengthen a signal to cover entire communities. Monitored medication dispensers (currently covered by CHOICE) can eliminate the need for someone to be in the home every time medications are taken.

An integrated computer system that allows AAAs, human service agencies, and the state to communicate on several levels concerning all state programs could identify people who are not being properly served and could save time and money in the delivery of services. The system should be smart and simple. Participants suggested that research into the technology that has served other states well would allow Indiana to design a plan for optimal use of technology in their own human services system.

Technology, or the incompetent use and misapplication of technology by DFR in the privatization and modernization of public benefit (welfare) programs, was also a major concern. Participants felt local DFR offices should use smart, simple new technologies that are client friendly to speed up services and to increase the time available for caseworkers to visit the homes of senior citizens and persons with disabilities that cannot come to DFR offices. (See the other references in these notes to the application of technology associated with welfare privatization and modernization that has been harmful to HCBS clients.)

Direct Care and Personal Care Workforce

Certified Nursing Assistants (CNAs) and personal service attendants deserve adequate training, good pay, and respect. The Generations Project was told as HCBS grows, the need for well trained CNAs and personal service attendants increases. Marketing these positions as the first step in a path to a health care career would improve the quality of applicants for this training. CNAs and attendants are trusted to care for our most frail citizens. Their value should be reflected not only in their salaries but by establishing minimum standards for training.

A personal service agency provides attendant care, homemaker and companion services, and assistance and other non-medical services to seniors and persons with disabilities who desire to remain in their own home. There appears to be little oversight of personal service agencies and few ways to assess the skills and training of their employees. Licensing requirements with appropriate oversight, continuing education including nutrition and cooking skills,

> *"CHOICE is remarkable. It gives low cost, high quality, consumer friendly care. We must defend it however we can from unwise cuts." ...a senior citizen leader.*

specialized training to serve select populations such as those with behavioral issues or brain injury, and other applicable information would do much to increase the reliability of this workforce. *Agencies should match workers' skills with the care needed and appropriate compensation.* Standardized training including on-the-job instruction would go far to strengthen the consistency of these services. Local high schools, community colleges (Ivy Tech), or professional organizations may be able to

partner with the state, AAAs, provider agencies, unions, and others to develop skills and training programs for these front-line workers. All parties should explore grant support to pay for the training.

Elder Neglect

The Project was told Adult Protective Services spends most of its resources to enforce the law, and uses too little time and effort to protect the victims of elder abuse. The best solutions to elder neglect must consider the long term benefit to the victims. Having neglect more clearly defined in state law would help. Educational programs on recognizing and reporting elder neglect, including self-neglect, should be ongoing and statewide.

Participants in the 2009 community discussions lead by The Generations Project team were asked to express their views on some possible solutions that have been broached by their peers, advocates, and other stakeholders. The highlights of these discussions are presented below.

Independent Provider System (IP)

The establishment of an official, independent provider (IP) system was well received, but discussion participants had many questions and caveats. Some agency providers thought the state should look at ways to increase capacity through current agencies before establishing an IP system. Increasing unit rates for providers would help make the recruiting and training of home care workers more viable.

There were other concerns associated with establishing a quality IP system (also called an IP network or registry) that were raised. An IP system should be properly resourced for training and fiscal mechanics. Certification, training standards and quality control monitoring must all be established. A safe method to recognize and report abuse, including self-neglect, in the self-directed IP system is essential. Monitoring the IP system for quality and thorough background checks on all independent providers are necessities for a good system. Any IP System would have to include a back-up or on-call workforce. Some thought that this system had the potential to work very well for younger persons with disabilities, and less well for the frail elderly.

Questions brought up about an IP system.

- Would training expenses be funded or have to be paid for by the person becoming an IP?
- How will consumers define and direct the development of an IP system?
- How can home care workers join consumers and providers in the development of an IP system?

- Could consumer organizations, area agencies on aging, provider agencies, employee associations, and/or community colleges offer training?
- Could training be combined with formal family caregiver training that would address family issues as well as care giving issues?
- Would independent providers be trained to recognize family issues and how would referrals for help be handled?
- Could the Indiana Rural Health Association be a partner in developing an independent provider system?
- What roll would be played by organized labor play in assisting the development of an IP system?

Presumptive Eligibility

Citizens throughout the state were in overwhelming agreement that giving presumptive eligibility to AAAs would solve many problems in the current system of eligibility determination, especially those caused by the most complicated cases involving Medicaid waivers and CHOICE. Presumptive eligibility would allow services to begin immediately and prevent many unwanted nursing home admissions. For example, by using presumptive eligibility the state of Kansas has a 24 to 48 hour turn-around time to get people into service. Spend down could also be determined by the local AAA during the presumptive eligibility process. However if the state over-managed the program, presumptive eligibility would not be effective.

Education Possibilities

Several topics for education and policy initiatives were suggested during the community discussions. They are listed below:

- The use of cost sharing through the CHOICE program.
- Best practices in independent provider systems and self-directed care.
- Small houses: hope and possibilities.
- Teaching accessible housing to builders, remodelers, communities, the elderly, and Baby Boomers.
- What DFR should be telling citizens about services and their legal rights.
- Educating citizens regarding all LTC and HCBS options.
- Providing AAAs and Hoosiers better tools for explaining the saving and benefits of the CHOICE Program.
- Providers and consumers educating lawmakers about HCBS reimbursement issues.
- What the statistics show: Indiana's LTC system is pushing people into institutions.
- Publicly funded HCBS: a tool for fighting the recession.

- State regulations requiring staffing ratios in nursing facilities.

- When HCBS and nursing home care are appropriate and affordable for the extremely sick.
- What the VA does not do in home therapy for veterans with brain injuries.
- Exploring the positive possibilities of comprehensive brain injury services in Indiana.
- Enforcement mechanisms when services are denied to persons needing HCBS.
- Addressing mental health needs in nursing facilities and HCBS throughout Indiana.
- LTC planning for the Baby Boomer generation across Indiana.
- Eliminating the infighting and the negative consequences for consumers in prior authorization.
- Reviewing the causes of EDS' high rate of denials for nutrition services.

The following report is a summary of written answers given in response to a questionnaire distributed by the Generations Project to participants in meetings held across the state in the fall of 2009 regarding home and community based services.

Question 1a: What are your three greatest concerns regarding publicly funded home and community based services (HCBS), which include Medicaid waivers and the CHOICE program?

Concerns

Funding for CHOICE services was the greatest concern of program participants. They were concerned by both a lack of current funds, not receiving funds in a timely manner and by decreased funding which has caused client waiting lists for services to grow while the number and quality of providers decreased. Lack of flexibility in approved funding and increased service needs of clients contribute to the problem.

Not only were CHOICE funding and wait lists concerns, people also expressed their anxieties regarding other aspects of the program. Mentioned most often was the lengthy processing time it takes to get CHOICE services. The requirement that a client must first be denied Medicaid status and then put on the waiting list in order to be eligible for CHOICE services before being allowed to receive those services, was considered onerous. Combined with slow approval from the state to proceed with the delivery of services, these requirements substantially increase wait times. Respondents said unnecessary long wait times jeopardize the health and independence of clients. In the past, flexibility of providing services through CHOICE had been an asset, but people feel the state administration has now taken excessive control of the program, leaving less money and time for flexibility and direct client services. There has been a decrease in the amount of CHOICE funds available for local home care services while the legislated allocation has remained constant. The directive that unspent Children's CHOICE money must be returned to the state instead of being used to serve adults inhibits the flexibility of the program and leaves even more people without services. Frequent rule changes by the state also contribute to an inefficient use of time and funds. One suggestion to increase flexibility of the CHOICE program was to allow CHOICE funds to be used to assist people in leaving nursing facilities and to transition into community and home based care.

(Readers of this survey should know the context of the above concerns. From 1988, when CHOICE services began, until 2005 the program was known for quickly enrolling and delivering high quality services to consumers at very low costs. Managed locally by the area agencies on aging the program also had a reputation for no corruption. It's major shortfall was the budgetary limits placed on the program by the General Assembly. Since 2005 the present state administration has imposed a series of restrictive requirements on the program. Those requirements were the focus of the above comments by respondents to The Generations Project survey.)

There are many concerns about access to Medicaid waiver services and the tightening of eligibility requirements by the present state administration. The forms are cumbersome and much too long. Too many people are being turned away from needed services and access to these services has become more limited. Medicaid spend down requirements are also a problem: they are hard to track and

confusing for many seniors and seriously disabled consumers. Having as little as $5.00 too much income eliminates these consumers from getting help with medications as well as energy assistance.
The process of establishing Medicaid waiver and CHOICE services is hindered by many things that could be corrected. The privatized eligibility system for Medicaid and food stamps, lack of policy consistency by the state, excessive levels of red tape by the state, poor administrative rules, lack of follow through by the Division of Aging personnel, and ineffective leadership and communications by state staff all have a negative impact on the health of people needing and applying for services. The state middle management staff would greatly benefit from training, both in program knowledge and effective management techniques. Integration of information between services would increase efficiency and decrease costs. In order to properly serve their clients, local case managers who serve senior citizens and persons with disabilities have been forced to do what Division of Family Resources (DFR) caseworkers did before welfare privatization. They have also been forced to carry increased case loads. They have assumed these tasks and working-through weekends without increased pay. They are required to do too many unfunded activities. More case managers are needed with appropriate funding for services.

The privatized Medicaid eligibility program is a major concern. Not only is the processing time too long, but too many mistakes are being made. Legally eligible clients are losing services or unable to begin services because of mistakes in the determination and re-determination of Medicaid eligibility. Employees working for the private companies through DFR do not have the knowledge base needed to do the work and don't have the skills to respond professionally to inquiries. Area agency on aging case managers at the local level use far too much of their time correcting or minimizing the mistakes and delays caused by the untrained privatized workers used by DFR. Trust in the privatized system is non-existent.

HCBS provider capacity is decreasing. Low provider rates are the crux of the problem. Inadequate rates for providers increase staffing shortages and turnover and are driving providers out of the system. Low rates and late payments of providers caused by the state's failure to distribute funds in a timely manner prevent growth in provider capacity and insure a decrease in the quality of direct care workers. Rates need to be set that support the needs of the consumer and which cover provider costs. Rates that would allow mileage reimbursements for rural providers would do much to increase capacity in these underserved areas. Provider reimbursement should be less complicated and much more timely.

Other concerns regarding publically funded HCBS include: missing the people who need services, the lack of knowledge about the availability of HCBS by the general public, care that seems to be provider-centered and not client-centered, and poor communications between providers and consumers. There is a lack of training, services and programs to serve the mentally ill, elderly, and persons with brain injury of any age. Adequate, safe, accessible housing is not often available to serve clients who want to leave or avoid institutionalization. Family caregiver burn out and illnesses induced by care-giving will put more demands on the system if the causative factors are not addressed.

Question 1b: Identify the three most important features or assets of Indiana's HCBS system?

Assets of current system

The most listed asset of the current HCBS system was being able to keep folks in their homes which increases their quality of life, adds to their dignity, and encourages independence. People are treated as

individuals and can age in place in their own homes and communities. Services are individualized and flexible. Case managers make a concerted effort to include consumer choice in the process.
The cost effectiveness of HCBS is a big asset for the state and taxpayers.
The CHOICE program increases self-determination, is often the only money available to help clients, and allows people to receive care while waiting on Medicaid waiver approval. Local control of CHOICE dollars is critical if the necessary flexibility in the use of these funds is to be retained and the ability to serve those most in need is to be optimized.
Quality of service is an asset that many thought was a key feature of HCBS.
Aging and Disability Resource Centers (ADRCs) were also listed as an asset of the current system.

Question 2: What are the most significant challenges facing the delivery of human services in your community, region, or the state?

1. Lack of sufficient funding which affects all of the following:
    a. Programs and options of services offered.
    b. Adequate number of case workers with manageable case loads.
    c. Number of waiver slots available.
    d. Low reimbursement rates for providers.
    e. Retaining quality caregivers.
    f. An inadequate number of providers, especially in rural areas.
    g. Clients don't have enough money or are not allowed to keep enough to support themselves in the community.
2. The negative impact of privatization and modernization on the Medicaid, food stamps and TANF eligibility system:
    a. Leaving legally eligible people without services.
    b. Overburdening local agencies with work that should be done by state employees instead of private for-profit companies.
    c. Too much centralization by the state and the private companies.
    d. Incompetence of call center staff regarding Medicaid system.
    e. Lack of face-to-face contact with clients.
3. Lack of education and outreach programs for HCBS:
    a. Too many professionals and much of the general population don't know about publicly-funded HCBS in order to access them.
    b. Too many people fail to receive the care they need.
    c. Timely identification of people needing services could decrease future expenses.
    d. The state fails to promote preventative measures and healthy aging.
    e. The lack of education prevents people from planning for their futures and blocks their ability to make needed decisions before they are in a crisis situation.
    f. The lack of education and outreach programs decreases the collaborative abilities of agencies, the public, and HCBS consumers.
4. Poor state leadership and cooperation regarding HCBS with local agencies has caused the following:

   a. Increased bureaucracy, over regulation, excessive paperwork, inconsistent application of rules and laws.
   b. The ignoring of consumer needs.
   c. The politicizing of the process.
   d. Less flexibility at the local level regarding CHOICE and other funding sources.
   e. Duplication of services at the state level.
   f. Inefficiencies at the state level that have led to
      i. Excessive waits for approval of services, while consumer health and function deteriorate.
      ii. Providers not being paid and forced out of business.
      iii. Cash flow issues for local agencies.
5. Child welfare reform has left thousands of children without services:
   a. The third party (IMPG) that manages support services, developmental disabilities, and autism waivers is inefficient, poorly supervised, and hires inferior case managers.
   b. Waiting time for BDDS waivers is eleven years.
6. Other issues include
   a. Need for more transportation options: Medicaid reimbursements are lower than costs.
   b. Food pantries are not able to meet the overall demand for food, do not have the variety of foods that people want to eat in order to minimize waste, and do not have the capacity to properly store it.
   c. Lack of mental health services for the elderly in HCBS system.
   d. Growing elderly population caused by demographic and medical care dynamics and lack of preparation for the increased future needs.
   e. Lack of "small house" concept new generation nursing homes and other living options for long term care.

Question 3 : What do you consider to be most significant regarding welfare privatization and modernization? Please identify your answer as a positive or negative quality.

Negative

1. Lack of face to face contact by local caseworkers.
2. Lost documents and information.
3. Untrained privatized staff with no professional standards.
4. Access to eligibility processing services is terrible: there is no access to services if one cannot use a telephone or computer.
5. Improper denials.
6. Prolonged processing times.
7. Profits overshadowing client needs.
8. System has a dehumanizing impact on current and potential clients.
9. No accountability for a case as it passes through the system.

10. Failure of technology, as applied, to improve the system.

Positive

1. Attempted use of technology to streamline process.
2. VCAN members can be a good resource for consumers.

Question 4: How can advocacy and social service education organizations provide better service?

Social service and education organizations can best help Hoosiers by providing education to everyone about long term care services in Indiana, which include nursing homes and HCBS. The public needs to learn about the options, process, and roadblocks in the current system. Education has to be provided before a crisis point is reached. The elderly, disabled, and their potential caregivers need to understand that they have choices and a right to make decisions about their future. More people need to know about the CHOICE program and how it works in conjunction with Medicaid waivers. They need to know about the access points through the Aging and Disabled Resource Centers (ADRC's). In addition, all staff in the social service organizations must know more about the current system and how to navigate it.

Case managers need to learn more about the providers and what services are offered. Legislators should be included among those needing to learn about what really goes on in today's long term care system.
Suggested ways of providing education included a statewide booklet and public awareness program that targets all general patient services in long term care. This could be complemented with training seminars through the workplace, churches, nursing facilities, and schools. AAAs should have full and continuing access to LTC education materials for informing consumers and training their employees, and the funding that is needed to sustain education and advocacy activities.

Even though education was listed as the most important service that advocacy and social service organizations can provide to Hoosiers, the information needs to go both ways. Open forums that reach out and listen to consumers about what they want and need in life are critical. Regular opportunities for dialogue, networking, and coordinating ideas and services would do much to improve HCBS in Indiana.

Organization should use education and public input to empower citizens locally and across the state. Citizens need to be taught that they have a right to advocate for themselves and their loved ones. Advocacy skills should be taught to social service staff as well as consumers and caregivers. People need to know that care can be person-centered, with planning focused on the needs and wants of the consumer and their families. Consumers need to learn about and understand the concept of consumer-centered care, and providers need to be held to a level of professionalism that encourages this.
Advocacy and social service organizations have a responsibility to keep the public informed of the problems and issues they are encountering. These problems and issues presently include funding for HCBS programs and state staff who are not engaged in providing quality services for the elderly and disabled populations. The state needs to institute a quick and easy complaint process that works for the consumer to resolve problems in a timely manner. Guidelines for service delivery need to be

established. Capacity must be increased. Current laws need to be understood and followed by the state and everyone in the system of care.
Advocacy and social service organizations need to work cooperatively and not get into turf issues. With open communication resources can be used more efficiently, and duplication of services can be minimized - for example ADRC's and 211 services provide many of the same things. Agencies must collaborate and streamline or change their leadership. Coalitions need to combine resources to work for the good of the people they are serving.

Question 5: Do you interact with network or coalition based organizations, if so which ones?

The majority of persons responding to the survey indicated that they were clearly aware of both The Generations Project and the Indiana Home Care Task Force. That response was not considered significant since the surveys were distributed at community meetings conducted by The Generations Project. More importantly the respondents indicated that they had *previously* interacted with individual organizations that were part of the network of organizations involved in the Indiana Home Care Task Force or as part of The Generations Project. They listed the following organizations as being a part of these networks. The number beside each organization indicates how many times they were listed by the survey respondents. In actuality, a number of the following organizations are not members of The Generations Project and/or the Indiana Home Care Task Force. The responses are significant in terms of the variety of organizations and institutions that people use to get information regarding long term care.

An area agency on aging (AAA) , 9
An aging and disability resource center (ADRC), 1
Indiana Association of Area Agencies on Aging, 4
National Association of Area Agencies on Aging, 1
United Senior Action of Indiana, 4
An independent living center, 4
Indiana Association for Home and Hospice Care, 4
Home care agencies, 3
The Generations Project, 3
Indiana Home Care Task Force, 2
Fifth Freedom, 2
The Arc of Indiana, 2
National Council on Aging - Aging In Place Reverse Mortgage Network, 2
AARP
Adult Protective Services
Alliance of Information and Referral Systems (accreditation)
Altrussa
Alzheimer's Association
CHOICE Advisory Board
Citizen's Action Coalition of Indiana
Community Mental Health Centers
Council on Aging
County Chamber (of Commerce)
Governor's Council for People with Disabilities

Health Care Advisory Co.
Indiana Health Care Association
HOPE LANE
IBM led coalition
Indiana 211 Partnership
Indiana Association of Homes and Services for the Aging
Indiana Association of Rehabilitation Facilities
Indiana Care Circle
Indiana Culture Change Coalition
Indiana General Assembly
Nursing facilities
Retired and Senior Volunteer Program
Indiana Retired Teachers Association
Senior Center Association
Society of Certified Senior Advisors
State Health Insurance Program, Indiana Department of Insurance
The National Consumer Voice for Quality Long-Term Care
Triad
Veterans Administration

Question 6: Of the draft policy concepts and solutions presented at today's meeting, which is best, which would you support, and which would you oppose. Identify the drafts by number or name.
Of the 109 questionnaires collected at the 2009 regional community discussions, the following are the responses to question 6.

Draft 2010 Policy Concepts and Solutions	Support	Don't support	Not Sure
1 The Generations Project Lessons from Home Recommendations.	24	0	2
2 SEA 493 II: HCBS client service targets set by statute and savings used to grow the home care system.	41	0	0
3 HCBS established as entitlement.	33	0	0
4 Presumptive eligibility authority given to AAAs.	66	0	0
5 Pre-Admission Screening (PAS) officers in hospitals & nursing facilities.	43	2	1
6 Independent provider network or registry.	25	6	5
7 Releasing appropriated HCBS dollars (CHOICE and Medicaid waiver funding).	39	1	0
8 Establish "Small House System" for a new model of nursing home care	30	0	2
9 Establish Brain Injury (BI) Treatment Capacity	31	1	0

Family and Social Services Administration Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE)

Annual Report State Fiscal Year 2009

July 1, 2008 to June 30, 2009

Executive Summary

The Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program continued to provide needed services for thousands of Hoosiers in State Fiscal Year 2009 (SFY09), which encompasses July 1, 2008 through June 30, 2009. In SFY09, CHOICE provided community and home care services as an alternative to institutional care for 9,225 Hoosiers. Total CHOICE expenditures for the fiscal year were $46,915,624, which are exclusively state dollars. While the spectrum of CHOICE service recipients varies greatly, the average program participant was a Caucasian female, age eighty-five or greater, and the only member of her household. Additionally, she would have circulatory, nervous, and/or muscular impairments and be unable to perform three or more assessed activities of daily living, or ADLs.

The average cost per month for a CHOICE client was $423.81 compared to the average cost per month of a client in a nursing facility of $4,575.89. The average yearly cost for a CHOICE client was $5,086, compared to the average yearly cost per month of a nursing facility client of $54,911. The overall yearly savings is $49,825, of which $18,470 is the state's share and the remaining $31,355 is the federal share.

Overall, State Fiscal Year 2009 figures illustrate that the CHOICE program continues to be a cost-effective way to provide needed services to Hoosiers.

Introduction

The Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program was established during the 1987 legislative session through House Enrolled Act 1094 and began as a pilot program in Knox, Daviess, and Tippecanoe counties in 1988. In 1990, the program expanded to eleven additional counties and by 1992, the program included services to all of Indiana's 92 counties. In 2005, Indiana Code 12-10-10-4 was amended to include an individual asset limit to not exceed the worth of five hundred thousand dollars. CHOICE is funded exclusively with state dollars.

To be an "eligible individual" for CHOICE program services, one must:

> be a resident of the State of Indiana;
>
> be 60 years of age or older or disabled;
>
> not have assets exceeding the worth of five hundred thousand dollars, as determined by the Indiana Division of Aging; and
>
> qualify under the criteria developed by the board as having an impairment that places the individual at risk of losing the individual's independence if the individual is unable to perform two (2) or more assessed activities of daily living.

CHOICE funding for services is used after all other possible payment sources have been identified and all reasonable efforts have been employed to utilize those sources. While there are no income restrictions on eligibility, a cost share exists for anyone above 150% of Federal Poverty Level. The 2009 Federal Poverty Level for a one person household was $10,830 and a two person household was $14,570. (CHOICE FY2009 Annual Report Page 1)

Comparison of Costs for All Publicly Funded Long Term Care Programs
IC 12-10-10-11(a) (5)

SFY09	CHOICE	Older Americans Act - Title III	Combined Home and Community-Based Waivers	Social Services Block Grants (SSBG)
Annual Expenditures[16]	**$46,915,624**	**$23,801,182**	**$88,130,557[17]**	**$9,543,358**

CHOICE[18]	**Total**	**State**	**Federal**
Average Cost			
Per Day	$13.93	$13.93	$0.00
Per Month	$423.81	$423.81	$0.00
Per Year	$5,085.70	$5,085.70	$0.00
Nursing Facilities[19]	**Total**	**State**	**Federal**
Average Cost			
Per Day	$150.44	$56.13	$94.31
Per Month	$4,575.89	$1,707.29	$2,868.60
Per Year	$54,910.68	$20,487.48	$34,423.20

*The average cost per month is the average cost per day multiplied by 30.4167, which represents the average number of days per month. The average cost per year is the average cost per month multiplied by 12 months per year.

Client Care Outcomes[20]
IC 12-10-10-11(a) (6)

CHOICE provided community and home care services as an alternative to institutional care for 9,225 clients for SFY09.

For SFY09, there were 657 CHOICE clients who were approved and confirmed to start the Aged and Disabled Waiver, thus transferring from the CHOICE program to a Medicaid Waiver service.

Estimated Number of Applicants for Services from CHOICE with One ADL[21]
IC 12-10-10-11(a) (7) (A)

A determination of the estimated number of applicants for services from the community and home options to institutional care for the elderly and disabled program who have one (1) assessed activity of daily living (ADL) that cannot be performed.

CHOICE clients unable to perform 1 ADL: 169
*Clients receiving only Case Management services are included in this number.

(CHOICE FY2009 Annual Report Page 9)

Estimated Number of Applicants for Services from CHOICE with Two ADLs[22]
IC 12-10-10-11(a) (7) (B)

A determination of the estimated number of applicants for services from the community and home options to institutional care for the elderly and disabled program who have two (2) assessed activities of daily living (ADLs) that cannot be performed.

CHOICE clients unable to perform 2 ADLs: 1,951 people
*Clients receiving only Case Management services are included in this number.

Estimated Number of Applicants for Services from CHOICE with Three or More ADLs[23]
IC 12-10-10-11(a) (7) (C)

A determination of the estimated number of applicants for services from the community and home options to institutional care for the elderly and disabled program who have three (3) or more assessed activities of daily living (ADLs) that cannot be performed.

CHOICE clients unable to perform 3 or more ADLs: 5,466 people

CHOICE clients with care plans not yet finalized: 201 people

CHOICE clients with severe medical conditions: 1,034 people
*Clients receiving only Case Management services are included in these numbers.

Estimated Effect on Program Funding, Program Savings, Client Care Outcomes and Comparative Costs
IC 12-10-10-11(a) (7) (A) (B) and (C)

Program savings

The average cost per month for CHOICE services was $4,152 less than the average cost to maintain someone in an institution ($424 vs. $4,576). The breakdown of State versus Federal portion of the savings (by day, month, and year) is illustrated below. The calculation of the savings is based on the total savings (A-B).

	Daily Rate	Monthly Rate	Yearly Rate
A. Nursing Home	$150	$4,576	**$54,911**
B. CHOICE	$14	$424	$5,086
C. Savings (A - B)	**$136**	**$4,152**	**$49,825**
D. State Share of Savings[24]	$50	$1,539	$18,470
E. Federal Share of Savings[25]	$86	$2,613	$31,355

(CHOICE FY2009 Annual Report Page 10)

Client access

In SFY09, CHOICE clients had access to an array of services. CHOICE services include the following:

Adult Day Services
Transport - Adult Day Services
Specialized Medical Equipment
Assisted Transportation
Attendant Care
Bath Aide
Behavior Management
Case Management
Environmental Modification
Family and Care Training
Foot Care
Home Delivered Meals
Skilled Care, RN
Respite Nursing
RN
Skilled Nursing
Homemaker
Home Health Aide
Home Health Supplies
LPN
Medication Setup
Medication Time Reminders
Occupational Therapy
Other Needed Services
Physical Therapy
Respite
Resident Based Habilitation
Respite - Homemaker
Speech Therapy
Social Worker
Transportation
Wheelchair Transportation

(CHOICE FY 2009 Annual Report Page 11)

Introduced Version

SENATE CONCURRENT
RESOLUTION No. 0031

DIGEST OF INTRODUCED RESOLUTION

A CONCURRENT RESOLUTION requesting that the Health Finance Commission review innovations in nursing home services and housing.

Becker, Miller

read first time and referred to Committee on

Introduced

Second Regular Session 116th General Assembly (2010)

SENATE CONCURRENT
RESOLUTION

A CONCURRENT RESOLUTION requesting that the Health Finance Commission review innovations in nursing home services and housing.

Whereas, There is a growing trend of new and alternative approaches to nursing home services and housing that are supported by consumers and providers; and

Whereas, The new and alternative approaches to nursing home services and housing may have significant implications for those services in Indiana, including the financing of those services: Therefore,

Be it resolved by the Senate of the General Assembly

of the State of Indiana, the House of Representatives concurring:

SECTION 1. That the Health Finance Commission is requested to review new and alternative approaches to nursing home services and housing that are occurring across the nation and in Indiana, to consider the views of consumers and providers, and to report its findings to the General Assembly.

SECTION 2. That copies of this resolution be transmitted by the Secretary of the Senate to the Secretary of the Family and Social Services Administration.

Introduced Version

SENATE CONCURRENT RESOLUTION No. 0032

DIGEST OF INTRODUCED RESOLUTION

A CONCURRENT RESOLUTION requesting that the Health Finance Commission review the prevalence of brain injury, the scope of brain injury services, and financing for those services in Indiana.

Miller, Becker

Second Regular Session 116th General Assembly (2010)

SENATE CONCURRENT RESOLUTION 0032

A CONCURRENT RESOLUTION requesting that the Health Finance Commission review the prevalence of brain injury, the scope of brain injury services, and financing for those services in Indiana.

Whereas, There is substantial evidence that brain injury may be growing in its prevalence;

Whereas, Medical science and life span therapies are effecting rapid and costly change in the treatment of brain injury; and

Whereas, The treatment and financing of brain injury is a growing public concern: Therefore,

Be it resolved by the Senate of the General Assembly
of the State of Indiana, the House of Representatives concurring:

SECTION 1. That the Health Finance Commission is requested to review and make recommendations regarding the need and the availability of services for Hoosiers with brain injuries.

SECTION 2. That in developing its findings and recommendations, the Commission may include in its consideration the following factors:

(1) the prevalence and scope of brain injuries;
(2) the existing and needed infrastructure for treating brain injuries;
(3) the need for acute, post-acute, and life span services;
(4) the need for brain injury education for health professionals and the public;
(5) employment issues for persons with brain injuries;
(6) housing and transportation needs of persons with brain injuries;
(7) current public expenditures associated with the treatment of persons with brain injuries;
(8) the projected costs should the state expand publicly funded brain injury services;
(9) the public cost of existing brain injury services;
(10) the impact of brain injury on the state's economy; and
(11) federal programs that may impact the availability and financing of brain injury services in Indiana.

SECTION 3. That the commission shall issue a final report when directed to do so by the legislative council.

A New Long Term Care Model
The Generations Project, 2010

Note to Reader: The following document represents model legislation originally prepared for the Indiana Home Care Task Force and the Round Table Education Series in January 2010. The model was developed by The Generations Project. The model legislation is intended to be an education piece to demonstrate that it is possible to re-balance Indiana's system of long term care using consumer driven and defined home and community based services. The model legislation is based directly on the input of citizens who participated in community meetings throughout the state in 2007, 2008 and 2009. The meetings concluded with a conference in Indianapolis on November 18, 2009. The format used for the model legislation is NOT the official style used by the Indiana General Assembly and should not be seen as such. The dates used in the model are for illustrative purposes only and certain sections of the model language may not be compatible with current practices employed by the state.

Section 1: Definitions.

Sec. 1. HCBS means home care and community based services that are provided to an individual in the individual's home or place of residence that are provided through the CHOICE In-Home Services program, a Medicaid aged and disabled waiver, the Older Americans Act, a Social Services Block Grant, or other locally delivered services intended to maintain the independence of an individual, including meals and transportation services.

Sec. 2. A home care worker is a person who provides a service, or services, to an individual, or individuals, that would qualify as a service under the CHOICE In-Home Services program or a Medicaid aged and disabled waiver or other HCBS authorized by an area agency on aging.

Sec. 3. Agency is the Indiana Family and Social Services Administration.

Sec. 4. Division is the Indiana Division of Aging.

Sec. 5. An area agency on aging, or AAA, is an is an independent non-profit corporation chartered by the federal government under the provisions of the Older Americans Act to serve senior citizens and other persons, that also provides services to senior citizens, persons with disabilities, and other persons as stipulated in contract and by statute with the state of Indiana.

Sec. 6. ADRC is an aging and disability resource center maintained and operated by each of the area agencies on aging to provide services for members of the public seeking information and assistance regarding HCBS, LTC services and other quality of life services in the local communities served by the ADRC.

Sec. 7. Case manager is an employee of an area agency on aging that assists individuals who need home and community based services and other services administered by the AAA.
Sec. 8. Network is an independent provider network composed of individuals trained and certified according to standards established by the agency and the division to provide HCBS to an individual.

Sec. 9. Independent provider is an individual who operates independently and has been trained and certified to provide HCBS to individuals according to standards established by the agency and the division.

Section 2. (a) The agency and the division are directed to take the following actions regarding the placement of individuals into HCBS under the CHOICE and Medicaid waiver programs: establish the means for increasing the net combined number of individuals served through the CHOICE and Medicaid aged and disabled waiver programs by 1,500 individuals per year for each state fiscal year for two years beginning July 1, 2011; by 2,250 individuals per year for each state fiscal year for two years beginning July 1, 2013; and by 3,000 individuals per year for each state fiscal year for two years beginning July 1, 2015.

(b) Should the net increase of individuals in the CHOICE and Medicaid aged and disabled waiver programs exceed the statutory target in a fiscal year then the calculation for the net increase in the following year shall be based on the higher number.

(c) The agency and the division, in consultation with the AAAs, shall calculate the number of individuals at the end of each fiscal year who would have been served in a nursing home under the Medicaid program during the course of the fiscal year if the provisions of this act were not in effect, and the average cost to serve each of those individuals in a nursing home under the Medicaid program.

(d) The State Budget Agency shall transfer the calculated savings identified in sub-section (c) above to the agency and the division for the purchase of HCBS for additional individuals under the provisions of this act.

(e) Should the transfer of dollars to the agency and the division be insufficient to meet the provisions of this act in a state fiscal year the State Budget Agency shall transfer additional dollars as stipulated by the agency until the need is met.

(f) Should the transfer of dollars exceed the need as targeted under the provisions of this act the agency may apply those dollars for the purchase of additional HCBS.

(g) The calculation and allocations of funds to fulfill the purposes of Section 2 of this action shall include funds to cover the additional administrative and case management needs of the AAAs that are responsible for its local implementation.
Section 3. Beginning July 1, 2017 any individual who is found eligible for HCBS under the provisions of the Medicaid aged and disabled waiver shall be entitled to those services.
Section 4. In a manner that is allowed under federal law and rule, an individual applying for services through a Medicaid aged and disabled waiver may be presumptively determined to be eligible for those services by a case manager and the case manager supervisor employed by the AAA where the application is made.

Section 5. An individual applying for services through the CHOICE In-Home Services program may be reviewed and determined eligible for services by a case manager and the case manager supervisor employed by the AAA where the application is made if the individual has first been reviewed and

presumptively or otherwise determined not to be eligible for services through a Medicaid aged and disabled waiver.

Section 6. The agency and the division may employ sampling techniques to determine the reliability of presumptive eligibility determinations by an area agency on aging insofar as the techniques are in compliance with federal law and regulations.

Section 7. The agency and the division shall consult with each of the area agencies on aging in determining the number of additional AAA case workers, administrative personnel and associated resources that are needed to properly implement the provisions of this act.

Section 8. In implementing the provisions of this act, or any act involving the area agencies on aging, the authority of the state is strictly limited to the provisions of the contractual agreement between the state and the AAAs and shall not impinge on the obligations and operations of any AAA as an independently chartered corporation under the provisions of the Older Americans Act.

Section 9. (a) Beginning July 1, 2011 employees of the division, or case managers contracted through a local AAA who have no fiduciary or other ties to the institution or institutions where posted, shall be assigned as pre-admission screening officers to each hospital and acute care facility in the state to screen each patient per the patient's most appropriate placement and treatment if additional facility based treatment and therapy is needed once the patient's acute care stay is completed.

(b) A pre-admission screening officer shall review each patient's case and consult with the patient, or the patient's legal representative or family as appropriate, before any decision is made regarding the placement and treatment of a patient if it is determined the patient needs long term care and therapy in a facility.

(c) The pre-admission screening officer may use the advice of medical and social work personnel not associated with the hospital or acute care facility where the patient is receiving care in making recommendations regarding a patient whenever the officer believes such advice is appropriate.

(d) The hospital or acute care facility must cooperate with the pre-admission screening officer including notifying the officer in a timely manner of any patient who may need long term care or therapy in a facility and is subject to discharge.

(e) Should a hospital or acute care facility recommend placement of a patient upon discharge to a long term care or therapy facility owned in full or in part by the hospital or acute care facility, or owned in full or in part by officers or employees of the hospital or acute care facility, the pre-admission screening officer must be shown the placement is the best available option for the patient.

(f) In no case can a patient be discharged to a facility that is owned in full or in part by the discharging institution, or officers and employees of the discharging institution, without the consent of the patient, or the patient's legal representative or family as appropriate, and the pre-admission screening officer.

(g) It is the obligation of the hospital or acute care facility to inform the agency, division and any pre-admission screening officer of any ownership interests, including ownership interests held by officers or employees of the hospital or acute care facility, in any facility to which a patient may be discharged.

(h) A hospital or acute care facility that violates the provisions of this act may be assessed by the division the value of the extra costs incurred by the state and the patient to correct an inappropriate placement if additional costs are incurred by the state or the patient as a result of the post acute placement.

Section 10. (a) The agency and the division shall establish an independent provider network; an office of independent provider and self directed care services within the division; and a program and standards for identifying, recruiting, training and certifying individuals to be independent providers of HCBS to individuals.

(b) The standards and the program for identifying, recruiting, training, paying for training costs, and certifying individuals to be independent providers shall be established, and ready to enroll individuals for training, no later than July 1, 2011.

(c) The program for training and certifying individuals to be independent providers may be done in conjunction with a state institution of higher learning and the area agencies on aging.

(d) In developing standards and a program for identifying, recruiting, training, paying for training costs, and certifying standards for independent providers the agency and the division shall consult the following entities: area agencies on aging, Indiana Association for Home and Hospice Care, Indiana Home Care Task Force, United Senior Action, Indiana Alliance for Retired Americans, AARP Indiana, centers for independent living, and any employees association or union that represents HCBS workers in the state.

(e) As of July 1, 2010 an office of independent provider and self directed care services is established within the division to do the following: (i) create and maintain a state wide registry of independent providers who have been trained and certified according to the provisions of this act and subsets of that registry for each of the area agencies on aging, (ii) develop liability and health insurance service options for independent providers, (iii) establish fiscal intermediary services within the division for individuals who self direct their own HCBS through the CHOICE and Medicaid aged and disable waiver programs, (iv) create in-service training and professional enrichment programs with the area agencies on aging for maintaining the skills and quality of service of independent providers, and (v) maintain a self-directed care hotline and support services to address emergencies and other needs for individuals that self direct their care.

Section 11. (a) The state shall release on July 1st of each state fiscal year 50 percent of the funds that have been appropriated or allocated by the General Assembly to the AAAs for HCBS, other services and administration including federal dollars allocated for those purposes.

(b) On January 1 of each fiscal year the state shall release to the AAAs the remaining state and federal dollars that have been appropriated or allocated to the AAA by the general assembly.

(c) Should the agency or any state entity fail to release the funds appropriated and allocated to the AAAs under the provisions of this act the state must pay all financing costs plus an additional 2 percent interest on the borrowed principle, equity, or line of credit used by a AAA to maintain services and operations as a result of the delayed payment(s) from the state.

Section 12. (a) Beginning July 1, 2010 the agency and the division shall establish the small house initiative fund for the development and construction of "small" house concept nursing facilities for citizens who quality for long term care services through the Medicaid program. (i) The fund shall be administered by the agency. (ii) The fund shall not release funds for the development and construction of small houses prior to July 1, 2011. (iii) Any small house project must be matched on a 3:1 basis by a private for-profit or non-profit entity that demonstrates to the agency and the division plans and a capacity to construct and manage a small house as defined by this act and as delineated by the commission established by this act. (iv) The agency shall establish a cap on the total number of dollars that can be provided to a developer or owner for matching purposes from the fund, and under no circumstances can the fund incur a debt. (v) Should a developer and manager of a small house fail to meet and maintain the terms and conditions that define a small house as established by this act and the commission, the agency may withdraw the small house designation given to the facility and recommend to the attorney general legal action to recover from the developer and/or owner the matching funds plus damages.

(b) Beginning July 1, 2010 the small house initiative fund shall be capitalized with twenty (20) percent of the funds collected by the state from the quality assessment fee (*nursing home bed tax*) established by the general assembly in 2003 and renewed in 2009.

(c) Beginning July 1, 2010 the small house initiative fund commission shall be established to define what constitutes a "small" house, to make recommendations per their establishment, financing, operations, the terms and conditions for any individual living in a small house, the rights of any and all residents and the retention of their personal wealth and belongings, and other quality of life measures. (i) The commission shall be the primary advisor to the agency and the division on the development, establishment, operations, and ongoing oversight of small houses. (ii) The agency and the division must give consideration to the commission's rulings and advisory opinions. (iii) The members of the commission shall be selected from nominations made by the following organizations: five senior citizens nominated by United Senior Action, Indiana Alliance for Retired Americans, and AARP; three individuals with disabilities nominated by centers for independent living and the Governor's Council for persons with Disabilities; one member nominated by the Indiana Association for Area Agencies on Aging; one member nominated by an association representing for profit nursing homes; one member nominated by an association representing non-profit nursing homes; two members from the Senate nominated by the President Pro Temp with advice from the minority leader; and two members from the House nominated by the Speaker with advice from the minority leader. (iv) The terms of the commission shall be for three (3) years and the members of the commission shall elect their own chair and vice-chair annually, the commission shall meet a minimum of four (4) times per year, when conducting the business of the commission the members shall be paid per diem and mileage equal to that

paid to the members of the general assembly, and the commission shall receive staff and record keeping services from the division.

(d) A small house is defined as a place of residence for an individual who needs nursing home level of care through the Medicaid program that establishes a living environment that emulates the independence, personal and physical qualities of the environment where the individual lived to the extent feasible prior to assuming residency in the small house. (i) The agency and the division shall determine if a developer and/or owner of a small house operates the facility in a manner that meets the definition established by this act and as further delineated by the commission. (ii) The agency and the division shall establish and maintain compliance procedures for developers and/or owners.

Section 13. (a) As of July 1, 2010 the Indiana office of brain injury services is established within the office of Medicaid policy and planning (OMPP) to coordinate and develop brain injury services in the state for any individual that has had a traumatic brain injury or an acquired brain injury that requires post-acute and life span treatment and therapy.

(b) The office shall work with the agency and OMPP to recommend and put in place the capacity and access to care within the state to treat the short term and life span needs of all Hoosiers who have traumatic and acquired brain injuries.

(c) The available treatments must include acute, post acute, intensive and ongoing therapy for any individual with any diagnosed brain injury regardless of origin and severity.

(d) The treatments must include therapies that optimize the independence of any individual with a brain injury including in-home and community based services.

(e) The treatments must include a full array of intensive post-acute long term neuro-behavioral therapies.

(f) The treatments may be financed by any combination of private pay, insurance, Medicaid, and other public funding sources.

(g) The office and OMPP shall design funding models that use the resources identified in subsection (f) above, and shall make recommendations to the general assembly for additional funding resources by January 1, 2011.

(h) The office shall utilize any opportunities created by Congress to fund and treat individuals per the provisions of this act and shall take into considerations those opportunities when making recommendations to the general assembly.

(i) The office shall confer with the federal veterans administration regarding opportunities for joint services and cooperative programs including HCBS for veterans and non-veterans.

(j) The office shall confer with the area agencies on aging per their expertise in establishing HCBS case management services.

(k) The office shall establish an advisory panel to review its actions and to make recommendations for implementing the provisions of this act that shall include five members who have brain injury or are family caregivers of an individual with a brain injury, one medical professional who treats people with brain injury, one administrator of a facility that treats individuals with brain injury post-acute and long term, one professional experienced in life span HCBS for individuals with brain injury, and an area agency on aging director or case management supervisor.

(l) The services established under the provisions of this act shall become effective July 1, 2011.

Section 14. The General Assembly shall re-authorize for five (5) years any provisions of SEA 493 (2003) that have expired insofar as the re-authorization of those provisions do not conflict with the provisions of this act.

Section 15. The General Assembly shall review any provisions in federal law that can be used to support and expand the home and community based services offered under the provisions of this act.

Section 16. Unless otherwise stipulated the provisions of this act shall become effective on July 1, 2010.

A New Model for Public Benefit Programs in Indiana, 2009

Note to Reader: The following document represents model legislation prepared for the Indiana Home Care Task Force and the Round Table Education Series. The model was developed by The Generations Project. The model legislation is intended to be an education piece to demonstrate possible solutions to the crisis facing Hoosiers who use Medicaid, SNAP and TANF services since the Division of Family Resources was privatized and modernized by the Indiana Family and Social Services Administration in 2007. The model legislation is based directly on the input of citizens who participated in community meetings throughout the state and at a conference in Indianapolis on November 18, 2009. It is intended to represent their views and should only be seen as an education piece. The format used for the model legislation is NOT the official style used by the Indiana General Assembly and should not be seen as such. The dates used in the model are for illustrative purposes only and certain sections of the model may not be compatible with current practices employed by the state.

Section 1. Definitions.
Sec. 1. Welfare and welfare services defined. (a) Welfare, or public welfare, consists of those programs and services provided under 42 U.S.C. ~1396, et.seq. and IC 12 -15 (the Medicaid program), 7 U.S.C.~2011, et seq. (Supplemental Nutrition Assistance Program known as SNAP or the Food Stamp program), and 42 U.S.C.~601, et seq (the Temporary Assistance for Needy Families program, or TANF).

(b) Welfare services, or public welfare services, are services provided to a client who qualifies for publicly financed benefits as established under federal and state law for any of the following programs: Medicaid, SNAP, or TANF.

Sec. 2. County welfare office defined. The county welfare office, or office, is the Division of Family Resources office that is located in each of the state's 92 counties.

Sec. 3. Call center defined. Is any office under the authority of the Indiana Family and Social Services Administration that may provide telephone, computer and fax based eligibility and information services for persons receiving services under the provisions of this act and is not a county office.

Sec. 4. Client defined. A client may be any individual, or individual family, that qualifies for services under the provisions of this act.

Sec.5. A client with disabilities and special needs defined. A client with disabilities and special needs is any individual who receives services under the provisions of this act who is an individual with a disability that in any manner impairs the ability of that individual to process, access or otherwise obtain the services provided under this act including but not limited to physical, sensory, medical, mental health, cognitive, developmental, transportation, residential or age related limitations.

Sec. 6. Welfare services defined. Welfare services include the publicly financed benefits and related caseworker services that are provided to qualified individuals under the provisions of this act.

Sec. 7. Caseworker and casework defined. Caseworker and casework have the following meanings: (a) A caseworker is a public employee that shall meet in person with every individual needing services under the provisions of this act in the DFR office in the county where the person resides or in the individual's current place of residence, determine if an individual is eligible for services in a manner that fully complies with federal and state laws and regulations governing the programs and services provided under this act, remain in contact with and assist any individual as needed per the services provided under this act, and assist any individual in the process of re-determining eligibility for the services provided.

(b) Casework is the performance of the activities described in Sec. 6 and Sec. 7(a) above and elsewhere in this act.

(c) Any individual who does casework must be an employee of the state of Indiana who is eligible to provide said services under the job classifications and standards used by the Indiana Family and Social Services Administration as of January 1, 2005.

(d) Beginning July 1, 2011 any individual who is newly employed by the state to perform duties as a caseworker as defined by this act must also have earned a bachelor's degree from an accredited college or university.

(e) Any individual employed by the state prior to July 1, 2011 as a caseworker may continue in that capacity if the person meets the criteria establish in subsection (c) above.

Sec. 8. Division is the Division of Family Resources.

Sec. 9. FSSA is the Indiana Family and Social Services Administration.

Sec. 10. State is the government of the state of Indiana as established under its constitution.
Section 2. (a) Welfare client services must be provided in a timely and safe manner in accordance and as defined by federal and state laws, in full compliance with the rights of an individual client as defined in federal and state law, and appropriate to the needs of each individual client.

(b) The division shall establish standards and detailed procedures for improving the initial client interview process that establishes eligibility in order to insure the accuracy and appropriate use of the client information that is gathered, the proper development of case plans, and the accurate maintenance of client records going forward.

(c) The division shall establish minimum standards for training and evaluating the ability of caseworkers to recognize and investigate the medical, health and nutrition needs of clients, to make proper referrals for additional services that are outside of the immediate scope of the

office, and to interface with social agencies, community organizations, churches, and local providers as necessary to assist clients.

(d) The division shall establish in cooperation with clients, their advocates, caseworkers and administrative employees ongoing measures and means for insuring the quality of client services, and the quality of the work environment for caseworkers and administrative staff including an ongoing review of best practices from other states.

(e) The division and county offices shall work in cooperation with local citizens, local units of government, social agencies, churches, consumer and client based organizations to improve the quality and delivery of services to eligible individuals with medical, health and nutrition needs.

(f) The division shall provide fraud protection and recognition units in the county offices.

Section 3. To enhance FSSA's ability to implement the provisions of this act the following shall be established by the agency: (a) an office of quality control within the division shall work with clients, their advocates, county caseworkers, and county administrators to develop operational standards for training staff to recognize and implement quality measures, and to establish and monitor those measures per the recognition of client rights, client health and social needs, workplace quality and safety issues for caseworkers and other county staff, and the monitoring and evaluation of error rates and timeliness in delivering services to clients.

(b) The division shall establish procedures for implementing findings made under subsection (a) above and for appropriately staffing qualify measures.

(c) The divisions shall establish ongoing consultation with county offices and clients to insure the maintenance of quality protocols and measures, program and service quality, program and operations consistency within the county offices, and corrective actions as needed.

(d) The division shall establish guidelines for the counties to accurately inform all clients of their appeal rights, for sharing with clients complete information regarding their files, for keeping medical and other client health records current, and for properly handling all client appeals including verbal appeals.

(e) The division shall provide at no cost to any individual that appeals a decision regarding services provided under the provisions of this act to the individual complete information from the client's files including the client's most recent medical report(s).

(f) (i) The failure of a medical review team to render a decision regarding a client within the framework for providing services to the client under federal Medicaid, food stamp, and TANF law cannot be used to deny services to the client within the time established by federal law and regulations.

(ii) Under no circumstances shall a client be forced to pay for a report rendered by a medical review team or by the division regarding the client.

Section 4. Services provided to an individual client under the provisions of this act by a provider enrolled for that purpose by the division, FSSA or the state shall be paid in a timely manner that does not jeopardize the well being of the client and in full compliance with the terms under which the provider agreed to provide services.

Section 5. Welfare services shall be provided to a client through an office in the county in which that individual is a resident.

Section 6. Any individual who receives services under the provisions of this act: (a) must first be interviewed and determined eligible for those services by a caseworker at a county office, or in the permanent or temporary residence of the individual should be individual be a person with a disability or special needs as defined by this act.

(b) The temporary residence of an individual may include a nursing home, a hospital, or other location necessitated by the individual's circumstances that prevents the individual from coming to the county office.

(c) Should an initial face to face interview with an individual jeopardize the individual's ability to receive services in an emergency situation, or jeopardize the receipt of services by the individual in a timely manner as required by federal law, a telephone or alternative interview format may be used if approved by the caseworker's supervisor and if the alternative format complies with state and federal laws and regulations regarding the individual's eligibility for services.

(d) Referrals to determine eligibility for an individual who may need to be interviewed by a caseworker in the individual's residence may come from a family member, a qualified medical professional who provides services to the individual, a court of law, an authorized legal representative, from a social service agency, or from any agency receiving public funds to provide medical, health and social services to senior citizens, other individuals with disabilities, persons with developmental disabilities, persons with mental health needs, children or families.
Section. 7. (a) Any individual that is determined eligible for services may choose, but cannot be required, to maintain continued eligibility for services remotely through computer and/or telephonic communications with the county office, or through a call center if established by the state under the provisions of this act, if the individual's caseworker and caseworker supervisor determines such arrangements are feasible and appropriate for the individual.

(b) Except as provided for in Section 6(c) and Section 7(f) of this act, in no case shall an individual receive services without first being determined eligible for services in a face to face interview with a caseworker, and only after the individual's identity and personal information has been properly verified by the county office in accordance with procedures established by the division and in compliance with applicable federal and state laws.

(c) The division shall establish a schedule for the re-determination of eligibility by a caseworker for any individual receiving services through Medicaid, SNAP and TANF programs that complies at a minimum with all applicable federal laws and regulations.

(e) Without exception, individual clients receiving services under the provisions of this act shall have their case records maintained in their county of residence and available for review by the individual or the individual's legal representative.

(f) Notwithstanding subsection 6(b) above and as stipulated elsewhere in this act, any individual that has been presumptively determined to be eligible for Medicaid waiver services by an area agency on aging for Medicaid waiver services, as authorized by the state, shall: (i) have submitted by the area agency on aging acting in the individual's behalf and in an electronic format approved by the division, the records of the individual to the county office in which the individual is a resident, (ii) the county office shall presume the individual is eligible for the waiver services as determined by the area agency on aging, (iii) The division and FSSA shall determine the processes for reviewing the eligibility of presumptively determined individuals including the use of sampling techniques that are in compliance with federal law.

Section 8. The division shall develop the following changes in the maintenance of client records and in communications with clients. (a) A paperless record keeping system to the extent that is feasible while maintaining the capacity to communicate in writing and in a paper format with all clients.

(b) A computer based system of client records in which each client's records are maintained in the client's county of residence but which can be electronically transferred to another county without delay should the client's residence change.

(c) Eligibility application forms and eligibility re-determination forms printed in large type, with written submissions of no more than four pages, and with all eligibility and re-determination forms and descriptive materials regarding services presented in alternative communication formats.

(d) All upgrades in technology, client services and administration should be done on an ongoing basis and tested multiple times with small sample populations of clients, providers, caseworkers and other employees before implemented on a large scale.

(e) The division is directed to establish an ongoing planning process for upgrades in technology, client services and administration that includes members of the general assembly and local units of government, employees of the division, advocacy and client based organizations, social service and community groups, and federal agencies.

Section 9. Every county office must be fully accessible to individuals that are served by the office. (a) Every county office shall have the appropriate technology and staff trained and available during all business hours to assist individuals who must communicate in alternative communication formats, and appropriately trained staff available to visit the residence of any individual who must communicate in an alternative communication format when it is not feasible for that individual to come to the county office.

(b) Every county office must be fully accessible externally and internally to any individual and the location of each county office must be easily accessible to the public transportation systems that exist in the county.

(c) Every county office must advertise its location, its telephone number, and its email address in the media and through local social service agencies and service providers to make locating and communicating with the office as easy as possible for individuals needing services.

(d) Every county office must have staff in the field doing home visits to clients who cannot travel or are otherwise without the means to communicate externally, as well as in the office to assist clients and providers in resolving problems associated with the provision of services.

Section 10. Every county office must have staff trained to communicate with and to assist providers and other social agencies in the county in providing appropriate and timely services to clients.

Section 11. FSSA shall take the following steps to implement the provisions of this act: (a) Upon the act's passage, immediately begin the processes that are necessary to alter or terminate the provisions of any contract with a private entity that are in conflict with the terms and the purposes of this act in accordance with the constitution of the state of Indiana and applicable federal and state laws.

(b) Upon the act's passage, begin the process of identifying and recruiting the appropriately skilled and trained individuals that are needed to implement the provisions of this act.

(c) Upon the act's passage, begin the process of identifying additional changes and actions necessitated by the provisions of the act.

(d) FSSA and the state budget agency shall calculate the costs and the savings to the state necessitated by the implementation of this act, and in consultation with the state budget committee, apply the savings to the implementation of the act.

(e) FSSA shall calculate the number of caseworkers and administrative staff needed to implement the provisions of this act, shall use those calculations to establish staffing levels for the division and the county offices, and shall adjust those staffing levels should they prove to be inadequate to provide the services identified in this act in a safe, timely and appropriate manner.

Section 12. Notwithstanding other state laws and regulations, all employees of the division and the county offices shall be public employees unless otherwise stipulated by the provisions of this act.

Section 13. FSSA may allow a private vendor to provide under contract computer maintenance and related technical support services for the division and the county offices only if it can be demonstrated to the satisfaction of the legislative council and the state budget agency that a

private vendor can provide these services more effectively and with greater cost effectiveness than establishing the capacity with the agency.

Section 14. (a) The division may established one, or more, regional calling centers to service clients that are operated by state employees if the cost effectiveness of a calling center over like services provided through a county office can be demonstrated by FSSA to the state budget committee.

(b) An individual using services through a regional calling center must be approved to do so by a county office only after the individual's identity and initial eligibility has been determined and certified by a caseworker in that office through a face to face interview.

(c) Under no circumstances shall a calling center accept a client for services without prior approval and verification by the county office in which the client resides.

Section 15. (a) FSSA shall establish a schedule for phasing out the use of any private entity and individuals who are employed by a private entity to implement the provisions of this act.

(b) The only exceptions to subsection (a) above are those that are explicitly granted by the provisions of this act.

(c) The schedule and the process for implementing it established under subsection (a) above must be completed no later than June 30, 2013.

(d) FSSA may offer employment to any individual employed by a private entity to fulfill the state's obligations under the provisions of this act that was employed by a private entity for that purpose prior to July 1, 2011 if the individual is qualified for the position for which the individual is being considered as established by the requirements of this act and related state laws and regulations.

Section 16. (a) FSSA shall report within one year following the implementation date of this act, and each year after that, to the legislative council and the state budget committee on the agency's progress in implementing the act's provisions.

(b) The legislative council and the state budget committee shall hold a public hearing and receive public comment with thirty (30) days of receiving the annual report from FSSA.

(c) Should FSSA prove unable to properly and fully implement the provisions of the act within two (2) years of its passage, or is unable to show substantial and reasonable progress in its implementation, the agency, with the approval of the legislative council, the state budget committee, and the federal agencies that supervise Medicaid, SNAP and TANF services, shall publish a revised plan and schedule for the act's implementation that addresses the all problem areas including casework, quality of services, access to services, staffing, and compliance with federal laws.

(d) Should FSSA prove unable to properly and fully implement the provisions of the act within three (3) years of its implementation date, the legislative council and the state budget agency may do any of the following: (i) make recommendations to the general assembly for further action, after a public hearing and comment; (ii) ask the United States Department of Agriculture and the United States Department of Health and Human Services to provide a plan of recommended corrections to the state.

(e) This section shall become effective upon passage and expire on July 1, 2015.
Section 17. Unless otherwise indicated in specific sections of this act, the remaining sections of the act become effective on July 1, 2011.

Credits & Resources

Members of the Governing Board of The Generations Project

President: Elmer Blankenship

Vice President: Michelle Niemier

Secretary: Nancy Griffin

Treasurer: Clifford L. Willis

Board Member and Director of the Project: John Cardwell

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The seven hundred citizen participants in the Round Table Education Series from 2007 through 2009 and the representatives of the Indiana Home Care Task force in 2010.

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Other reports from The Generations Project (TGP) and United Senior Action (USA) that were used in the preparation of this report and not featured as exhibits are: Moving Forward, January 2006, TGP; What Citizens Are Saying, March 2007, TGP; The Miracle of CHOICE, April 2007, USA; and Lessons from Home, February 2008, TGP.

How to contact The Generations Project

The Generations Project can be reached on line at www.generationsproject.org.

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There are also links on the web site to the Project's member organizations and other agencies that service HCBS consumers

This report was made possible by the generous support of **The Retirement Research Foundation**, an overall underwriter of The Generations Project; **Eli Lilly and Company**, sponsor of the 2009 Round Table Education Series state conference; **and SEIU Health Care**, an underwriter of the report's production costs.

(L to R) Elmer Blankenship, June Holt, Nancy Griffin and Duane Etienne of The Generations Project, celebrate the success of the 2009 Round Table Education Series state conference that was sponsored by the Retirement Research Foundation, Eli Lilly and Company, and the Service Employees International Union.

The Round Table Education Series on Long Term Care
has been underwritten by:

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Exhibit L
Select Joint Commission
on Medicaid Oversight
August 12, 2010

Moving Forward

Senate Enrolled Act 493
& Long Term Care Rebalancing
In Indiana

January 2005

THE GENERATIONS PROJECT

The Generations Project, Inc. is a non-profit organization established in 2001 to educate citizens and private and public leaders about the opportunities for Hoosiers to implement a balanced and responsible long term care system. It is a collaborative effort of eleven leading civic organizations.

It is our belief, and that of the hundreds of thousands of Hoosiers represented by the member organizations of The Generations Project, that Indiana can and must do better for senior citizens and Hoosiers with disabilities in need of long term care.

It is our hope that this report will assist citizens and policy makers in building a long term care system that reflects the humanity and common sense values for which our great State is known.

www.generationsproject.org

Acknowledgements

Senate Enrolled Act 493 was passed by the Indiana General Assembly and signed into law by Governor Frank O'Bannon in 2003. The Act establishes the broad administrative authority and the programmatic and service foundation needed to re-balance Indiana's long-term care service delivery system.

The purpose of this paper is to provide a comprehensive evaluation of the provisions of Senate Enrolled Act 493 and its implications for Indiana's long-term care programs. It is intended to make several unique contributions to the distinguished assemblage of long-term care initiatives and reports that have come before it: first, it puts into words the intent and purpose of the Act; and second, it provides a specific evaluation of the major provisions of Senate Enrolled Act 493 and describes those provisions in the context of Indiana's current long-term care delivery system. Drafts of the paper were shared with several key state policymakers in order to generate productive discussion and to assure accuracy of program information.

This paper is underwritten by The Generations Project, which was established in 2001 to educate citizens and private and public leaders about the opportunities for Hoosiers to implement a balanced and responsible long-term care system. It is a collaborative effort supported by grant funds made available by the Nina Mason Pulliam Charitable Trust and The Health Foundation of Greater Indianapolis. The Pulliam Trust has underwritten the majority of activities supporting this paper.

Research, development, and writing of this paper was performed by Judith E. Becherer, BS, MPA, at the direction of The Generations Project and with the assistance of a number of other colleagues and stakeholders in the field of long-term care. Ms. Becherer is an independent subcontractor to The Generations Project.

John Cardwell, the founder and director of the Generations Project, conceived the concept and parameters of the paper and has served as its chief editor. Mr. Cardwell, together with the project's Governing Board, Advisory Board, and staff, has seen this paper through to its conclusion.

The Generations Project and this paper have been made possible through the collaborative efforts of the project's member organizations: AARP Indiana, CICOA Aging and In-Home Services, Citizens Action Coalition, Alzheimer's Association, Indiana Association of Area Agencies on Aging, Indiana Alliance for Retired Americans, Indiana Minority Health Coalition, Mental Health Association of Indiana, Council of Volunteer Organizations for Hoosiers with Disabilities, The ARC of Indiana, and United Senior Action of Indiana.

Moving Forward

Senate Enrolled Act 493 & Long Term Care Rebalancing in Indiana

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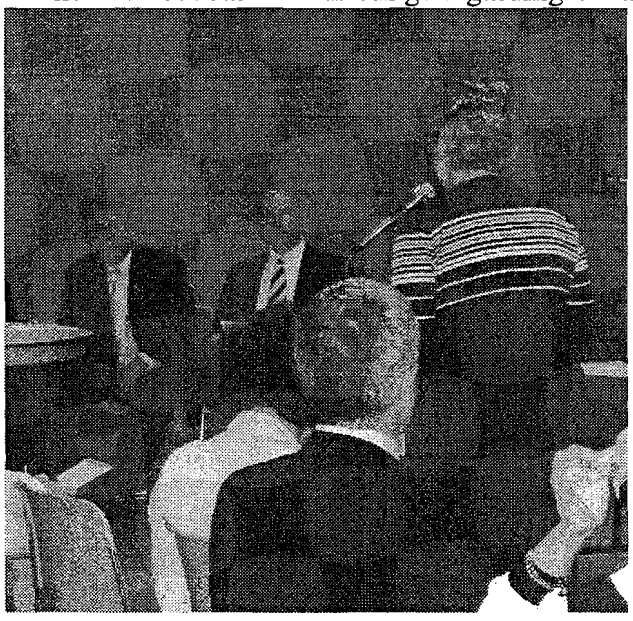
A Citizens' Prologue

In the three year history of The Generations Project, the need for better, more accessible, and affordable home and community based long term care services has been the overwhelming message gleaned from countless interactions with citizens across Indiana. That message was made extremely clear by citizens who attended a series of ten community forums on long term care jointly sponsored by the Indiana Home Care Task Force, local area agencies on aging, and The Generations Project in the fall of 2004. These forums were held in Anderson, Ellettsville, South Bend, Fort Wayne, Lafayette, Indianapolis, Hammond, Seymour, Vincennes, and Terre Haute and attended by more than 700 Hoosiers.

Intended as educational meetings regarding Senate Enrolled Act 493, Indiana's CHOICE home health care program, and related home and community based care issues, the forums became much more than that. At every location, citizens attended these forums as both individuals in need of home and community based services for themselves, friends, or family; and as taxpayers demanding that their tax dollars be invested in a more equitable and effective system of long term care. Significantly, citizens turned out to express that their patience was running thin and that the time for Indiana to implement SEA 493 was now!



A citizen addresses public officials at the Ft. Wayne community forum on long term care. Pictured, Representative Bob Alderman, Ft. Wayne and Senator Dennis Kruse, Auburn.

In Ellettsville, a couple with profound physical disabilities came not to talk about themselves, but about moving Indiana's system forward by implementing SEA 493. In spite of their personal struggles and obstacles to face each day, their message was focused on moving Indiana's long term care system for all Hoosiers.

At Anderson, three home care case managers described case loads of 90, 100, and 110 people. Their message was straight forward – people cannot be adequately served in a system that is so grossly under-resourced. Simply put, the failure to implement SEA 493 is resulting in the denial of needed home and community based services for some and forced placement into nursing homes for others.

The Hammond meeting highlighted a woman from Chesterton with a success story to share. Her mother recently celebrated her 96th birthday at home and had just qualified for

services. She now receives homemaker services, meals on wheels, and had just received a lift chair. She narrowly avoided placement in a nursing home. Due to these services, she is now able to stay in her own home.

State Representative David Crooks addresses citizens at the community forum on long term care in Vincennes, Indiana.

These accounts, and tens of thousands like them, *are* the reasons why Indiana must implement SEA 493.

Following is a report by The Generations Project – *Moving Forward: Senate Enrolled Act 493 and Long Term Care Rebalancing in Indiana.* This report details a system of long term care that is out of balance and presents the solutions - now contained in public law - that can bring sense to the lives of those in need of long term care services and institute a more efficient use of taxpayer dollars.

Located throughout this report are case studies that help paint the human picture of Indiana's system of long term health care. These case studies illuminate stories of both people who have succeeded within this system of care in spite of the odds as well as stories of tragic and senseless loss.

Executive Summary

Indiana's publicly-funded long-term care service delivery system lacks a number of basic program and service features that are essential for providing quality care and supports to Hoosiers who are elderly and disabled. Unlike many other states, scarce taxpayer funds in Indiana continue to be used to pay for care provided in expensive and largely undesirable institutional settings like nursing homes. In contrast, community-based services that can be made available in an individual's private home or other community-based setting and at less cost are rationed. As a result, many of Indiana's most vulnerable citizens are denied the opportunity to remain in their own homes and communities, to independently direct their own care and supports, and to gracefully and with dignity age in place among family and friends.

Senate Enrolled Act 493 (The Act) is a statute (Public Law 274) established by the 2003 Indiana General Assembly that resolves this long-standing inequity by establishing broad administrative authority and creating a number of critical community-based programs and services that have not been available in Indiana. The Act provides the means to rebalance Indiana's long-term care service delivery system so that more Hoosiers can receive needed services in their own homes and at less expense.

The bill was authored by Senator Greg Server, an Evansville Republican, and sponsored in the House by Representative Charlie Brown, a Democrat from Gary. It was based on a systems change model developed by The Generations Project for the Indiana Home Care Task Force and was later modified to incorporate language from legislation that had been authored by Senator Vi Simpson, a Democrat from Bloomington. The bill had unprecedented bipartisan support throughout the legislative process, with no dissenting votes cast against it at any time. The late Governor Frank O'Bannon signed Senate Bill 493 into law on May 8, 2003.

All provisions of The Act are now effective and must be implemented. With consumer input, the State must immediately determine how best to implement all provisions so that they fully complement each other and accomplish the objectives of the Law.

The Act includes a number of long-term care provisions. These are as follows:

- Raises the income eligibility threshold for community-based services to 300% of the federal Supplemental Security Income (SSI) amount, the maximum threshold allowed by federal law. This policy change makes community-based services equally available to low-income individuals for whom nursing home services had previously been the only alternative.
- Formalizes the adoption of spousal impoverishment protections that are already available for institutional eligibility in all of Indiana's Medicaid Home and Community-Based Services Waiver Programs. This ensures that married couples who choose to receive care in their own homes are extended the same financial protections that are available when one of the spouses resides in a nursing home.
- Establishes rule-making authority, assigns specific accounting and reporting responsibilities, and establishes deadlines that are necessary for developing a strong and enduring long-term care infrastructure in Indiana.
- Establishes self-directed care, assisted living, adult foster care, adult day services, respite care, and a caretaker support program within the array of long-term care services. All of these programs and services must be in place in order to expand community care options and reduce reliance on institutional care.

- Requires the coordination of services between the CHOICE and Indiana Medicaid Home and Community-Based Services Waiver Programs while maintaining the integrity of both. This is necessary to ensure that both programs manage scarce taxpayer funds in an optimal manner.
- Provides for training and promotion of best practices to enable Indiana policymakers to draw from and build upon the successes of others.
- Guarantees Medicaid Waiver clients the right to receive care plan development, advocacy, quality monitoring, information and referral services, and skilled nursing assistance, supervision, adaptive medical and non-medical equipment and devices.
- Establishes funding flexibility within existing aggregate long-term care expenditures, adds 20,000 new Medicaid waiver slots, and creates a "money follows the person" funding provision. These provisions put in place the features needed to make care available at less cost in non-institutional settings.
- Provides the authority for the Indiana Health Financing Authority to work with for-profit and non-profit entities to convert nursing homes to other forms of long term care through the issuance, sale, or delivery of a bond
- Requires discussion with the CHOICE Board on the establishment of a system of integrated services that includes transportation, housing, education, and workforce development. This eliminates the disconnect among long-term care services and creates a policymaking environment where integral programs are better coordinated.
- Provides the authority to include the use of volunteers and volunteer groups, including those that are faith-based, within the long-term care delivery system.

Financing for the Act is subject to funding available to the Office of the Secretary of the Family and Social Services Administration for all long-term care services, which in state fiscal year 2004 totaled approximately $1.6 billion.[1]

By 2025, Indiana's 65 and older population is expected to increase to over 1.2 million, making it the second-largest age category in the State.

The State of Indiana has a population of approximately 6 million persons, of whom 13%, or one in every eight Hoosiers, are persons age 65 years and older.[2] By 2025, Indiana's 65 and older population is expected to increase to over 1.2 million, making it the second-largest age category in the State. Within this population group, it is estimated that at least 60% of people 75 and older will require some form of long-term care during the remainder of their life.[3]

Senate Enrolled Act 493 broadly addresses long-term care services for Hoosiers, but focuses primarily on the Medicaid, Medicaid Waiver, and state-funded CHOICE programs since all three provide the bulk of public funding for Indiana's long-term care service delivery system.

Improvements and expansions to the Indiana Medicaid Waiver Programs are made regularly, but have focused in recent years primarily on the developmentally disabled population and not on Indiana's Aged and Physically Disabled population. In any event, there are still far too many people in all population groups in Indiana who are failing to receive critically needed home and community based services.

By the late 1990's, a number of states had already made significant investments in their Medicaid Home and Community-Based Services Waiver Programs due in large part to consumer demand for non-institutional service alternatives and the positive fiscal consequences of providing long-term care in home and community-residential settings. Indiana was not one of those states.

In Federal Fiscal Year 2001, Indiana ranked 47th among all states in the share of Medicaid long-term care expenditures provided in institutional versus community-based settings.[4]

By 2002, 70% of national Medicaid spending for long-term care services went to institutional care, and 30% went to community care.[5] For the same period, 84% of Indiana's Medicaid Program was spent on institutional care, and 16% went to community-based care.[6] This makes Indiana far below the national average for Medicaid spending on community-based care. Moreover in a recent spending analysis prepared by the Kaiser Commission on Medicaid and the Uninsured, Indiana ranked 48th among states[7] in the percentage of long-term care dollars spent in Federal fiscal year 2002 on Medicaid-funded community-based care for the aged and physically disabled.

Indiana State Medicaid projections[8] for state fiscal year 2005 continue to reveal a disproportionately high reliance on nursing home care, the institutional service alternative for Indiana's aged and physically disabled – almost $819 million of the $1.73 billion attributed to Medicaid-funded long-term care services. Another $338 million is budgeted for intermediate care facilities for persons with developmental disabilities, the institutional service alternative for that population.

Senate Enrolled Act 493 resolves this disparity. The Act not only captures the objectives of all of Indiana's previous long-term care initiatives, but also consolidates them into a cohesive and comprehensive framework upon which policymakers and stakeholders can effectuate the basic system changes needed to accomplish and sustain long-term care rebalancing in Indiana. Moreover, the Act complements legal requirements that have already been established by the U.S. Supreme Court in its *Olmstead v. L.C.* decision (1998). In this case, the Court ruled, among other things, that confinement in an institution severely diminishes the everyday life activities of individuals – including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.

Senate Enrolled Act 493 melds all of these goals into one public law that now governs Indiana's long-term care public assistance programs. But while the law has been effective since 2003, there continue to remain *a number of The Act's primary provisions that have not yet been implemented.* These include provisions for assisted living, adult foster, self-directed care, funding mechanisms, and the 300 percent Supplement Security Income eligibility standard, all of which are integral to successfully rebalance services within Indiana's long-term care service delivery system.

Indiana's long-term care service delivery system continues to lack a number of important policy features, administrative resources, and service programs that are essential for rebalancing services for Indiana's aged and disabled persons; nursing home care continues to be the primary service option available to meet the needs of low-income Hoosiers. Indiana has *not* kept pace with states such as Washington, Oregon, Maine, New Hampshire, Illinois, and Vermont, which have seized upon the opportunities presented by the federal Olmstead decision and the President's New Freedom Initiative. These states are simultaneously managing their budget deficits and responding to consumer interests by redesigning existing long-term care programs and shifting available resources away from nursing homes and other forms of institutional care to less costly, more efficient, and more desirable community-based services and programs.

Senate Enrolled Act 493 is expressly intended to put Indiana in the category of states that employ innovation to solve fiscal problems while better meeting the public need and demand for home and community-based long-term care services. By establishing funding flexibility within Indiana's long-term care budget, Senate Enrolled Act 493 defines available long-term care

spending and authorizes policymakers to shift funding among long-term care services as needed to respond to the growing demand for less-expensive, non-institutional care services. When implemented prudently, Senate Enrolled Act 493 will provoke positive and significant change in Indiana's approach and delivery of long-term care services. By reducing reliance on institutional forms of care for persons who can successfully have their care needs met in non-institutional settings, Indiana will be better positioned to serve more people in their own homes and other community-based settings, and at less expense.

Senate Enrolled Act 493 is expressly intended to put Indiana in the category of states that employ innovation to solve fiscal problems while better meeting the public need and demand for home and community-based long-term care services.

The funding provisions within Senate Enrolled Act 493 are intended to provide administrative control and to address most or all of the financing concerns that normally impede long-term care rebalancing. By balancing the start-up expenses that may be required to further develop essential long-term care services, such as assisted living and adult foster care, with savings that will be created in the simultaneous reduction of institutional services, The Act provides policymakers with a number of financing protections that allow for the controlled shifting of resources away from expensive institutional services. The Act further specifies that rebalancing can occur within the existing long-term care funding appropriation.

The Act builds upon the administrative structure of the CHOICE Program and the Medicaid Home and Community-Based Services Waiver Programs, the latter of which is specifically designed to provide states with great latitude and control in managing community-based services and in targeting the population of consumers who should receive those services. All Medicaid Waiver Programs include federal cost-effectiveness requirements and provide broad state administrative authority to manage spending. Program expansions and reductions are controlled by the states and are readily modified to correspond with changing funding dynamics.

The CHOICE Program appropriation for state fiscal year 2005 totals $48.67 million. CHOICE is paid with 100% state funds and contributes part of its funds (about 11%) to support related programs such as the Medicaid Aged and Disabled Waiver.

In SFY 2004, the CHOICE Program served approximately 10,420 persons at an average cost of $3,312 per year.[9] This relatively small per person financial investment is focused on providing the community-based support that is needed to keep elderly and disabled consumers independent and in their own homes for as long as possible. It should be noted that CHOICE funds support clients at much less cost than the Medicaid Aged and Disabled Waiver (which is also very cost-effective), and CHOICE clients do not utilize Medicaid State Plan services or depend on any other state funds.

Senate Enrolled Act 493 includes a provision commonly referred to as "Money Follows the Person", which refers to a system rebalancing policy like that already employed in CHOICE, where Medicaid funding is assigned to an individual, regardless of the setting in which long-term care services are delivered.

Unlike Indiana, a number of states do not limit their Medicaid Waiver Program services and therefore do not utilize waiting lists. States such as Oregon and Colorado operate an "open waiver" and provide community-based services to all who qualify. This approach has contributed to great success in rebalancing their long-term care programs (with over 50% of their long-term care expenditures and over 75% of their clients in community-based care) and has been endorsed in Indiana by a wide array of consumer advocacy organizations.

While Medicaid Waiver Program flexibility allows states to adjust long-term care service priorities and eligibility criteria according to changes in available funding, Oregon made a threshold adjustment only once in 20 years and Colorado only twice in 20 years.[10] Additionally, other states have also had open waivers without moving their thresholds. Having ready access to waiver slots for individuals to avoid nursing home placement at all times has led to positive rebalancing outcomes in those states.

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Today there is widespread agreement that shifting funds and services to support consumers in their own homes and other community settings can and does achieve per person program savings and makes imminent economic sense. Per person savings are fairly simple to calculate and generally involve comparison between the actual costs of daily or monthly institutional services and the actual costs of community-based services.

Historically, states that lead the country in long-term care rebalancing have accomplished their system reforms during times of economic strain and because of broad-scale commitment to the intrinsic and immeasurable value of the quality of life improvements that come with community-based care and in spite of their potential short-term cost.

There are some provisions of The Act (300% Supplemental Security Income, adult foster care, assisted living, and caretaker support) that may require additional resources. And while Senate Enrolled Act 493 presupposes that these program changes will be designed so that they can be simultaneously implemented with complementary modifications that will realign and redesign other aspects of the long-term care service delivery system, it may be necessary to make available some level of new funding that can provide the initial momentum needed to provoke other changes and outcomes to follow. Available research and the experience of other states indicates that with proper management and administrative focus, overall program savings can be achieved over time, or overall expenditures can be held to current levels while serving more people at lower average costs.

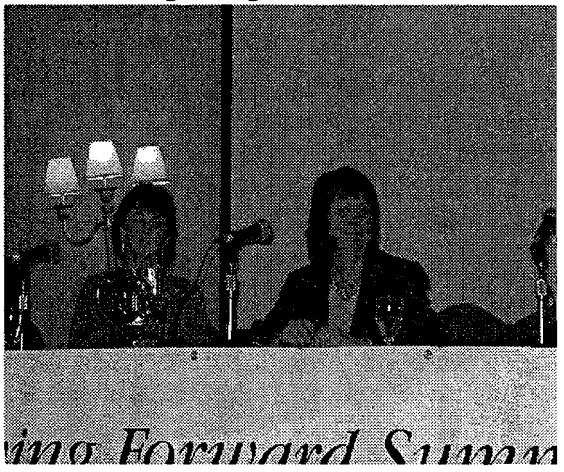
As long ago as 1996, community-based care in Oregon was reported to be 1/3 of that of nursing home care, only 17 percent in Washington, and only 14 percent in Colorado. Today, the Indiana Medicaid Aged and Disabled Waiver Program appears to have total costs that are 1/3 of nursing home costs, while costs for the CHOICE program appear to be far lower than that.

Compliance with Senate Enrolled Act 493 requires the State to significantly expand and expedite its efforts to transition more nursing home residents back into the community, as well as divert more persons away from initial nursing home admission or extended stays. The State is currently in the process of requesting an extension of the Nursing Home Transition Grant through September 30, 2005.[11] If extended, the grant will be used to continue the partnership with the Independent Living Center of Eastern Indiana, which is working with a coalition of stakeholders in the eastern, mostly rural part of the State to transition and divert additional individuals from nursing home care and to educate them about their right to community-based services. But while the Grant is a good start, it does not create the broad-scale process changes that are needed to achieve the consumer outcomes required by The Act and to create the level of savings needed to offset other implementation costs. The State must therefore significantly and immediately expand its efforts in this area. If it fails to do so, Indiana will be unable to afford long-term care services for the aging Baby Boomers.

The framers of Senate Enrolled Act 493 expect that long-term care rebalancing in Indiana will occur with a solid quality management structure already in place, and that all new initiatives and program expansions will include necessary quality features.

The quality management infrastructure must be flexible enough to adapt to the shift in service delivery from institutional to community-based settings. Consumer rights and protections that are already in place for institutional services may need to be redefined, expanded, or otherwise modified to better accommodate the needs and preferences of a growing number of consumers in their own home settings. The long-term care quality management structure must be responsive to consumers in all long-term care settings.

The Act was written from a consumer perspective and presumes their full involvement throughout the planning process and implementation and post-implementation phases of development. The Act provides the direction needed to make lasting change in Indiana, but bestows upon state policymakers the authority, flexibility, and responsibility for administration and oversight.



Penny Black (left) Director of Home & Community Based Programs for the State of Washington discusses at the November 2004 Moving Forward Summit how a rebalanced spending formula for long term care in Washington State led to an overall decrease in total expenditures. Dr. Susan Reinhard, Director for The Center for State Health Care Policy, Rutgers University is also pictured.

State policymakers must redefine relationships with stakeholders and commit to working closely with consumers, legislators, and providers of long-term care services in Indiana. This is essential for ensuring that the State fully meets both the legal requirements of The Law and the needs of consumers and providers who rely on Indiana's long-term care service delivery system. Representatives of all stakeholder groups should be included throughout the discussion, planning, design, implementation and post-implementation phases. This may be best accomplished through the establishment of a technical planning and implementation team composed of state agency staff, all major consumer representatives, and representative providers.

Senate Enrolled Act 493 provides all the service and program features, timelines, and policymaking authority needed to rebalance Indiana's long-term care service delivery system, but it does not (and should not), prescribe how rebalancing should be accomplished – exactly how it should be designed, implemented, and later evaluated. This is best left to a core team of technical and implementation specialists made up of state policymakers and advisory consumer and provider representatives. These stakeholders should collaborate on an approach that optimizes available resources and selects best methods for implementing permanent and lasting change, while taking fully into consideration Indiana's existing systems and structures and drawing upon the best practices of other states.

Senate Enrolled Act 493 not only provides state agencies with the authority needed to make critical changes to Indiana's long-term care service delivery system, but it also introduces a number of new opportunities for program and service collaboration, consideration of best practice models, and innovative funding and service delivery approaches. In so doing, the Act provides

the framework for helping the State of Indiana meet its federal Olmstead decision requirements, respond to the recommendations of the late Governor O'Bannon's Commission on Home and Community Based Services (2002 - 2003), and meet the goals established by the Indiana Family and Social Services Administration in its Comprehensive Plan for Community Integration and Support of Persons with Disabilities (June 1, 2001).

Senate Enrolled Act 493 embodies the goals and objectives of legislators, state policymakers, consumers, community-based providers, and all Hoosiers; namely, to provide quality health care and supports to its most vulnerable, low-income elderly and disabled populations in the least restrictive and most desirable settings, while optimizing consumer dignity, independence and choice in the most efficient, safe, and cost-effective manner possible

Background

What Is Senate Enrolled Act 493/Public Law 274?
Challenges & Opportunities within Indiana's system of long term care.

Indiana's publicly-funded long-term care service delivery system lacks a number of basic program and service features that are essential for providing quality care and supports to Hoosiers who are elderly and disabled. Unlike many other states, scarce taxpayer funds in Indiana continue to be used to pay for care provided in expensive and largely undesirable institutional settings like nursing homes. In contrast, community-based services that can be provided in an individual's private home or other community-based setting and at less cost are rationed. As a result, many of Indiana's most vulnerable citizens are denied the opportunity to remain in their own homes and communities, to independently direct their own care and supports, and to gracefully and with dignity age in place among family and friends.

Senate Enrolled Act 493 (The Act) is a public law (Public Law 274) established by the 2003 Indiana General Assembly that will resolve this long-standing service delivery inequity. By establishing the broad administrative authority and the programmatic and service foundation needed to *rebalance* Indiana's long-term care service delivery system. All provisions of The Act are now effective and must be implemented. With consumer input, the State must now determine how best to implement all provisions so that they fully complement each other and accomplish the full objectives of the Law.

Long-term care refers to healthcare and service supports that are provided in a private home, community residential, or institutional setting to persons who are unable to manage common activities of daily living because of disability, frailty, chronic illness, or mental incapacity. Services may include home health care, nursing, respite, homemaker, attendant care, home modifications, and other supports.

The Act includes a number of long-term care provisions. These are as follows:

- Raises the income eligibility threshold for community-based services to 300% of the federal Supplemental Security Income (SSI) amount, the maximum threshold allowed by federal law
- Formalizes the adoption of spousal impoverishment protections that are already available for institutional eligibility in all of Indiana's Medicaid Home and Community-Based Services Waiver Programs.
- Establishes rule-making authority, assigns specific accounting and reporting responsibilities, and establishes deadlines
- Establishes self-directed care, assisted living, adult foster care, adult day services, respite care, and a caretaker support program within the array of long-term care services
- Requires the coordination of services between the CHOICE and Indiana Medicaid Home and Community-Based Services Waiver Programs
- Provides for training and promotion of best practices
- Guarantees Medicaid Waiver clients the right to receive care plan development, advocacy, quality monitoring, information and referral services, and skilled nursing assistance, supervision, adaptive medical and non-medical equipment and devices
- Establishes funding flexibility within existing aggregate long-term care expenditures, adds 20,000 new Medicaid waiver slots, and creates a "money follows the person" funding provision

- Provides the authority for the Indiana Health Financing Authority to work with for-profit and non-profit entities to convert health facility beds through the issuance, sale, or delivery of a bond
- Requires discussion with the CHOICE Board on the establishment of a system of integrated services that includes transportation, housing, education, and workforce development
- Provides the authority to include the use of volunteers and volunteer groups, including those that are faith-based, within the long-term care delivery system.

Financing for the Act is subject to funding available to the Office of the Secretary of the Family and Social Services Administration for all long-term care services. In state fiscal year 2004, that would have totaled approximately $1.6 billion.[12]

By the year 2025, it is estimated that at least 60% of Indiana's 75 and older population will require some sort of long term care during the remainder of their life.

The bill was authored by Senator Greg Server, an Evansville Republican, and sponsored in the House by Representative Charlie Brown, a Democrat from Gary. It was based on a systems change model developed by The Generations Project for the Indiana Home Care Task Force and was later modified to incorporate language from legislation that had been authored by Senator Vi Simpson, a Democrat from Bloomington. The bill had unprecedented bipartisan support throughout the legislative process, with no dissenting votes cast against it at any time. The late Governor Frank O'Bannon signed Senate Bill 493 into law on May 8, 2003.

Indiana's Aged and Disabled

The State of Indiana has a population of approximately 6 million persons, of whom 13%, or one in every eight Hoosiers, are persons age 65 years and older.[13] By 2025, Indiana's 65 and older population is expected to increase to over 1.2 million, making it the second-largest age category in the State. Within this population group, it is estimated that at least 60% of people 75 and older will require some form of long-term care during the remainder of their life.[14]

When comparing Indiana's distribution of population by age with the rest of the country, Indiana is in line with that of the United States in the year 2000 but pulls considerably ahead by the year 2020.[15] See Figure 1 for the population projections for the year 2020.

In order to better understand the implications of long-term care services with respect to Indiana's elderly (65 + years) and disabled population, a brief snapshot of relevant statistics is presented as follows:

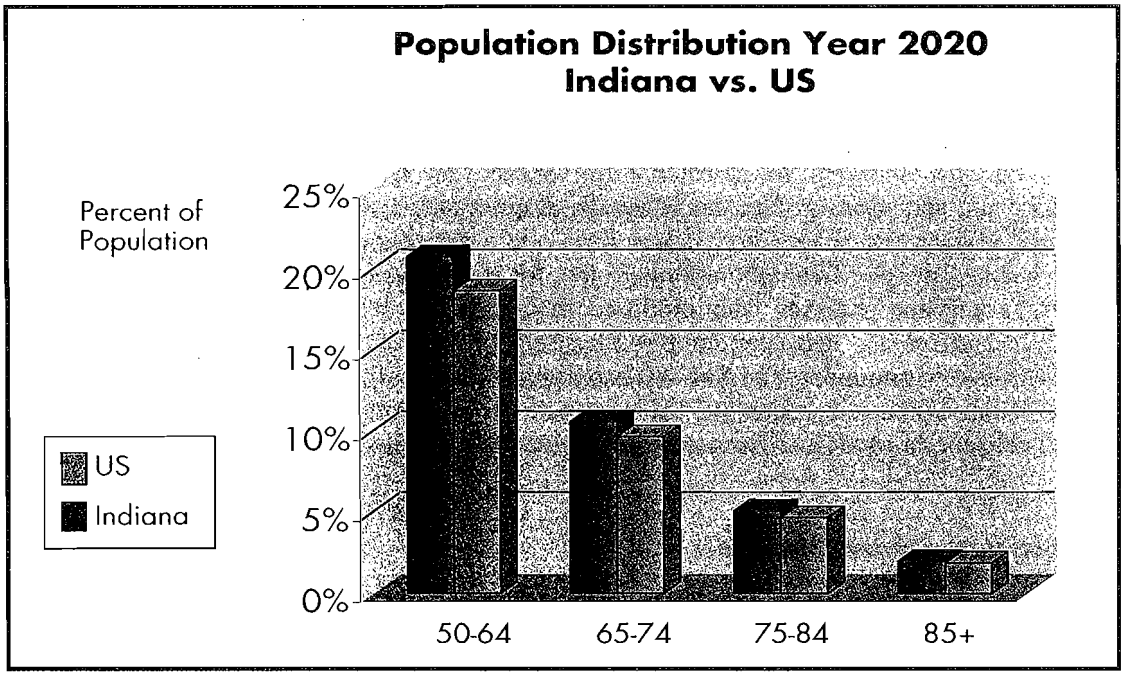
- In 2002, national spending on long-term care totaled $180 billion, or about 12 percent of total health care expenditures. Nearly two-thirds of long-term care expenditures are for institutional care.[16]

- In 2002, Medicaid accounted for 47 percent of national long-term care spending and 48 percent of national spending for institutional care.[17]

- In 2002, the national average annual cost of nursing home care was $52,000 for a semi-private room and $61,000 for a private room.[18]

- For the same year, nearly 8% of Indiana seniors aged 65 and older fell below the Federal Poverty Level, compared to the national average of 9.9%. Approximately 70,000 Hoosier seniors had monthly incomes less than $738 and annual incomes less then $8,860.[19] Additionally, 6,596 aged residents received Supplemental Security Income.[20]

Figure 1



- 104,528, or 65% of Indiana's 160,636 Aged and Disabled Medicaid enrollees, are dual-eligibles (Medicare and Medicaid).[21 22]

- Nationally, more than 11 million Americans (5.4%) report limitations in activities of daily living and/or instrumental activities of daily living. Of those, 1.87 million are at or below the Federal Poverty Level.[23] Another 2.3 million are between 100% and 200% of the Federal Poverty Level.

- According to U.S. Census Bureau, Census 2000 PHC-T-32, 643,470 Indiana residents aged 16 and older have a sensory, physical and/or mental disability. Of these, 378,865 (almost 59%) are non-elderly.

Indiana's Publicly-Funded Long-Term Care Delivery System

In Indiana, low-income persons in need of long-term care depend upon services provided through a number of federal and state programs, including Medicare and Medicaid, CHOICE, Title III of the Older Americans Act, the Social Services Block Grant, the Older Hoosiers Account, and the U.S. Department of Agriculture Meals Program. While Senate Enrolled Act 493 broadly addresses long-term care services for Hoosiers, the law focuses primarily on the services provided

through the Indiana Medicaid and CHOICE Programs. As a result, that will also be the main focus of this report.

Medicare. Medicare is a social health insurance program that is financed largely through payroll taxes. It provides basic non-long-term care coverage to most persons aged 65 and older and to persons under 65 who receive Social Security cash payments due to a disability. It was established in 1965 and now covers more than 35 million seniors and 6 million non-elderly persons with disabilities[24]. Medicare consists of four parts: Part A is the Hospital Insurance program that provides coverage for inpatient hospital, short-term skilled nursing facility services, hospice, and home health care; Part B is the voluntary Supplemental Medical Insurance program that provides coverage for physician and outpatient hospital care, laboratory tests, medical supplies, and home health; Part C or Medicare Advantage is the managed care program that provides Part A and Part B benefits to enrollees; and Part D is the new Prescription Drug Program that becomes effective on January 1, 2006. The Medicare Program is administered by the Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services. In 2002, 865,366 or 14% of Indiana residents were Medicare beneficiaries. Of those, 85% were 65 years or older and 15% were non-elderly disabled. Medicare spending for these residents totaled approximately $5 billion.[25]

Medicaid. The Medicaid Program was created in 1965 and is a jointly-funded federal and state program that provides health insurance coverage primarily to low-income elderly and disabled adults, pregnant women, and children who meet strict categorical and financial eligibility requirements. Medicaid operates within broad federal guidelines but extends considerable authority to the states in determining what populations are eligible for services, service scope, coverage and payment rates, and administrative structure. It is administered at the federal level by the Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services, and at the state level by the Indiana Family and Social Services Administration. In Indiana, the Medicaid Program serves over 800,000 Hoosiers, at a combined state and federal cost of around $4.5 billion annually.[26]

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The Medicare and Medicaid Programs combine to provide services to the low-income elderly and non-elderly disabled populations, who are often referred to as the dual-eligibles. For the dual-eligibles, Medicare serves as the primary payer and covers hospital, home health, physician, skilled nursing home care, and other services, while Medicaid covers prescription drugs and long-term care. There are approximately 6-7 million dual-eligibles nationwide. In Indiana, there are approximately 125,000 Medicare/Medicaid dual eligibles.[27]

Institutional long-term care in Medicaid consists of the services provided in a nursing home and in intermediate care facilities for the mentally retarded/developmentally disabled. Institutional long-term care spending in Indiana is expected to be almost $1.8 billion in state fiscal year 2005.[28]

Home and community-based services provided through the Medicaid Program consist of home health services, personal care, and Medicaid Home and Community-Based Services Waivers. Home health services are a mandatory Medicaid benefit that must be provided to persons who are entitled to nursing home services. Personal care (services) is an optional benefit that is typically used to assist persons with disabilities and chronic conditions with activities of daily living. In 1999, twenty-six states offered the personal care benefit[29]; Indiana was not one of them.

Medicaid Home and Community-Based Services Waivers are described in greater detail in the following subsection.

Medicaid Home and Community-Based Services Waiver Program. When the Medicaid Program was first created, it was intended to cover only primary and acute care services for low-income and medically needy populations. The only mandatory long-term care service that states had to cover was nursing home care for people age 21 and older. In response to the high costs of nursing facility care, combined with criticism of Medicaid's bias toward funding institutional care ("institutional bias"), states and the Federal government began to look for ways to provide long-term care services in less restrictive ways.[30] Thus began myriad changes in the Medicaid program that eventually led to the establishment of Section 1915(c) of the Social Security Act in 1981, which created Medicaid home and community-based services waivers.

The term Medicaid Waiver refers to federal authorization for states to "waive" certain basic Medicaid program requirements to allow persons who are eligible for nursing home and other forms of institutional care to receive traditional and non-traditional long-term care services in their own home or other non-institutional community setting, providing they do so cost-effectively. There are three Medicaid Program standards that may be "waived": statewideness, which requires services to be made available throughout the state; comparability, which requires that all services be made available to all eligible individuals; and income and resource rules, which, with the exception of institutional care, require states to use a single income and resource standard for determining eligibility.

A major distinction between institutional and non-institutional services provided through Medicaid Home and Community-Based Services Waiver Programs is that aged and disabled persons who meet the financial, categorical, and program criteria for Medicaid are "entitled" to receive nursing home care, which is a mandatory state-provided Medicaid service. In contrast, services provided in Medicaid Waiver Programs are not mandatory and may be limited by state law and policy. This too is a functional of the long-standing "institutional bias" within federal Medicaid law.

The Office of Medicaid Policy and Planning and the Bureau of Aging and In-Home Services within the Indiana Family and Social Services Administration jointly administer the Indiana Medicaid Waiver Programs, which currently include eight (8) separate Medicaid home and community-based services waivers. These are: Aged and Disabled Waiver; Assisted Living Waiver; Traumatic Brain Injury Waiver; Medically Fragile Children's Waiver; Developmental Disabilities Waiver; Autism Waiver; Support Services Waiver; and SED (Serious Emotionally Disturbed Children) Waiver. As required by federal law, all eight waivers are targeted to provide services to individuals who meet eligibility requirements for institutional care, but who choose to, be served in their own home or other residential setting at an aggregate expense that is no more than that of institutional care. The Medicaid Waiver Programs that serve Indiana's Aged and Disabled Medicaid population are managed locally through Indiana's sixteen area agencies on aging, which provide a single point of entry for consumers to receive information on long-term care programs and services in Indiana and to facilitate enrollment in programs for which consumers qualify.

Improvements and expansions to the Indiana Medicaid Waiver Programs are made regularly, but have focused in recent years primarily on the mentally retarded/developmentally disabled population. Community-based services that are targeted to Indiana's Aged and Physically Disabled population, in contrast, have not been similarly expanded, and have therefore not significantly reduced reliance on institutional services. Senate Enrolled Act 493 includes a

number of critical policy and administrative features that are specifically targeted to the Medicaid Waiver Programs but that have not been implemented.

CHOICE Program. Indiana's CHOICE Program (Community and Home Options to Institutional Care for the Elderly and Disabled) was established in 1987 and began as a pilot program in Knox, Daviess, and Tippecanoe counties in 1988. The program went through several expansions until it became available statewide in 1992. It is a 100% state-funded program specifically intended to keep individuals out of nursing homes, to keep individuals from being forced into poverty by long-term care costs, and to maintain dignity, independence and choice with consumer-driven services. CHOICE provides services to Indiana residents who are age 60 and older, and to persons with disabilities of any age who are unable to perform two or more activities of daily living. CHOICE pays for a range of community-based services, including home health, attendant and personal care, chore services, transportation, adult day care, respite care, and more. CHOICE funds are available on a sliding scale according to income. The CHOICE Program has been so successful in meeting its objectives that it has been heralded throughout the country for its remarkable versatility and flexibility in the cost-effective delivery of long-term care services to consumers in their own home settings. Additionally, Indiana's continuing success in recent years of holding down nursing home growth despite changing demographics has been attributed in large part to the availability of CHOICE.

CHOICE and most of the other community-based programs for the aged and disabled are administered by the Bureau of Aging and In-Home Services within the Indiana Family and Social Services Administration, and is managed locally through Indiana's sixteen area agencies on aging. CHOICE services are assigned on a first-come, first-served basis through a waiting list process. Historically, the waiting list has always been longer than the level of available funding can accommodate.

Indiana's Long-Term Care Rebalancing Efforts

Indiana, like many states, has a long history of long-term care initiatives, all intended to improve the lives of Indiana's low-income elderly and disabled persons who depend upon public assistance for their healthcare and other support needs. The breadth of these initiatives range from development of specific programs – like CHOICE, Medicaid Home and Community-Based Services Waivers, Medicaid for Employees with Disabilities (M.E.D. Works), and Indiana's Long Term Care Insurance Partnership – to closure of state-operated facilities and deinstitutionalization of persons with mental illness and developmental disabilities.

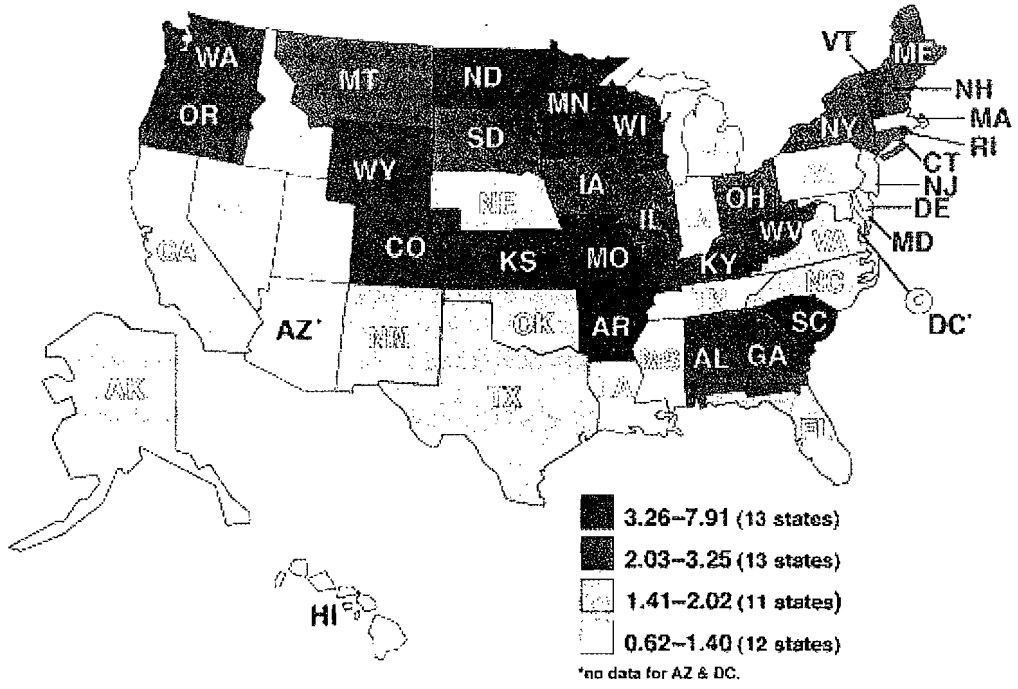
The origin of these initiatives can be traced back to many sources, including grassroots efforts by consumer groups, state-sponsored initiatives, and assembly of numerous task forces, workgroups, and commissions for the purpose of study or to provide expert advice and guidance. These initiatives have been supported through legislative review and directives, executive order, litigation, and administrative action.

Regardless of their historical background, however, all were intended to respond to a pressing need for information or action, or to specifically resolve some problem facing Indiana's most vulnerable citizens. Their success has nevertheless been limited, in large part due to Indiana's historic reliance on institutional care, and many consumer-oriented system changes have been slow to evolve.

By the late 1990's, a number of states had already made significant investments in their Medicaid Home and Community-Based Services Waiver Programs. Indiana was not, however, one of them. Figure 2 on the following page shows where Indiana and the rest of the states rank in terms of the number of Medicaid waiver participants per 1000 population in 1997. For the entire United States, there were 2.10 Medicaid waiver participants per 1000 population (not shown). Figure 2 illustrates the large amount of variation between states in the number of waiver participants (ranging from .62 to 7.91 per 1,000).[31]

Figure 2

1915(c) HCBS Medicaid Waiver Program
Participants Per 1,000 Population Across the States, 1997



Source:
Harrington, D., Carrillo, Hl, and Wellin, V. (1999b). 1915(c) Medicaid Program Data (Form 372). San Francisco, Calif.: University of California, San Francisco.

Indiana's investment in Medicaid Waiver Programs has improved significantly since 1997 with respect to services provided to persons with mental retardation/developmental disabilities, but not so with respect to Hoosiers who are aged and physically or cognitively disabled. Table 1 on the following page was prepared by the Henry J. Kaiser Family Foundation as part of its "State Health Facts Online" series of reports and statistics; it provides a more recent comparison (federal fiscal year 2002) between Indiana and nationally for spending for long-term care services. As the table shows, Indiana spending for home and community-based services for persons who are aged and disabled is only 17% compared to 32% spent on average nationally.

Table 1.

Indiana: Distribution of Medicaid Spending (Federal and State) on Long Term Care, FFY2002

	IN $	IN %	US $	US %
ICF-MR	371,750,882	22	11,320,883,557	12
Mental Health Facilities	192,954,537	11	4,079,418,190	4
Nursing Facilities	871,617,100	50	47,954,904,018	51
Home Health & Personal Care	292,352,690	17	29,863,902,243	32
Total	1,728,675,209	100	93,219,108,009	100

Notes: Figures may not sum to totals due to rounding.
Definitions: ICF-MR stands for intermediate care facility for the mentally retarded. Mental Health Facilities include inpatient psychiatric services for individuals age 21 and under, and other mental health facilities for people age 65 and older. Home Health and Personal Care includes standard home health services, personal care, targeted case management, hospice, home and community-based care for the functionally disabled elderly, and services provided under home and community-based services waivers.
Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Centers for Medicare and Medicaid Services-64 reports, 2004.

Senate Enrolled Act 493 resolves this disparity. The Act not only captures the objectives of all of Indiana's previous long-term care initiatives, but also consolidates them into a cohesive and comprehensive framework upon which policymakers and stakeholders can effectuate the basic system changes needed to accomplish and sustain long-term care rebalancing in Indiana. Moreover, the Act complements legal requirements that have already been established by the U.S. Supreme Court in its *Olmstead v. L.C.* decision (1998). In this case, the Court ruled that institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. Further, the Court noted that confinement in an institution severely diminishes the everyday life activities of individuals – including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. The Court also noted, however, that nothing in the Americans with Disabilities Act (ADA) condones termination of institutional settings for persons unable to handle or benefit from community settings, and that a state's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited.

Senate Enrolled Act 493 also specifically complements the policy objectives and program goals established and presented by the Indiana Family and Social Services Administration in its June 1, 2001 report entitled "Indiana's Comprehensive Plan for Community Integration and Support of Persons with Disabilities". In addition, most of the provisions of SEA 493 were independently researched and evaluated by the late Governor Frank O'Bannon's Commission on Home and Community Based Services (2002 through 2003), and were presented in the form of specific recommendations and action items in both the Commission's December 24, 2002 Interim Report and its June 30 Report 2003, respectively.

Pervading all of Indiana's historic initiatives are the same overarching goals. Namely, to develop a long-term care service delivery system that provides quality care and support services to more persons in need, in safe and affordable settings within the community, at minimal cost to the taxpayer, and in ways that will incorporate basic quality of life elements, such as personal independence, dignity, and choice.

Senate Enrolled Act 493 melds all of these goals into one public law that now governs Indiana's long-term care public assistance programs. But while the law has been effective since 2003, there continue to remain a number of The Act's primary provisions that have not yet been implemented, all of which are integral to successfully rebalance services within Indiana's long-term care service delivery system.

"The President's New Freedom Initiative was announced by President Bush on February 1, 2001 and followed up by Executive Order 13217 on June 18, 2001. The initiative is a nationwide effort to remove barriers to community living for people of all ages with disabilities and long term illness. It represents an important step in working to ensure that all Americans have the opportunity to learn and develop skills, engage in productive work, choose where to live, and participate in community life. "
Source: Centers for Medicare and Medicaid Services

Opportunities for Resolving Long-Standing Administrative Challenges

There should be neither doubt nor disagreement that most of the efforts mounted over the years have been commendable and have helped to move Indiana's long-term care service delivery system forward. CHOICE Program funding has been increased, Medicaid Waiver Programs expanded, additional services made available, and more people served in community settings. Despite this progress, however, Indiana's long-term care service delivery system continues to lack a number of important policy features, administrative resources, and service programs are essential for rebalancing. Senate Enrolled Act 493 not only fills most of these "voids", but also presents unlimited opportunities for resolving most of the long-standing administrative challenges that have historically inhibited Indiana's progress in improving and expanding long-term care service delivery.

Budgetary pressures in Indiana and most other states have driven public policy-making in recent years, particularly with respect to the Medicaid Program and long-term care service delivery. This economic climate, combined with increasing consumer pressure to expand and improve long-term care services, has provoked many states to pursue program innovation and system redesign that are specifically targeted to redirect scarce taxpayer funds. States such as Washington, Oregon, Maine, New Hampshire, Illinois, and Vermont have seized upon the opportunities presented by the federal Olmstead decision and the President's New Freedom Initiative and are simultaneously managing their budget deficits and responding to consumer interests by redesigning existing long-term care programs and shifting available resources away from nursing homes and other forms of

institutional care to less costly, more efficient, and more desirable community-based services and programs.

This same degree of progress has not occurred in Indiana, particularly with the aged and physically disabled population, where development of community-based services and policy features have been modest, and nursing home care continues to the primary service option available to meet the needs of low-income Hoosiers.

Senate Enrolled Act 493/Public Law 274-2003 is expressly intended to put Indiana in the category of states that employ innovation to solve fiscal problems while better meeting the public need and demand for long-term care services. By establishing funding flexibility within Indiana's long-term care budget, Senate Enrolled Act 493 defines available long-term care spending and authorizes policymakers to shift funding among long-term care services as needed to respond to the growing demand for less-expensive, non-institutional care services. When implemented prudently, Senate Enrolled Act 493 will provoke positive and significant change in Indiana's approach and delivery of long-term care services. By reducing reliance on institutional forms of care for persons who could successfully have their care needs met in non-institutional settings, Indiana will be better positioned to serve more people in more efficient and effective community-based settings, and at less expense.

Every state that has successfully implemented a rebalancing of its long-term care system has had to overcome various forms of inertia. Indiana is no exception to that rule. What follows are several examples of the historic policy and administrative challenges that implementation of Senate Enrolled Act 493 will overcome.

Competing Political Forces. As in other states, the nursing home industry in Indiana remains quite strong and well funded, and continues to garner significant legislative support. A recent example is the enactment in 2004 of a nursing facility provider tax, or quality assessment fee, which, if approved by the Centers for Medicare and Medicaid Services, will augment Indiana nursing home expenditures by $150 million. Although this infiltration of new money will restore substantial nursing home rate reductions that have been made in recent years, conversely, it contradicts the State's overall long-term care objectives and directs significantly more resources back into institutional services. In so doing, a nursing facility bed tax undermines the progress made thus far by the State in shifting the long-term care service focus away from traditional forms of institutional care, and it perpetuates the nursing home industry's historic dominance in long-term care service delivery. In addition, it can be expected to tie-up financial and human resources that are needed to meet established community-based care service delivery objectives. It is for these and other reasons, that the State Administration opposed a provider tax in 2001.

In Indiana, a nursing facility provider tax or quality assessment fee was enacted in 2004, which, if approved by the Centers for Medicare and Medicaid, will use state and federal Medicaid funds to increase Indiana nursing home expenditures by $150 million annually.

And while anachronistic initiatives such as Indiana's nursing home bed tax will continue to hinder overall progress in achieving long-term care rebalancing, Senate Enrolled Act 493, nevertheless, establishes a long-term care service delivery infrastructure that is flexible and responsive to consumer choice and preference in how, where and by whom long-term care services are delivered. Once The Act is fully implemented, limited taxpayer funds will be allowed to fund Indiana's low-income elderly and disabled citizens in more desirable, less-

expensive community-based service alternatives, rather than be channeled only to institutional care.

Disconnect Among and Between Stakeholders. Despite the fact that many of Indiana's most significant long-term care initiatives can be attributed to the persistent lobbying efforts of consumer groups, there has been an historic lack of inclusion of consumers in the long-term care program planning and implementation phases. This is a pervasive problem that has led to the development of administrative rules and programs by state policymakers that were not properly designed to take all needs into account and to the impediment of progress that could otherwise have been achieved. It is not that all meetings require all stakeholders, but rather that a substantive and regular dialogue, with known assignments and timelines, should occur with all stakeholders throughout any program design and implementation process.

Senate Enrolled Act 493 is a consumer-driven law that presupposes that the public's interests are best served by a long-term care system that effectively and efficiently serves the needs of the persons qualified for its services. Productive engagement with all consumer interests and other stakeholders in the planning, design, and implementation phases is essential for achieving full and timely compliance and for fully addressing the long-term care needs of Hoosiers within the Law's parameters.

Common Administrative Challenges. There are a number of federal and state administrative challenges that often hinder efforts to implement change. Perhaps the most significant of these is the almost 40-year old federal requirement that establishes nursing home care as a long-term care service to which all Medicaid beneficiaries are entitled. In contrast, federal law does not require states to make available to nursing home-eligible beneficiaries the less-expensive services that can be provided in the community. Funding for community-based service alternatives remains an individual state option, which is often dwarfed by already huge investments in institutional forms of care. The consequence of this is that long-term care funding in Indiana and in most states continues to heavily favor nursing home services.

As has already been done in a number of other states, Senate Enrolled Act 493 resolves Indiana's long-standing institutional bias by establishing the program flexibility and funding authority needed by state policymakers to enable funds to follow consumer needs and preferences rather than to be dedicated to particular providers or services.

Other administrative obstacles include: the overlap of programs and policy initiatives within and between state agencies; high state administrative and technical staff turnover; lack of decision-making authority among key project staff persons; and a limited number of hands-on program and technical staff.

Senate Enrolled Act 493/Public Law 274-2003 now governs long-term care service delivery in Indiana. Full compliance, however, can be greatly facilitated by an assertive implementation effort by the State in full partnership with the representatives of the consumer interests that presented to the Indiana General Assembly the systems change model that became the law. This is the long-term care systems approach that has proven itself time and time again in states across the nation as one that works in harmony with consumer needs, and like Indiana's time-proven CHOICE Program, in the State's fiscal interests.

Case study 1 – Deep Frustrations; waiting for care

Ronald Maurer hasn't ventured away from his South Bend home since May. Any kind of pollen – even just the smell of a flower - could bring on a violent bronchial spasm and a trip to the hospital. He has emphysema and Chronic Obstructive Pulmonary Disease.

Ronald and Carol Ann Maurer, South Bend

Any kind of physical activity would do the same for this former truck driver, who used to lift 100-pound bags of concrete without wincing.

Mr. Maurer, 63, has been on a waiting list for home care services under CHOICE (Community and Home Options to Institutional Care for the Elderly) for more than two years. He's on the highest medical need list right now. He cannot bathe or dress himself, and he's tethered to an oxygen machine 24 hours a day.

His wife, Carol Ann, must take care of both him and their home all by herself. "I have to do it all," she says. "Fixing meals, bathing, bathroom assistance, laundry, shopping, driving to the drugstore. I'm exhausted."

She must go to the drug store several times a week to pick up her husband's inhalers. His doctor has prescribed five different ones for different times during the day - but she can't pick them up all at once due to insurance regulations.

His doctor also prescribed pulmonary therapy, but the Maurer's insurance won't pay for it because, as Mr. Maurer says, "I've got a chronic disease that's never going to get better. Pulmonary therapy isn't like cardiac therapy, where you might actually get better."

Mrs. Maurer's work as a caregiver is becoming more difficult because she suffers from her own disabilities. During breast cancer surgery 14 years ago, a nerve to her left hand was severed. She also has arthritis in her right hand. "My hands won't work for me," she says.

Mr. Maurer, 63, has been on a waiting list for home care services under CHOICE (Community and Home Options to Institutional Care for the Elderly) for more than two years. He's on the highest medical need list right now. He cannot bathe or dress himself, and he's tethered to an oxygen machine 24 hours a day.

With the won't-get-better nature of his illness, and her worsening arthritis, the Maurers are deeply frustrated by the lack of funding for the CHOICE program. Mrs. Maurer gets panic attacks just thinking about all the work that needs to be done.

To make the wait less frustrating, Mrs. Maurer was able to get respite care for six hours a week this year under the Family Caregiver Support Program, through Title 3 funds. Those helpers ran the sweeper, helped to change beds and did other heavy housework. But she chose to slow it down to three hours a week, to make the respite care last longer. Those funds ran out in October of 2004.

"If I get any respite help back, I am going to let them start helping me carry groceries and do other things besides staying in the house," says Mrs. Maurer. "It is getting harder and harder."

Financing

Senate Enrolled Act 493 Funding Provisions

Senate Enrolled Act 493 provides for the following funding requirements:

> "Chapter 11.5 Long Term Care Services, Section 2. (a) This chapter is subject to funding available to the office of the secretary of family and social services. (b) The secretary and the director of the state budget agency are responsible for ensuring that the cost of the services provided under this chapter does not exceed the total amount of funding, including state and federal funds, that is made available by the budget agency for the program established under this chapter to provide long term care, including home and community based services."
>
> "Section 3. The office of the secretary of family and social services shall establish a comprehensive program of home and community based long term care services to provide eligible individuals with care that is not more costly than services provided to similarly situated individuals who reside in institutions."

A companion of the funding section described above is the section that describes savings.

> "Section 6. (a) The office of the secretary of family and social services shall annually determine any state savings generated by home and community based services under this chapter by reducing the use of institutional care. (b) The secretary shall annually report to the governor, the budget agency, the budget committee, the select commission on Medicaid oversight, and the executive director of the legislative services agency the savings determined under subsection (a). (c) Savings determined under subsection (a) may be used to fund the state's share of additional home and community based Medicaid waiver slots."

The Act also includes a "money follows the person" funding provision. Specifically, Section 14 reads as follows:

> (a) Beginning July 1, 2003, the office of Medicaid policy and planning shall implement a policy that allows the amount of Medicaid funds necessary to provide for services to follow an individual who is transferring from institutional care to Medicaid home and community based care. The amount may not exceed the amount that would have been spent on the individual if the individual had stayed in institutional care. (b) This section expires July 1, 2005.

And finally, the Act includes a bond provision that supports the conversion of nursing home beds to less intensive care beds. It is included within Senate Enrolled Act 493, Section 11 and reads as follows:

> (a) The Indiana health facility financing authority created by I.C. 5-1-16-2(a) is encouraged to work with for profit health facilities and nonprofit organizations that are operating under a joint agreement to convert health facility beds to less intensive care beds through the issuance, sale, or delivery of a bond under I.C. 5-1-16.

The funding provisions within Senate Enrolled Act 493 are intended to provide administrative control and to address most or all of the financing concerns that normally impede long-term care rebalancing.

By balancing the start-up expenses that may be required to further develop essential long-term care services such as assisted living and adult foster care with savings that will be created in the simultaneous reduction of institutional services, The Act provides policymakers with a number of financing protections that allow for the controlled shifting of resources away from expensive institutional services. The Act further specifies that rebalancing can occur within the existing long-term care funding appropriation.

Senate Enrolled Act 493 also addresses the impact of rebalancing on the nursing home industry by establishing bonding authority that will assist interested nursing home providers in transitioning their businesses to support some form of community-based services.

The Act builds upon the administrative structure of the Medicaid Home and Community-Based Services Waiver Programs, which is specifically designed to provide states with great latitude and control in managing community-based services and in targeting the population of consumers who should receive those services. All Medicaid Waiver Programs include federal cost-effectiveness requirements and provide broad state administrative authority to manage spending. Program expansions and reductions are controlled by the states and are readily modified to correspond with changing funding dynamics.

This bonding provision is intended not only to assist with transitional expenses, but also to fill existing staffing and service gaps in community-based services.

Senate Enrolled Act 493 directs the State to make every effort to quickly determine how and under what timeline full implementation and compliance can occur. It not only requires state policymakers to focus on analysis of the immediate and longer-term costs and savings of specific long-term care service expansions, but it also addresses the administrative modifications that are needed to provide optimal care in less-costly and more innovative and efficient ways. The almost $2 billion spent annually for long-term care through Medicaid and CHOICE represent a significant portion of the State's Medicaid budget and total expenditures. Therefore, understanding the full fiscal and program implications of rebalancing is, in many ways, the key to moving forward.

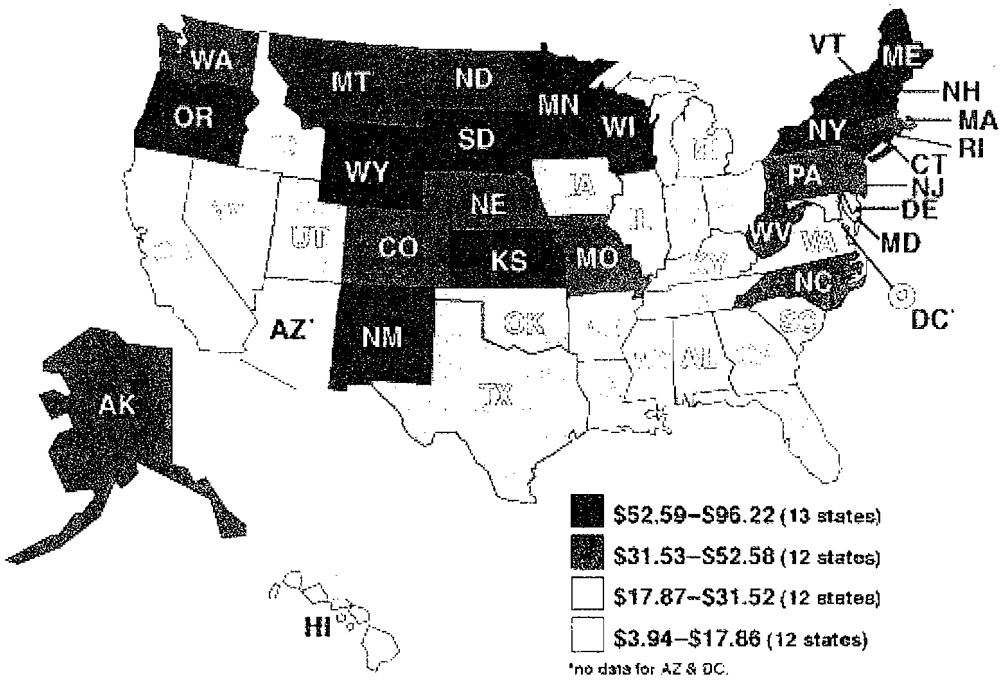
Long-Term Care Funding in Indiana

Medicaid and Medicaid Waivers. In a state-by-state comparison of 1997 Medicaid waiver expenditures, Indiana was among the twelve states with the lowest total Medicaid waiver expenditures per capita.[32] Figure 3 on the following page shows the distribution of spending in Indiana and nationwide.

Indiana had not improved significantly by Federal Fiscal Year 2001, ranking 47th among all states in the share of Medicaid long-term care expenditures provided in institutional versus community-based settings.[33]

Figure 3

1915(c) HCBS Medicaid Waiver Program
Total Expenditures Per Capita Across the States, 1997



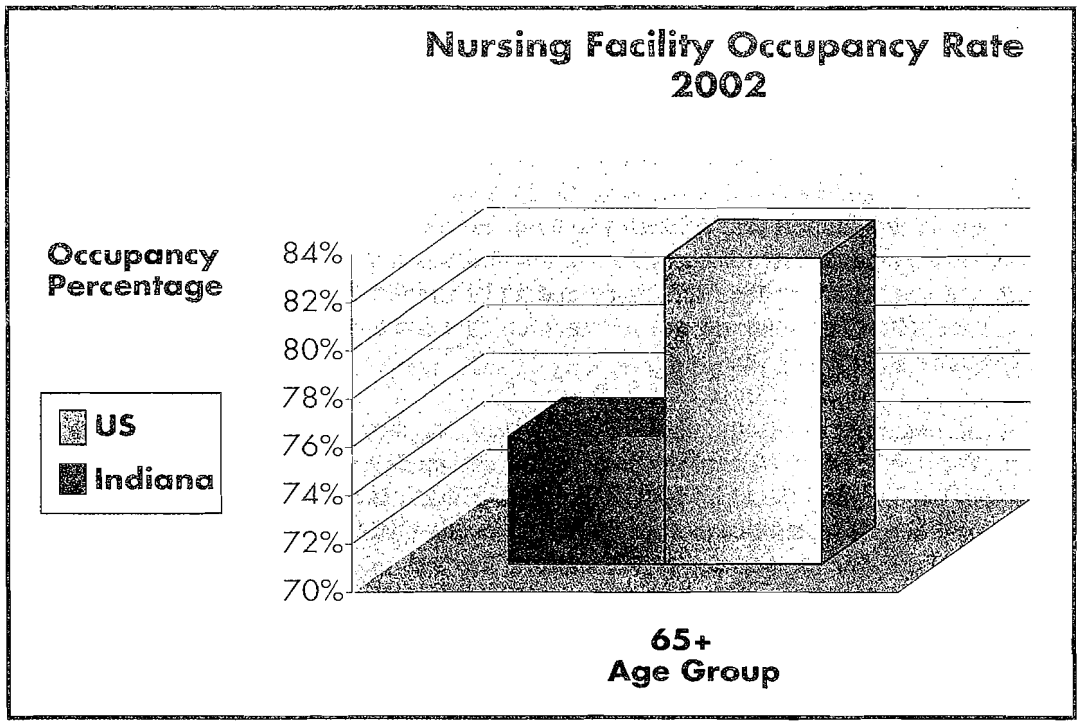
Source:
Harrington, C., Carrillo, H., and Wellin, V. (1999b). 1915(c) Medicaid Program Data (Form 372). San Francisco, Calif.: University of California, San Francisco.

By 2002, 70% of national Medicaid spending for long-term care services went to institutional care, and 30% went to community care.[34] For the same period, 84% of Indiana's Medicaid Program was spent on institutional care, and 16% went to community-based care.[35] This makes Indiana far below the national average for Medicaid spending on community-based care. Moreover in a recent spending analysis prepared by the Kaiser Commission on Medicaid and the Uninsured, Indiana ranked 48th among states[36] in the percentage of long-term care dollars spent in Federal fiscal year 2002 on Medicaid-funded community-based care for the aged and physically disabled.

In 2001, Indiana ranked 12th highest in the ratio of nursing home beds (67) per 1000 seniors. This number dramatically exceeded the national average of 54 beds per 1000 seniors, demonstrating Indiana's continuing over-reliance on nursing home care. Similarly, Indiana ranked 10th highest in the total number of nursing facility residents, and 7th highest (5.6%) in the percentage of nursing facility residents aged 65 and older. This is compared to 4.2% nationally.[37]

Due in large part to a failed certificate of need program that served to grow rather than control nursing home bed capacity, Indiana has for many years led the country in the number of empty nursing home beds. Or said another way, Indiana has historically, and continues today to rank in the lowest number of states (45th in 2002) in terms of nursing home bed occupancy[38]. See Figure 4.

Figure 4



In state fiscal year 2005, the Indiana Medicaid Program is projected to spend $4.81 billion (state and federal funds).[39] Of that, $1.73 billion (state and federal funds) is attributed to long-term care services: $1.16 billion, or 69%, for institutional care; $61.5 million, or 3.5% for home health; and $515 million, or 31%, is projected to support the Medicaid Waiver Programs.

There has been significant movement in recent years by the State in closing and downsizing state operated facilities for the developmentally disabled and moving consumers to Medicaid Home and Community-Based Services Waivers. This focus on the developmentally disabled population represents the vast majority of the growth associated with the Medicaid Waiver Programs since the late 1990's.

Indiana's focus on the MR/DD population can best be demonstrated by examining State Fiscal Year 2005 projections where Medicaid Waiver spending is projected to total $515 million. Of that, $464.5 million (90%) will be spent on Medicaid Waivers for the developmentally disabled population, compared to only $50.5 million (10%) for the Medicaid Waivers that serve the aged and disabled population[40]. Similarly, for the first three quarters of 2004[41], Medicaid Waivers served 9,141 developmentally disabled persons at an average cost of $32,272, compared to 4,980 aged and physically disabled at an average cost of $7,533.

Compared to services provided to the developmentally disabled population, there has been far less progress made in expanding Medicaid-funded community-based service options for Indiana's aged and physically disabled populations. Indiana State Medicaid projections for state fiscal year 2005[42] continue to reveal a disproportionately high reliance on nursing home care, the institutional service alternative for Indiana's aged and physically disabled – almost $819 million

of the $1.73 billion attributed to Medicaid-funded long-term care services. Another $338 million is budgeted for intermediate care facilities for people with developmental disabilities, the institutional service alternative that population.

Indiana's CHOICE Program. The CHOICE Program appropriation for state fiscal year 2005 totals $48.67 million. CHOICE is paid with 100% state funds and contributes part of its funds (about 11%) to support related programs such as the Medicaid Aged and Disabled Waiver.

In SFY 2004, the CHOICE Program served approximately 10,420 persons at an average cost of $3,312 per year.[43] This relatively small per person financial investment is focused on providing the community-based support that is needed to keep elderly and disabled consumers independent and in their own homes for as long as possible. It should be noted that CHOICE funds support clients at much less cost than the Medicaid Aged and Disabled Waiver (which is also very cost-effective), and CHOICE clients do not utilize Medicaid State Plan services or depend on any other state funds.

Because of its funding flexibility, the CHOICE Program supports a range of care needs for consumers who are aged and disabled. In a recent survey (unscientific) conducted by the area agencies on aging[44], over 77% of all CHOICE clients needed assistance with 3 or more activities of daily living (ADLS). This makes the disabilities of the CHOICE clients comparable to those of the Medicaid Waiver clients, yet serves them at far less expense. In addition, CHOICE is compensating for limitations in Indiana Medicaid Waiver Programs by picking up Medicaid spend down expenses for a number of Medicaid Waiver Program clients, as well as supplementing the Medicaid Waiver Program in other ways.

CHOICE funds are often used to supplement Medicaid Waiver services because the current design and level of funding dedicated to the Indiana's Medicaid Waiver Program continues to be inadequate to meet the needs of its elderly and disabled clients. The current income eligibility threshold for the Medicaid Aged and Disabled Waiver is established at 100% of the Supplemental Security Income amount ($564 per month for an individual), and therefore meets the health care needs of only the poorest of Indiana's low-income elderly and disabled citizens; namely, those who are at or below 77% of the federal poverty limit (FPL). This extremely strict income eligibility standard has so limited the number of consumers who qualify for the Indiana Medicaid Aged and Disabled Waiver that its waiting list has been historically short or altogether absent. Moreover, because application of the Medicaid income standard is treated differently for nursing home care than for the Aged and Disabled Waiver Program, many low-income consumers who are in immediate need of long-term care services find the more expensive nursing home care their only service option unless CHOICE funds are made available. In this instance, consumers who are unwilling to obtain nursing home services, seek services provided through the CHOICE Program or through Medicaid Waiver Services. When services are not available because of CHOICE funding limitations, a lack of Medicaid Waiver Program slots, or Medicaid's restrictive pre-493 income eligibility standards, many individuals forego needed services and join the waiting lists, thereby worsening their health condition and threatening their ability to remain independent.

The extremely strict income eligibility standard (77% FPL) of the Indiana Medicaid Waiver Program for the Aged and Diabled has so limited the number of consumers who qualify for the Program that its waiting list has been historically short or absent altogether.

This dynamic will change once Senate Enrolled Act 493 is fully implemented and service rebalancing is achieved. When this occurs, a seamless funding hierarchy can be established to minimize state expense, to identify savings, and to refocus scarce CHOICE Program funds on

providing community-based supports to people who may not be eligible for Medicaid, who are elderly and disabled and for whom a little support may provide significant and long-lasting benefit. This will allow the Medicaid Waiver and CHOICE Programs to function as truly complementary programs, which when combined, can be expected to significantly delay or eliminate an elderly or disabled person's reliance on institutional care.

Money Follows the Person

Senate Enrolled Act 493 includes a provision commonly referred to as "Money Follows the Person", which refers to a system rebalancing policy like that already employed in CHOICE, where Medicaid funding is assigned to an individual, regardless of the setting in which long-term care services are delivered. The Centers for Medicare and Medicaid Services provides this definition[45]:

> "Money Follows the Person refers to a system of flexible financing for long term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change. It is a market-based approach that gives individuals more choice over the location and type of services they receive.... [It] is also [a system] that incorporates the philosophy of self-direction and individual control in state policies and programs. It includes, but is not limited to, key systems to ensure: 1) the delivery of comprehensive information to individuals on long term supports and services through single access points; 2) the availability of responsive supports across settings and providers; 3) the existence of systems to ensure quality of life and services; and 4) the ability of separate funding streams to appear seamless on the part of the individual."

A "money follows the person" provision may apply to either or both of two types of consumer populations: those who meet nursing home eligibility criteria but who have not yet been admitted (also known as consumers who are "at risk" of institutionalization); and those consumers who already reside in a nursing home.

A "money follows the person" policy approach that targets the at-risk population is commonly referred to as a *diversion policy*, which refers to the provision of services intended to delay or prevent institutionalization. A "money follows the person" policy approach that targets the nursing home resident population is commonly referred to as a *deinstitutionalization, or conversion policy*, which refers to the provision of services to support the transition of a consumer out of a nursing facility and back into a community residential setting.

What this means with respect to The Act, is that most or all of the Medicaid funds that are already or would be paid to support a consumer in a nursing home setting must be made available to support that consumer in an alternative, non-institutional setting, such as the individual's private home, assisted living facility, adult foster care home, or some other community residential home. The goal is to allow consumers the opportunity to receive needed long-term care services in the setting of their choice and at less expense in the longer term. Under Indiana's current long-term care service delivery system, however, the opportunity for consumers to transition out of a nursing home is severely limited by the lack of affordable and accessible community residential care options that provide both housing and services. Once fully implemented, Senate Enrolled Act 493 resolves this problem by mandating the development and implementation of viable assisted living and adult foster care programs, and other essential community-based services.

While to someone unfamiliar with the complexities of public healthcare and state and federal financing, a "money follows the person" policy may seem to be fairly basic and simple to implement, it is in fact, one of the more challenging aspects of long-term care rebalancing. This is because a "money follows the person" policy generally requires state policymakers to have some degree of funding flexibility. Fortunately, this flexibility is already available in states like Indiana that utilize a global long-term care budget to manage their expenses. In fact, Senate Enrolled Act 493 codifies the use of global budgeting for all Medicaid-funded long-term care. Global budgets are public assistance budgets that combine funds for all long-term care services in one account, rather than to designate specific funding caps for specific types of service in separate long-term care accounts. This single appropriation structure provides the administrative flexibility needed to readily transfer funds among services as needed and according to program priority, provided that the total appropriation is not exceeded.

Until Senate Enrolled Act 493 is fully implemented, the opportunity for Hoosiers to transition out of a nursing home is severely limited by the lack of affordable and accessible community residential care options that provide both housing and services.

A deinstitutionalization approach, in contrast, provides an immediate, and easy-to-calculate, Medicaid funding source for the State to use in long-term care rebalancing. This funding opportunity presents itself when funds that are actually paid on behalf of an institutionalized consumer are allowed to transition with the consumer to a community setting and be redirected to pay for in-home services at no additional cost to the Medicaid Program. This approach provides an immediate Medicaid funding source, while freeing individuals from institutional care. A deinstitutionalization initiative is, however, a resource-intensive process. This is because most institutionalized consumers no longer have the finances or housing accommodations and community supports that they had prior to admission. As a result, the State may be responsible for arranging housing, such as assisted living or adult foster care, picking up some or all of the consumer's initial start-up expenses for rental deposits, utilities, clothing, and groceries, and providing specialized case management to help the consumer with adjustment to a non-institutional setting. Clearly, all of the activities and outlays that are a feature of deinstitutionalization need to be a part of any calculated savings. However, the enormous costs associated with institutional care still make transitioning to community-based housing highly attractive.

It is precisely because of the administrative resources that are often committed to deinstitutionalization initiatives that state policymakers recognize the financial, economic, and societal value of making Medicaid Waiver services available to consumers *at the time that they become nursing home eligible and before or shortly after* they are admitted. Doing so eliminates or delays the consumer's permanent move to a costly nursing home setting while preserving the consumer's private home environment and family and community support network, and eliminating the state's responsibility for later picking up housing and other expenses for which federal Medicaid funds are not available. With respect to homeownership, Indiana ranks 11th highest among states in the percentage of people (83.4%) age 65 and older who own their own home.[46] Because of this positive housing dynamic in Indiana, it makes good public policy and economic sense to preserve a consumer's private homeownership for as long as possible.

Senate Enrolled Act 493 requires the State to establish flexible, consumer-friendly funding policies and to develop community-based service alternatives that can be used to develop affordable and accessible housing alternatives that can optimize the State's ability to obtain federal matching funds. While the Medicaid Program is explicitly prohibited from paying for room and board expenses in non-institutional settings, the Medicaid Waiver Program is permitted

to cover the services that are provided in non-traditional community residential settings, such as assisted living, adult day care services, and adult foster care.

States that employ a "money follows the person" approach include: Florida; New Jersey; Texas; Vermont; Utah; Washington; and Wisconsin.

Program Successes in Texas and New Jersey. The 2001 Texas Legislature authorized an appropriations rider (Rider 37) that allows Medicaid funding to follow a nursing home resident back into the community. Money is shifted away from nursing homes to fund the community-based services. The rider became effective in September 2001, and by October 2003 had successfully supported the transition of over 1,900 Medicaid participants. The 2003 Texas Legislature renewed the rider (Rider 28) to be effective through August 2005.[47]

With respect to home ownership, Indiana ranks 11th highest among states in the percentage of people (83.4%) age 65 and older who own their own home.

New Jersey took a different approach than Texas and implemented the Community Choice Initiative, which employs 40 counselors who are exclusively dedicated to informing and assisting hospital patients and nursing home residents with securing community-based services options. Between 1998 and 2001, over 3,400 people were discharged from nursing homes through the Community Choice Initiative. During the same time period, New Jersey's Medicaid nursing home population decreased by 1,500 (5%).[48]

Cost-Effectiveness Requirements and Waiting Lists

Senate Enrolled Act 493 prescribes that community-based services must be provided at costs that are no greater than the costs for services provided to persons who reside in institutional settings. This provision complements federal cost-effectiveness requirements that govern administration of Medicaid Home and Community-Based Services Waivers.

Specifically, federal regulations require states to demonstrate that they provide home and community-based services at overall average costs to the Medicaid Program that are no higher than that of serving persons in the alternative institutional setting. Therefore, by definition, Indiana Medicaid Waiver Programs that serve the low-income aged and disabled population can be no more expensive than that of services provided in a nursing home.

Federal regulations give states some discretion in establishing cost-effectiveness criteria. States may establish a hard limit or cap on individual per person Medicaid Waiver service costs, or an aggregate cost limit that takes into account the average Medicaid Waiver service cost of all individuals served on the Medicaid Waiver Program. Costs associated with Medicaid State Plan services, such as home health, physician, and hospital, are not included in the calculation.

The practical application and budgetary effects between the two cost-effectiveness approaches are quite different. With the first approach, limiting individual costs, the state establishes a maximum budget for each individual. This budget ceiling is normally set at some percentage less than 100% of the total costs for comparable institutional care. Using this approach, expenditures are always and predictably less than the amount budgeted, therefore freeing up more money to serve additional persons or to support program enhancements elsewhere. Budgets and expenditures can be easily monitored to assure individual and overall cost-effectiveness, which is especially important when administrative responsibilities are shared by two or more state agencies. Hard

limits generally offer no flexibility to accommodate temporary episodes where individual care needs are higher than what the budget allows. Therefore, states may establish a special administrative process to evaluate circumstances that may warrant temporary approval for maximum budgets to be exceeded and to track those expenses.

With the second approach, establishing a limit based on the *average costs of all persons* served on the Medicaid Waiver Program, the State establishes a person-specific budget that allows individuals with higher and lower service needs to be served on the Medicaid Waiver Program. This approach provides the flexibility needed to respond to the episodic and naturally changing care needs of the individual but also requires careful and regular monitoring to assure that individual budgets do not exceed overall program limits. Additionally, waiver funds that are "freed up" are often dedicated to increasing the services for those already on the waiver rather than to grow the number of individuals served.

Regardless of the cost-effectiveness approach used, federal regulations allow states to regularly adjust the administrative structure of the Medicaid Waiver Program to accommodate changes in program priorities and funding levels. This may be accomplished in any of a number of ways, including: modifying the targeted number of consumers to be served, modifying eligibility requirements, modifying individual budget amounts, modifying the hours of services to be provided, and adjusting provider payment rates.

The Indiana Medicaid Aged and Disabled Waiver is targeted to serve only those consumers who are eligible for nursing home services, and has consistently done so at levels that are significantly below the cost of care provided in the nursing home setting.

Indiana originally administered its Medicaid Waiver Programs by using hard individual spending limits and consistently ran under budget. It then changed its cost-effectiveness calculation in the late 1990s to an aggregate average spending limit in order to introduce flexibility within individual care plans and budgets, and to expand the availability of needed services.

The Indiana Medicaid Aged and Disabled Waiver Program has demonstrated cost-effectiveness since its inception, and has continued to operate at levels significantly below allowed amounts, regardless of the cost-effectiveness approach utilized. The Medicaid Aged and Disabled Waiver is targeted to serve only those consumers who are eligible for nursing home services, and has consistently done so at levels that are significantly below the cost of care provided in the nursing home setting.

Indiana Medicaid Waiver Programs that serve the Aged and Disabled populations and the CHOICE Program normally operate through a waiting list system whereby clients are served on a first-come, first-served basis according to waiver slot and funding availability. Consumers for whom funds are not available are placed on a waiting list and prioritized according to date of application. As new funds become available, the waiting list provides the mechanism for selecting new Waiver Program consumers. Waiting lists are managed at the local level and are drawn from as new waiver slots or CHOICE funds become available. Because of historically limited funding levels in Indiana, waiting lists consist primarily of self-referring consumers who seek and are subsequently denied services, rather than consumers who have been identified through a targeted outreach effort. Waiting lists may not be updated, monitored, or managed by each area agency on aging in a consistent manner. It is also possible for a consumer to appear on more than one waiting list although area agencies on aging report that they attempt to maintain unduplicated lists. Nevertheless, the CHOICE and Medicaid Waiver Program waiting lists continue to represent the best measures available for predicting the scope of unmet need among Indiana's low-income elderly and disabled residents. (It should also be noted that area agencies

on aging have typically had to address the local administration of publicly-funded home and community based services with restricted budgets for services, staffing, and monitoring duties.)

Waiting list management can be a complicated responsibility. Some of the policy factors that must be considered when administering long-term care program waiting lists include the following:

- Whether consumers receive an eligibility screen before waiting list placement. This may be a costly initiative for the State and may not be valuable if the consumers' average length of time on a waiting list exceeds six months. It does, however, provide assurance that the majority of consumers on the waiting list do meet eligibility requirements.
- Whether exceptions to first-come, first served selection are available to respond to consumers with emergency service needs.
- Whether consumers are placed on more than one waiting list or whether waiting lists are unduplicated.
- Whether program outreach is used to identify the full population of consumers with unmet need, or whether outreach is limited to correspond with availability of funding.
- Whether waiting lists are regularly reviewed and updated to reflect changes in consumer service needs.

Unlike Indiana, a number of states do not limit their Medicaid Waiver Program services and therefore do not utilize waiting lists. States such as Oregon and Colorado operate an "open waiver" and provide community-based services to all who qualify. This approach has contributed to great success in rebalancing their long-term care programs (with over 50% of their long-term care expenditures and over 75% of their clients in community-based care) and has been endorsed in Indiana by a wide array of consumer advocacy organizations.

While Medicaid Waiver Program flexibility allows states to adjust long-term care service priorities and eligibility criteria according to changes in available funding, Oregon made a threshold adjustment only once in 20 years and Colorado only twice in 20 years. Additionally, other states have also had open waivers without moving their thresholds. Having ready access to waiver slots for individuals to avoid nursing home placement at all times has led to positive rebalancing outcomes in those states.

Still other states are aggressively pursuing reforms that push long-term care rebalancing initiatives further than they have ever gone before. Some of these efforts include limiting nursing facility admissions and making less expensive Medicaid Waiver services the primary source for needed services. The State of Vermont, for example, is currently pursuing a Medicaid 1115 demonstration waiver that will "...constitute a wholesale replacement of most of Vermont's existing Long-Term Care Medicaid program. All individuals currently eligible for Medicaid and in receipt of long-term care services in a nursing facility, Home and Community-Based Services Waiver or ERC Waiver, will be enrolled in the demonstration...It will be operated as a managed care model under a global budget." [49]

Savings

Senate Enrolled Act 493 specifies that savings attributed to long-term care rebalancing must be annually determined and reported and that it can be used to fund the state's share of additional waiver slots.

Historically, a frank discussion about the savings opportunities that long-term care reform can generate yielded a fairly polarized debate. Proponents of community-based care argued that institutional care is so expensive by nature that any alternative mode of service delivery must necessarily be less expensive, not to mention that federal regulation related to the Medicaid Waiver Program requires that it be so. In contrast, opponents and skeptics argued that the use of the term "savings" is arbitrary and unsubstantiated, since service expansions may increase the total number of persons served, since community-based populations may have lower needs than those who are institutionalized, and since savings calculations may not fully account for a number of other factors, like an unanticipated influx of new eligibles, greater administrative expenses, and other unknown costs associated with overall system reform.

That debate has, however, changed considerably in recent years. Today there is widespread agreement that shifting funds and services to support consumers in their own homes and other community settings can and does achieve per person program savings and makes imminent economic sense. Per person savings are fairly simple to calculate and generally involve comparison between the actual costs of daily or monthly institutional services and the actual costs of community-based services.

The Indiana Home Care Task Force recently examined data collected by an area agency on aging and concluded that Medicaid costs for a consumer on Indiana's Aged and Disabled Waiver average under $13,000 per year.

The data reviewed by the Task Force is consistent with documented savings that have been achieved in other states. Colorado and other states have reported savings on the order of 3 to 1 when comparing home and community-based services with institutional care.

Depending upon each state's funding priorities, per person savings generated by rebalancing initiatives may be used to accomplish overall program savings, to expand or enhance the array of long-term care services, to increase the number of consumers receiving services (and thereby decrease the waiting list), or to address any combination of these funding objectives.

Calculation of overall savings associated with long-term care system rebalancing will likely depend upon a combination of new program and service initiatives and investments that will be implemented concurrently or with a phase-in approach, some of which will require an upfront investment but can be expected to generate savings once implemented. Or said another way, some short-term investments may be required in order to achieve overall savings in the longer term and accomplish all of the State's rebalancing objectives. Moreover, the financial and social benefits that are generated by development and expansion of volunteer and caregiver support programs and on preserving home ownership by consumers are often not measured but have a definite economic value and are certain to positively influence outcomes.

States may approach the calculation of costs and savings by ordering the completion of a comprehensive fiscal impact analysis, or by developing a plan for system redesign that carefully and methodically introduces program and service changes in order of priority with respect to the state's long-term care objectives. Regardless of the approach taken, there is normally great value

for policymakers to obtain stakeholder agreement on key assumptions that drive the cost and savings factors and the implementation plan and timelines.

Some states that have aggressively pursued long-term care rebalancing have reported programmatic and overall cost savings, ranging from levels that are modest to substantial. The State of Oregon, for example, reported a cumulative savings for both its Medicaid waiver program and its state-funded Oregon Project Independence of $400 million by 1995[50].

Historically, states that lead the country in long-term care rebalancing have accomplished their system reforms during times of economic strain and because of a broad-scale commitment to the intrinsic and immeasurable value of the quality of life improvements that come with community-based care. Savings may not be the only motivating factor, and policymakers may decide to pursue long-term care policy changes because of their human and societal value and in spite of their potential short-term cost.

Bonding

Senate Enrolled Act 493 provides the authority for standard bond financing to be made available to nursing home providers to help finance construction and renovation projects that can help them transition from providing long-term care services in traditional, institutional settings, to providing community-based services, such as assisted living, adult day care, adult foster care, and other forms of in-home care. Bond financing provides a nursing home borrower with access to low interest rate capital markets through the issuance of tax-exempt revenue bonds. Proceeds from the loan may be used by eligible borrowers to fund construction/renovation projects, land acquisition for future project, acquisition of existing health facilities, refinancing of existing debt, working capital for start-up facilities and pay costs of issuance. Given the cost of issuing bonds, this is the option often pursued by borrowers with capital projects in excess of $5 million.

Logistical Requirements

Senate Enrolled Act 493 provides a comprehensive framework for long-term care rebalancing that is supported by a number of funding protections. Included in The Act are descriptions of the services needed to provide a full array of care options to the consumer, as well as provisions that describe cost-effectiveness, a funding strategy and limit, savings, and bonding authority. Developers of The Act were motivated not only by fiscal and economic concerns, but also by the promise of a new consumer and market-driven system that will provide more and better long-term care services to Indiana's most frail, low-income elderly and disabled citizens.

If the State of Indiana opts to utilize a fiscal impact analysis to drive the approach and timelines required to comply with Senate Enrolled Act 493, it is important that consumer representatives be fully engaged in all aspects of the process. There should be agreement among stakeholders on the key assumptions used to determine costs and savings, and consumer inclusion with respect to evaluation and completion of the analysis, and subsequent development of an implementation plan.

Concerns with respect to unanticipated service expense that may occur as long-term care rebalancing is pursued are largely mitigated by the federally mandated cost-effectiveness requirements and the state-driven funding controls that exist within Medicaid Home and Community-Based Services Waiver Programs. Effects on administrative expenses will depend

upon existing administrative structures, and the level and scope of modifications necessary to achieve compliance with The Act.

Analysts from the Lewin Group who completed research on behalf of the AARP Public Policy Institute in a 1996 analysis of Oregon[51] suggest that there exists a paradigm by which states can ensure that home and community-based services are more cost effective than nursing home care. This paradigm requires states to do three fundamental things:

(1) Target a population likely to go into an institution;
(2) Keep home and community-based care costs down; and
(3) Provide a wide array of services.

The first requires states to ensure that the care needs of an elderly and disabled consumer of home and community-based services are truly comparable to those of a nursing home resident. This can be accomplished by performing nursing facility level of care assessments and by carefully targeting persons who are already on a pathway to institutional placement (for example, those who are in an inpatient hospital setting).

The second requires states to carefully monitor and keep home and community-based care costs consistently lower than nursing home care costs in order to accurately compensate for any unanticipated expenses. In 1995, for example, community-based care in Oregon cost 15% of that of nursing home care, Washington only 20%, and Colorado only 16%.[52] Oregon then reinvested its savings in building the long-term care system, serving more people and strengthening its infrastructure so that, by 1998, Oregon served 75% of Medicaid consumers and 70% of all adults with disabilities in home and community-based services settings[53].

And finally, the third requires states to have available a sufficient array of community-based services and supports that ensure that unnecessary institutionalization will not occur. In other words, the community-based service array must include a wide range and variety of service and residential care options (i.e. assisted living and adult foster care) that maximize flexibility and that can accommodate an individual's episodic and anticipated changes in care needs.

There are some provisions of The Act (300% Supplemental Security Income, adult foster care, assisted living, and caretaker support) that may require additional resources. And while Senate Enrolled Act 493 presupposes that these program changes will be designed so that they can be simultaneously implemented with complementary modifications that will realign and redesign other aspects of the long-term care service delivery system, it may be necessary to make available some level of new funding that can provide the initial momentum needed to provoke other changes and outcomes to follow. Available research and the experience of other states indicates that with proper management and administrative focus, overall program savings can be achieved over time, or overall expenditures can be held to current levels while serving more people at lower average costs.

Compliance with Senate Enrolled Act 493 requires the State to significantly expand and expedite its efforts to transition more nursing home residents back into the community, as well as divert more persons away from initial nursing home admission or extended stays. The State is currently in the process of requesting an extension of the Nursing Home Transition Grant through September 30, 2005.[54] If extended, the grant will be used to continue the partnership with the Independent Living Center of Eastern Indiana, which is working with a coalition of stakeholders in the eastern, mostly rural part of the State to transition and divert additional individuals from nursing home care and to educate them about their right to community-based services. It will

also be used to provide funding to three or four area agencies on aging that have developed successful models for diversion and transition of individuals to provide enhancements to existing models and to develop outreach materials and a best practices manual for the other area agencies on aging. But while the Grant is a good start, it does not create the broad-scale process changes that are needed to achieve the consumer outcomes required by The Act and to create the level of savings needed to offset other implementation costs. The State must therefore significantly and immediately expand its efforts in this area.

As The Act's provisions are fully implemented, there can be expected additional growth in the Medicaid Waiver Program waiting lists. This growth may or may not be significant but will help to determine the level of unmet need that exists in Indiana and to develop plans to address the future needs of a greatly expanding aging and disabled population. To put it simply, Indiana will be unable to afford long-term care services for the aging Baby Boomers if nursing home care remains the primary service available.

While Senate Enrolled Act 493 provisions authorize the State to achieve compliance within the existing long-term care appropriation, The Act neither presupposes nor preempts new investments from being made to Indiana's long-term care service delivery system. Other possible avenues to make available new funding to support these rebalancing efforts include pursuit of some or all of the new grant opportunities that continue to be made available through the President's New Freedom Initiative (which was also an action step included in the late Governor O'Bannon's Commission on Home and Community Based Services' June 30, 2003 Report). Administrative interest should especially be focused on several new federal grant opportunities. LIFE Accounts is an initiative targeted to allow individuals who self-direct their services to accumulate savings and still retain Medicaid eligibility. Some additional New Freedom demonstrations make available $18 million in FY 2005 and $327 million over five years to target respite services to caregivers of adults with disabilities. This grant opportunity could be specifically targeted to the currently un-enrolled elderly and disabled population that would be expected to comprise expenses associated with targeted efforts to address unmet need. There are other new grant opportunities available as well, including Real Choice Systems Change, Presumptive Eligibility, and a Demonstration to Improve the Direct Service Community Workforce.

Not only in Indiana, but throughout the country, state policymakers are recognizing the value in shifting long-term care services away from traditional, institutional forms of care toward care and supports that can be provided safely in the community, at less expense, with greater consumer control, and with better health care outcomes. A press release issued on August 27, 2004 notes that Illinois Governor Blagojevich signed into law Senate Bill 2880, which "...calls for the restructuring of all aspects of [long-term care] service, including the provision of housing, health, financial and supportive services for older people. It also calls for the development of a Nursing Home Conversion Program to be established by the state departments of Public Health and Public Aid. The program would reduce reliance on nursing homes by Medicaid... Savings from this effort would be reallocated to a broader array of options for home-based or community based services to older adults."

Similarly, on July 19, 2004, in an address to members of the National Governor's Association, Idaho Governor Dirk Kempthorne said "...we should make investments now in community-based care programs. In-home care is simply less expensive than a long-term care facility, and more importantly, it is a far more dignified way of life."

Spousal Impoverishment Protections

Senate Enrolled Act 493 Provisions

Senate Enrolled Act 493 requires the following:

> Section 8. (c) Before September 1, 2003, the office shall seek approval from the United States Department of Health and Human Services to amend the waiver to modify income eligibility requirements to include spousal impoverishment protection provisions under 42 U.S.C. 1396r-5 that are at least at the level of the spousal impoverishment protections afforded to individuals who reside in health facilities licensed under I.C. 16-28.

This provision directs the addition of spousal impoverishment protections to all of Indiana's Medicaid Home and Community-Based Waiver Programs that serve the elderly and disabled (adult) populations. This will ensure that the same spousal impoverishment protections that are offered to nursing home residents are made equally available to married adults who choose non-institutional care services delivered in a community setting.

What Is Spousal Impoverishment and Why Is It Important?

Spousal impoverishment is a term used to describe the financial eligibility requirements of a married couple when one person requires long-term care services normally provided in an institution and the other spouse does not. Prior to 1988, the Medicaid Program required the couple to meet all traditional financial eligibility requirements – namely, to spend down their assets and protect only a small amount of income – before coverage was made available. As a result, the high cost of nursing home care created a circumstance whereby the non-institutional spouse also became impoverished and dependent upon public assistance. This was a devastating life circumstance for many middle-income persons who had never before had to rely on the public welfare system.

When spousal impoverishment protections are not included in the Medicaid Waiver Programs, the financial eligibility criteria for married couples essentially makes community-based care unaffordable.

But then in 1988, Congress mandated that states allow married couples who were faced with separation due to the institutionalization of one spouse to protect a certain amount of assets and income for the non-institutionalized spouse. At that time, spousal protection was also made a state option for Medicaid Home and Community Based Services Waiver Programs, which are designed to serve persons who are at risk of, or who require institutional care.

When spousal impoverishment protections are not included in the Medicaid Waiver Programs, the financial eligibility criteria for married couples essentially makes community-based care unaffordable. Specifically, the spouse of a person who enters a nursing home is allowed to maintain up to $87,000 in assets, while the spouse of a person who prefers to receive services in their own home through a Medicaid Waiver Program may only have combined assets of $3,500. As a result, the couple must divorce to receive Waiver Program services, choose to go without care, or agree to separate so that the spouse can receive care in a nursing home.

In contrast, the inclusion of spousal impoverishment protections within a Waiver Program enables states to level the playing field by protecting spousal income/assets for waiver

participants to the same extent as they do for spouses of Medicaid residents in institutions.[55] As a result, eligibility requirements for persons who are aged and disabled are the same whether they seek to receive care in a nursing facility setting or in a private home or other community residential setting.

Spousal Impoverishment in Indiana

Spousal impoverishment protections were added to the Indiana Medicaid Assisted Living Waiver Program in 2001 and to the Indiana Medicaid Aged and Disabled Waiver in 2003. Spousal impoverishment provisions must still however, be added to the Indiana Medicaid Waiver for Persons with Traumatic Brain Injury.

Logistical Requirements

The late Governor O'Bannon's Commission on Home and Community Based Services (2002 – 2003) addressed long-term care equity issues that included evaluation of the programmatic and fiscal implications of extending spousal impoverishment policy to Indiana's Medicaid Waiver Programs. During those discussions, State staff reported that the addition of spousal impoverishment protections to the Medicaid Traumatic Brain Injury Waiver could be done for little or no additional cost. This is because the Waiver operates under a fixed budget and serves a fairly small number of people (227 in state fiscal year 2004[56]).

In 2003, Indiana state staff reported that the addition of spousal impoverishment protections to the Medicaid Traumatic Brain Injury Waiver could be done for little or no additional cost.

- Therefore, to ensure consistency, fairness, and equity among all of Indiana's Medicaid Waivers, spousal impoverishment protections should be added to Indiana's Medicaid Waiver for Persons with Traumatic Brain Injury. It should also be automatically included with any additional waiver program for the aged and disabled populations (such as adult foster care) that will be developed in the future.

- Implementation requires only the submission of a Medicaid Waiver Amendment, training of Medicaid Waiver Program staff and area agencies on aging, and update of applicable consumer education and outreach materials.

Policy Outcomes and Opportunities

The addition of spousal impoverishment protections to Indiana's Medicaid Aged and Disabled Waiver in 2003 marks one of Indiana's greatest long-term care rebalancing accomplishments in recent years. By extending those financial protections to Indiana's largest elderly and disabled Medicaid Waiver population, Indiana made significant progress in reducing the disparities between nursing home and community-based care by breaking down one of the most significant barriers in Indiana's long-term care service delivery system.

Those protections need now be extended to Indiana's Traumatic Brain Injury Waiver to resolve the issue entirely. In so doing, spousal impoverishment protections that are applied to married couples in Indiana will be the same, regardless of whether the service setting is community-based

or institutional. There is no good policy reason that the Traumatic Brain Injury Waiver should be the only one excluded. Moreover, spousal impoverishment protections are included in most other Medicaid aged and disabled waiver programs throughout the country.

300% Federal Supplemental Security Income Level

Establishing parity between nursing home and community based care.

Senate Enrolled Act 493 Provisions

Senate Enrolled Act 493 explicitly raises the income eligibility standard for aged and disabled Medicaid waiver clients from 100% to 300% of the Federal Supplemental Security Income (SSI) Level. The provision is presented as follows:

> "Section 4. An individual who has resided in the state for at least ninety (90) days shall be eligible for the home and community based long term care services program if the individual...(2) meets the following requirements, which must meet the general eligibility standards for an individual receiving services under a home and community based Medicaid waiver: (A) Has an income of not more than three hundred percent (300%) of the federal Supplemental Security Income level..."

This provision is intended to establish parity between nursing home and community-based care by eliminating financial eligibility differences between the two. The effect of this policy change will be to make community-based and nursing home care equally affordable for Indiana's low-income elderly and disabled populations.

What Is the 300% Supplemental Security Income Issue, And Why Is It Important?

Supplemental Security Income (SSI) is a Federal income supplement program managed by the Social Security Administration and funded by U.S. Treasury general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people who have little or no income by providing monthly cash payments to meet basic needs for food, clothing, and shelter. The basic SSI amount is the same nationwide, however many states, including Indiana, add money to the basic benefit. Persons who receive SSI and have worked and paid into Social Security long enough, may also be eligible for Social Security benefits.

The policy decision regarding the income level at which persons should be made eligible for Medicaid waiver services is one of the most significant issues that impact long-term care rebalancing.

Since 1972, financial eligibility for the joint federal/state Medicaid Program has been linked to Supplemental Security Income. Within broad Federal guidelines, however, states are permitted to raise the income eligibility standard above the minimum SSI level in order to serve more of their low-income citizens.

The 2004 SSI individual benefit of $564 per month, or $846 for a couple, is considered by the Federal government to be "...minimally sufficient to enable recipients to pay for a basic level of ordinary living expenses, such as food, shelter, and clothing."[57] Yet, for many people who depend exclusively on SSI for their income, the $564 per month is not enough to pay for all of their basic living expenses and their health care and prescription drug needs.

The policy decision regarding the income level at which persons should be made eligible for Medicaid waiver services is one of the most significant issues that impact long-term care rebalancing. This is because the 100% SSI income level standard that continues to be used by Indiana in determining Medicaid eligibility creates an unintended consequence – it makes

Waiver, but that the expense is eliminated over time. Regardless of the short-term expense, however, there is no question that savings can be anticipated in the longer-term once more elderly and disabled persons are given the opportunity to receive long-term care services in their own home.

Program savings are, however, dependent upon careful oversight and management of the Medicaid Waiver Program. Additionally, short-term costs will not be eliminated or mitigated if other long-term care state policies continue to favor institutional care over cost-effective care provided in the community.

Logistical Requirements

Implementation of the 300% Supplemental Security Income eligibility standard will require the following actions:

- Availability of the start-up funds needed to cover the state costs associated with removal of a number of existing Aged and Disabled Waiver clients from Medicaid spend down requirements.
- Although Senate Enrolled Act 493 mandates the approval of 20,000 additional Medicaid waiver slots to accommodate the increase in persons who are diverted or who transition out of nursing home care and the other expansions authorized by The Act, the additional waiver slots have not yet been approved by the Centers for Medicare and Medicaid Services.
- A reliable tracking mechanism will need to be developed that can evaluate the policy effects on the three aged and disabled Medicaid Waiver programs and nursing facility resident census, as well as their expenditures.
- A Medicaid State Plan Amendment must be submitted to the Centers for Medicare and Medicaid Services.
- Regulations (405 IAC 2-3-18) will need to be amended in order to establish consistency with the statutory language of Senate Enrolled Act 493. *Similarly, it appears that recently published draft Medicaid Waiver Program rules (LSA Document #03-245) will need to be substantially amended to support and complement the requirements and vision of The Act.*
- Training will be required for Medicaid eligibility staff and area agency on aging case managers.
- Targeted educational outreach will need to be performed for all Medicaid Waiver consumers who will be affected by elimination of a monthly Medicaid spend down.
- Targeted educational outreach will need to be performed for all frail elderly and disabled consumers prior to discharge from an inpatient hospital stay.
- Medicaid Waiver Manuals and other instructional materials will need to be modified.

Policy Outcomes and Opportunities

Implementation of the 300% Supplemental Security Income eligibility standard for the Medicaid Waiver Program will accomplish many of the State's long-term care rebalancing objectives. These include: compliance with Senate Enrolled Act 493; elimination of Medicaid spend down for most low-income aged and disabled individuals already receiving services through the Medicaid Waiver Programs; progress in further breaking down the long-standing institutional bias toward nursing home care by providing Indiana's low-income, frail elderly and disabled

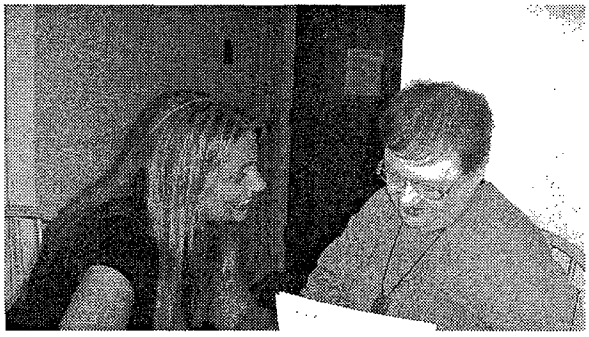
citizens with real choice in what services that they will receive and by whom; establishing policy consistency and equality among all Medicaid Waiver programs; shifting approximately 314 Medicaid spend down[61] waiver clients off of the CHOICE Program, which is paid with 100% state dollars, and onto the Medicaid Program, for which the state pays only 37.22%; and reduction of administrative burdens associated with calculation and oversight of monthly Medicaid spend down amounts for persons who are currently, or would otherwise be in spend down status and eligible for and receiving waiver services.

Unfortunately, until the Supplemental Security Income eligibility policy in Indiana is changed from 100% to 300%, it is impossible to achieve long-term care system rebalancing. This is because consumers who would prefer to and could safely be served in their own homes with some community-based service supports will continue to find nursing home care the only affordable option. The implications of this are threefold. First, frail elderly and disabled persons who would prefer to remain at home for as long as possible will be forced to seek nursing home services (or forego needed services altogether). Second, these individuals will eventually have to sell their home and deplete their assets in order to meet their financial obligations for the expensive institutional care. And finally, the depletion of assets will create a life circumstance whereby the individual has no home to return to, so (s)he will have no living and service option other than nursing home. In other words, once this all-to-common chain-of-events occurs, a nursing home typically becomes the consumer's permanent (and final) place of residence.

Case Study 2 - Moving Home, A Success Story

Mabel's Homecoming – Nursing Home Resident Goes Home after Seven Years

Nursing homes are perceived as "the end of the line." They're where the most fragile of us may find ourselves when we're no longer able to live on our own. For certain people, nursing home placement is appropriate. For others, though, independence – in one's own home – can be possible with just a bit of cost-effective assistance.



CICOA Care Manager Carrie Cross (left) and client Mabel Gamet

Mabel Gamet, 78, of Greenwood, is a former nursing home resident who is celebrating her own personal "homecoming."

"In the nursing home, I got good care. But I felt like if I had to stay there another day, I would die," said Gamet, who now lives on her own in a subsidized apartment after having spent seven years in a nursing home. She says her placement in a nursing home was the result of stress and aggravation of her early onset Parkinson's disease.

Gamet said, "My husband told me, 'I can't take care of you anymore. I'm calling the doctor and putting you in a nursing home.' "

Once there, she had to learn to walk again. Asked about that struggle, she proudly displays an award given to her by the nursing home in 1998 for progress made in her physical therapy. However, a nursing home isn't a rehabilitation hospital. It's not where a person goes to become stronger and Gamet *was* getting stronger – both mentally and physically.

"When I first met Mabel, I thought she was so organized and really knows what she's doing," said Carrie Cross, a CICOA care manager. Gamet called Cross because she'd heard about a fellow resident who was able to leave the nursing home. Gamet didn't know exactly how that was possible, but she made it her mission to find out. Cross went to the nursing home, met with Gamet and told her about a program that would allow her to leave the nursing home.

It didn't take long for Cross to realize that Gamet was the perfect candidate for independent living. She gave Gamet a list of subsidized housing and Gamet made the calls herself. Gamet's doctor signed the necessary paperwork stating that she was fit to leave.

"I felt she was trapped there," said Cross. "It was empowering for her to be able to say, 'I want to go home.' And it was a neat feeling for me to be able to help. It's probably the most rewarding thing I've done in my job."

Together, they moved Gamet into her Greenwood apartment on May 24. She now enjoys her independence and receives all of the services that make living at home possible for her: an emergency response system, home-delivered meals, a home health aide to help with bathing and light housekeeping and a skilled nurse who comes once a week to set up her medication for the week.

"Mabel is so independent. She's on the ball with all of her paperwork. She's made many friends. She goes to activities. She's around people like her," said Cross.

"People in the nursing home didn't think she'd be able to make it on her own after seven years and most people might think the same thing. But, she's educated and very independent. She just had a hard road to go."

Self-Directed Care

Developing care plans that reflect personal wishes and preferences

Senate Enrolled Act 493 Provisions

Senate Enrolled Act 493 requires the development and implementation of a self-directed care model in both the Medicaid Waiver and CHOICE Programs. This provision is presented as follows:

> "Section 5. The state shall provide access to the following long term care services that are appropriate and needed for an individual who is eligible for these services under this chapter: (3) Self-directed care."

A companion requirement is:

> Section 10. (b) Before July 1, 2004, the office shall have self-directed care options services available for: (1) the community and home options to institutional care for the elderly and disabled program established by IC. 12-10-10-6; and (2) a Medicaid waiver; for an eligible individual who chooses self-directed care services.

These provisions establish a service model that will enable Indiana's low-income elderly and disabled clients to self-direct how and by whom they receive their care.

What Is Self-Directed Care and Why Is It Important?

Self-directed care (or consumer-directed care as it is also known) is a service delivery model that gives consumers and/or their families the right and the authority to develop service and support plans that reflect their wishes and preferences and to choose some or all of the following: who will provide their care; training, hiring, and firing of the person selected; service scheduling; purchasing and supervising the service; and possibly directing the payment of personal assistance and other support providers.

The concept of self-direction grew out of the independent living movement during the 1960s and 1970s and has been incorporated in state Medicaid Programs for more than 20 years. One of the largest consumer-directed Medicaid programs in the country is in California, where the program serves around 200,000 annually, 135,000 of which are Medicaid-funded.[62]

Self-directed care is a critical element for Indiana's long-term care service delivery system for three main reasons: (1) because it affords low-income elderly and disabled individuals more control and choice in how and by whom they receive personal care and assistance; (2) because it provides a new recruitment opportunity to grow an otherwise limited pool of low-wage workers; and (3) because it provides additional quality assurance opportunities. Through a self-directed care model, consumers are encouraged to network within their own community to identify family members, friends, fellow churchgoers, or others who may be able and willing to provide them with the personal care that they need to remain safe and independent in the community. It may serve to formalize a care relationship that already exists, to replace a previous personal care arrangement that was not reliable or otherwise satisfactory, or to establish a new relationship where previously there was none.

Although there are many variations in how self-directed care is administered, there are three general service delivery models that states typically follow in establishing a self-directed care program.

- *Direct Pay Model.* A service model whereby the consumer assumes responsibility for all functions. The consumer is the employer of record and handles hiring, firing, training, supervising, and scheduling, and assumes payroll and tax responsibilities. The State of Kansas uses a variation of this model.
- *Fiscal Intermediary Model.* A service model whereby personal care workers are selected, hired, and trained by the consumer, but responsibility for wages, payroll taxes, and worker's compensation insurance are assigned to a state agency or a third-party fiscal intermediary with whom the state contracts. The State of Florida uses a variation of this model through one of the Cash and Counseling Demonstration grants.
- *Cash and Counseling.* A service model whereby personal care workers are selected, hired, trained, and paid for by the consumer with monthly cash payments deposited electronically into participants' bank accounts. A fiscal intermediary is available but not required. Several states use this model through one of the Federal Independent Choices research and demonstration waiver initiatives.

Self-Directed Care in Indiana

In 2002, the Indiana Family and Social Services Administration was awarded a Consumer Personal Assistance Services and Supports (CPASS) grant through the Centers for Medicare and Medicaid Services to assist in the design, development and implementation of a self-directed care program. The grant was coordinated with other federal grants that supported the late Governor O'Bannon's Commission on Home and Community-Based Services (2002 – 2003) and remains funded through today. Work performed through the grant is charged to a CPASS Task Force, which includes consumer and provider representatives, as well as a number of state staff.

Self-direction for consumers had been a focus of Representative Gloria Goeglein for a number of years prior to the time of her death. In her memory, House Bill 1252, which prescribed a design model for self-directed care, was passed in 2002.

Indiana currently offers self-directed care on a limited basis through its state-fund CHOICE Program. It is administered through the sixteen area agencies on aging and serves approximately 100 elderly and disabled individuals.[63]

Self-directed care is not currently available on the Indiana Medicaid Aged and Disabled Waiver but has been approved by the Centers for Medicare and Medicaid Services as a service option within attendant care. The CPASS Task Force is continuing to address structural issues and establish program design parameters. It has developed a Request for Information (RFI) to solicit interest and information regarding a fiscal intermediary function and design. Once the RFI responses are received, the State will develop and issue a Request for Proposal (RFP) to select one or more contractors to serve as fiscal intermediary. A formal timeline for implementation has not been completed.

Administrative rules are in the early stages of the promulgation process. The proposed rule addresses qualifications of the person to be hired as the private attendant, as well as the duties of the fiscal intermediary.

Logistical Requirements

There are several logistical requirements that must be met in order to design a successful self-directed care model that can be implemented on a broad-scale through Indiana's CHOICE and Medicaid Waiver Programs. These include:

- Amend the Medicaid Aged and Disabled Waiver to remove self-directed care from the definition of attendant care and to add self-directed care as a separate service.
- Design program parameters that assign consumer, fiscal intermediary, area agency on aging, and state responsibilities.
- Promulgate a rule to address fiscal intermediary and time record needs for the fiscal intermediary and consumer.
- Develop the program infrastructure that will support payment to and from a fiscal intermediary. This will require start-up money to ensure adequate cash flow.
- Educate and provide Universal Precautions for consumer and provider training.
- Develop consumer outreach materials that can be used to generate interest and participation.
- Assess and, if necessary, implement system changes.
- Amend the Medicaid Aged and Disabled and Traumatic Brain Injury Waiver Programs that serve elderly and disabled persons to include self-directed care as a separate service option (Self-directed care does not apply to the Medicaid Assisted Living Waiver).
- Modify, if necessary, I.C. 12-10 in order to add sufficient flexibility to accommodate operation of the self-directed care model.

Policy Outcomes and Opportunities

In addition to the specific provisions of Senate Enrolled Act 493, development and implementation of self-directed care was a high priority of Governor O'Bannon's Commission on Home and Community Based Services and is included as a priority Action in the Commission's June 30, 2003 Report. It is also addressed in "Indiana's Comprehensive Plan for Community Integration and Support of Persons with Disabilities" (FSSA June 1, 2001), and in House Enrolled Act 1252 (2003).

Implementation of a self-directed care initiative within the Indiana Medicaid Waiver Programs can be expected to accomplish a number of long-term care rebalancing objectives. Specifically, a successful self-directed care program can be expected to grow the pool of personal care workers, improve employment retention rates for persons already serving as personal care workers, reduce unnecessary institutionalizations, and most importantly, improve consumer health outcomes and quality of life. Finally, implementation of a self-directed care program helps to satisfy some of the State's objectives in meeting the requirements of the Federal *Olmstead* decision.

Program Success in Arkansas

Some states with established Medicaid-funded self-directed care programs include: Alaska, Arkansas, California, Colorado, Florida, Michigan, New Jersey, New York, and Oklahoma.

The national Cash and Counseling Demonstration and Evaluation Program uses a randomized design to compare an innovative model of consumer direction with the traditional agency-directed

approach. Arkansas, the first state in which the Cash and Counseling Program was implemented, designed IndependentChoices as a voluntary demonstration project targeted to adults who were eligible for personal care services. In this model, consumers were divided into two groups: a treatment group that would receive a monthly allowance to be spent on personal care services; and a control group that would receive personal care services from a traditional agency.

Findings from the Cash and Counseling evaluation revealed that the vast majority of Medicaid enrollees who were given the opportunity to direct their own personal care services using a cash allowance hired a family member or friend to perform the services and indicated a higher quality of life, greatly-improved satisfaction, were more likely to get the services for which they were entitled, and were able to receive significantly more personal care services at no greater net costs to the Medicaid Program.

Treatment group participants worked with an IndependentChoices counselor to develop written plans for spending their allowance, and to receive assistance and/or training in recruiting, training, and supervising workers. The allowance could be used to hire personal care workers, and to purchase other services or goods related to their needs, such as supplies, assistive devices, and home modifications. They were required to keep receipts for most of their purchases. Consumers were given the choice to maintain their own bank accounts, write checks, and handle their own taxes, but most chose to assign this responsibility to a fiscal agent.

The U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation supported Mathematica Policy Research, Inc. in conducting an evaluation of the Arkansas Cash and Counseling Demonstration and Evaluation. Findings from that evaluation revealed that the vast majority of Medicaid enrollees who were given the opportunity to direct their own personal care services using a cash allowance hired a family member or friend to perform the services and indicated a higher quality of life, greatly-improved satisfaction, were more likely to get the services for which they were entitled, and were able to receive significantly more personal care services at no greater net costs to the Medicaid Program.[64]

Adult Day Care Services

Senate Enrolled Act 493 Provisions

Senate Enrolled Act 493 requires the following:

> "Section 5. The state shall provide access to the following long term care services that are appropriate and needed for an individual who is eligible for these services under this chapter: (6) Adult day care services."

This provision provides for the formal development and incorporation of adult day care services within the array of long-term care services that are needed to safely support the health care, social, and support needs of low-income elderly and disabled Hoosiers and their families in a community-based setting.

What Is Adult Day Care and Why Is It Important?

Adult day care, or adult day services, are community-based, group day-time programs that include health, therapy and social services furnished in an outpatient setting on a regular basis for one or more days a week. Many centers also offer consumers and their families assistance with transportation either at no charge or based on trip or mileage.

Adult day care services are normally customized to meet each consumer's needs. It provides a unique opportunity for both consumers and their families; consumers are able to receive needed health monitoring and care and/or supportive social interaction on a regular basis, while spouses and other family members who are primary caregivers are given the opportunity to work outside the home or to receive occasional respite care.

Adult day care has been in existence for more than twenty years, and has grown to around 4,000 centers nationwide.[65] According to a national survey of adult day care service providers, 35% of all adult day care center participants live in the home of a child, 20% live with a spouse, and 11% live alone.[66]

Adult day care is provided through one of three models:

- A medical model that provides more intensive health care, including therapies, nursing, and personal assistance, and social services for persons with more intense medical needs and who are at risk of institutionalization.
- A social model that provides primarily social activities, but also includes meals, recreation, and some health-related services.
- Alzheimer's specific adult day care that provides health and social services only to persons with Alzheimer 's disease or other forms of dementia.

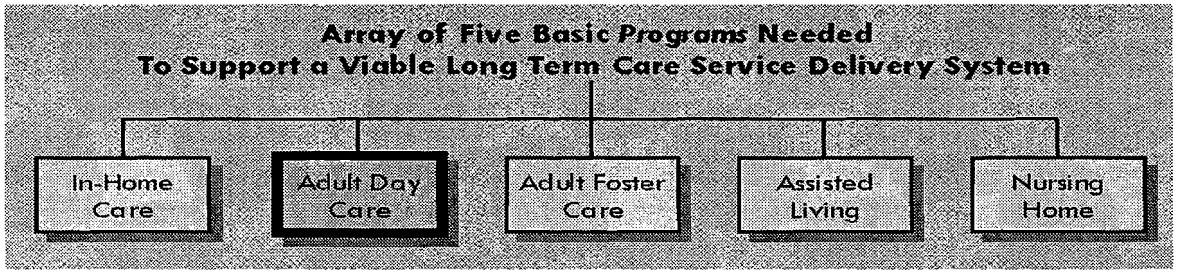
Daily fees vary by center and by service model, but the average daily cost throughout the country is approximately $56 per day. This is normally less than the cost of a home care visit and about half the cost of a nursing home.[67] Adult day services may be funded through the consumer's private funds, health insurance, long-term care insurance, or through Medicaid. For consumers who pay privately, many centers offer services on a sliding fee schedule based on income.

The vast majority of adult day centers (78%) operate on a not-for-profit basis[68]. Thirty percent of all adult day centers nationwide are free-standing facilities, while the other 70% operate under a parent organization, such as a nursing home, senior service organization, hospital, residential care facility, religious organization, etc.[69]

Like respite care, adult day care is an essential component of a family caretaker support program. The Medicaid Home and Community-Based Services Waiver program is permitted to include adult day care services and respite care, but it cannot fund family caretaker support services. All three are essential for supporting and sustaining the unpaid caregiver in the prominent role that (s)he plays within the long-term care service delivery system.

Graph 1 below presents the array of five basic programs needed to support long-term care rebalancing. The first two, in-home and *adult day care*, represent the two complementary programs that promote the delivery of services in an individual's own home within the community. *Adult day care* provides a necessary in-home support by delivering health and supportive services and social activities on an occasional or regular basis in a community setting outside the individual's home. Adult day services help to maintain the individual's present level of functioning for as long as possible, preventing or delaying further deterioration, and provide a key support role to caretakers who are employed outside the home or who need occasional respite. For those reasons, adult day care services contribute significantly to support in-home care within the array of long-term care services. The third and fourth boxes represent adult foster care and assisted living, which are the two community residential service options within a non-institutional community care setting. And finally, the fifth box represents nursing home care, which is the primary institutional service for people who are elderly and for people of any age who have physical disabilities and for whom alternative long-term care options may not be available.

Graph 1



Adult day care services are an important option for all elderly and disabled people, not only those with low-income. By introducing a combination of healthcare and social services, adults with mental and/or physical impairments may maintain or improve their level of functioning in order to remain in the community. Adult day care services may contribute to an individual's overall quality of life and level of independence, while also preserving the economic status of their families.

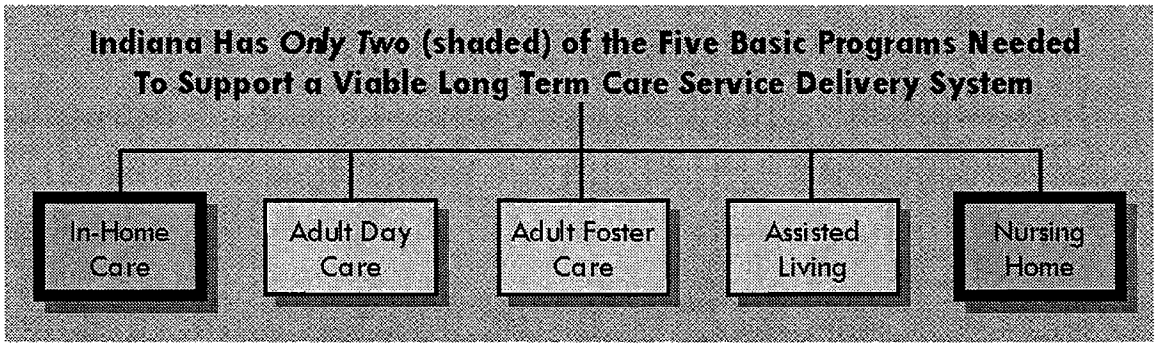
Adult Day Care Services in Indiana

Adult day services are available only on a limited basis throughout Indiana.

Of the five long-term care service settings needed to support a full array of long-term care service options, Indiana has available only two on a statewide basis: in-home care and nursing home care. (Please see Graph 2 below) Of the two, nursing home services are automatically available to all eligible Hoosiers, while services provided in a consumer's own home, and to consumers in an adult day care settings, are available only on a limited basis and may require placement on a waiting list for an extended period of time. Therefore, even though nursing home care is the most expensive long-term care service option, it is fully funded while in-home care and community residential services are not. This does not make good fiscal sense and is in direct contrast to the policies of other states such as Colorado, Oregon, and Washington, which make community-based services and nursing home services equally available to all eligible consumers.

Like adult day care, adult foster care and assisted living are technically included as service options within Indiana's Medicaid Aged and Disabled Waiver, but they are available only on an extremely limited basis and collectively serve only a small number of persons.

Graph 2



In order to improve consumer outreach, availability and access of non-institutional long-term care service options, the late Governor O'Bannon's Commission on Home and Community-Based Services (2002 – 2003) evaluated adult day services specifically. The Commission determined that much still needs to be done to expand adult day services in Indiana, and formally addressed it as one of eight primary long-term care actions targeted within its June 30, 2003 Report. At the time that the Report was published, there were 68 adult day centers located mostly in urban areas that served 26 of Indiana's 92 counties.[70] Only 48% of available services are utilized, despite a projection by the Robert Wood Johnson Foundation that Indiana has only 35% of its adult day care needs met and needs 119 more centers to fully address Indiana's adult day care service needs.

Logistical Requirements

Governor O'Bannon's Commission developed a number of logistical requirements for further developing adult day care within Indiana's array of long-term care services and supports. These are repeated here since little progress has occurred since the publication of its June 30, 2003 report.

Adult day services should become a targeted service within Indiana's long-term care service delivery system, not only for consumers who receive public assistance, but also for consumers who are able to pay privately. The targeting effort should include:

- Development of a written marketing/development plan that includes a plan to increase utilization within the CHOICE and Medicaid Waiver Programs;
- Development of educational materials and outreach to consumers and referral sources;
- Development of enhanced orientation and training for adult day services staff;
- Exploration and implementation of successful models of rural home and community-based service delivery models for potential replication.

The cost of expanding adult day services in Indiana are minimal, since adult day services are currently available through the CHOICE Program and through the Medicaid Waiver Programs and are funded within budget amounts already established for Program participants. Program and service expansion costs will be borne primarily by adult day service providers who are effectively and productively engaged in a collaborative partnership with the State.

Policy Outcomes and Opportunities

Successful implementation of adult day care services within Indiana's long-term care service delivery system will assist the State in accomplishing a number of objectives, including compliance with Senate Enrolled Act 493, the *Olmstead* decision, and "Indiana's Comprehensive Plan for Community Integration and Support of Persons with Disabilities" (FSSA June 1, 2001).

Development of a viable adult day care service delivery system throughout the State is essential for improving the opportunity for low and higher-income consumers to live safely and independently in the community. It will provide another opportunity to support family caretakers who struggle to find support for their loved ones and to maintain their own employment. Moreover, expanded adult day services can be expected to provide fiscal benefit to both the providers and the State as increased adult day service availability and utilization can be expected to grow less expensive community service options while further reducing hospital visits and admissions and nursing home care.

Targeted growth of this provider base may appeal to nursing facility and hospital providers who are considering a service shift to non-institutional forms of care.

Many states include adult day care services within their Medicaid Home and Community-Based Services Waiver Programs. Adult day service providers must typically be licensed or certified to participate, and services are available normally within the area of other long-term care services offered through their waiver programs, rather than as a separate Medicaid Waiver Program. California, however, has provided an adult day health care program as a State Medicaid Plan benefit since 1978. It is now working with the Centers for Medicare and Medicaid Services as

part of its Medicaid Program (Medi-Cal) redesign initiative to convert the program to a separate Medicaid Home and Community-Based Services Waiver.

Adult Foster Care

Senate Enrolled Act 493 Provisions

Senate Enrolled Act 493 requires:

> "Section 5. The state shall provide access to the following long term care services that are appropriate and needed for an individual who is eligible for these services under this chapter: (5) Adult foster care."

This provision is intended to establish an adult foster care program within Indiana's long-term care delivery system.

What Is Adult Foster Care and Why Is It Important?

Adult foster care, or adult family care as it is also known, is a community residential services option that provides both affordable and accessible housing and necessary healthcare services in a small, family-like setting. It is an especially important service option within any state's long-term care service delivery system. This is because adult foster care (like assisted living) provides an essential placement alternative for consumers who are no longer able to remain in their own homes but who do not desire nursing home services, and for persons who are transitioning out of nursing homes and who no longer have a home in which to return.

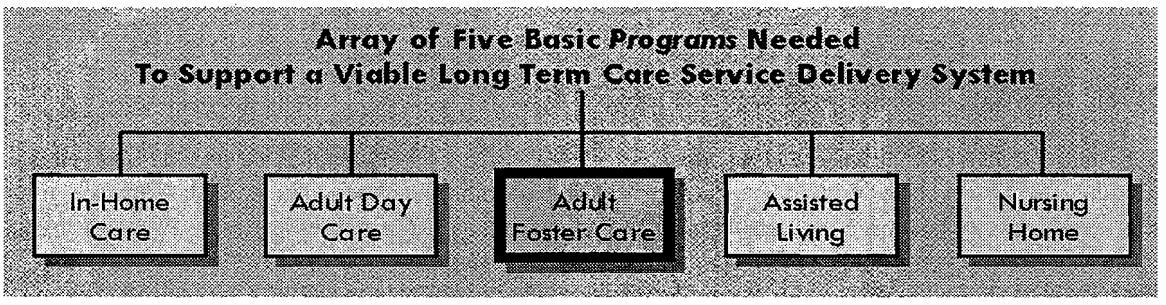
There is no common adult foster care definition among states. It is generally defined in Indiana as any family home or other facility in which residential care is provided in a home-like environment for compensation to three or fewer elderly persons or adults with physical and/or cognitive disabilities who are not related to the provider. The owner normally lives in the same house as the residents and oversees the provision of services and supports. Services include: room and board; meals; supervision; personal care; homemaker; chore; attendant care and companion services; and medication oversight (to the extent permitted under state law).

Regulation and licensure of adult foster care services also varies greatly among states. When regulated by state law, adult foster care may be identified and licensed as a separate service, or as a service within a broader assisted living or community-based service or provider category. When not regulated at the state level (as in Indiana), adult foster care services may be provided through Medicaid Home and Community Based Services Waivers only if the services are governed by provider certification standards that are specifically established for the Waiver Program and are promulgated in state Medicaid Program regulation. Funding for adult foster care may come from private paying residents, state programs for the elderly and disabled, and/or Medicaid through the Medicaid Home and Community Based Services Waiver Programs. Medicare does not cover adult foster care.

Adult foster care is a community residential services option that provides both affordable and accessible housing and necessary healthcare services in a convenient, apartment-like setting. It is an especially important service option within any state's long-term care service delivery system. This is because adult foster care (like assisted living) provides an essential placement alternative for consumers who are no longer able to remain in their own homes but who do not desire nursing home services, and for persons who are transitioning out of nursing homes and who no longer have a home in which to return.

Graph 3 presents the array of five basic programs needed to support long-term care rebalancing. The first two, in-home and adult day care, represent the two complementary programs that promote the delivery of services within an individual's own home within the community. The third and fourth boxes represent *adult foster care* and assisted living, which are the two residential or supportive housing options within a non-institutional community care setting. The fifth box represents nursing home care, which is the primary institutional service for people who are elderly and for people of any age who have physical and/or cognitive disabilities and for whom alternative long-term care options may not be available.

Graph 3



Adult foster care can be offered by states through either or both of two channels: as a *service* option offered through a broader Medicaid Home and Community-Based Services Waiver; and/or as a unique *program* within a targeted Medicaid Home and Community-Based Services Waiver. The distinction between the two is considerable and has significant implications for the success of adult foster care in Indiana.

The existence of affordable and accessible adult foster care and assisted living services is especially critical as states develop programs designed to successfully transition nursing home residents back into the community. It is, in fact, the lack of housing with services options such as adult foster care and assisted living that severely hinders the ability of Indiana and other states to transition low-income nursing home residents back into a community setting and prevents consumers from reclaiming some form of community life after institutionalization. Transitioning programs have gained significant momentum in recent years as states struggle to meet their *Olmstead* and state-directed long-term care service initiatives. Furthermore, recognition of these *Olmstead*-related state responsibilities by the Centers for Medicare and Medicaid Services led to the approval in May 2002 of federal funding specifically dedicated to assist states in paying for one-time basic living expenses that are not normally covered by the Medicaid Program solely to assist in the transitioning of nursing facility residents back into the community.

And finally, it is important to note here that all states that are heralded for their "Best Practices" in providing long-term care services to low-income elderly and disabled populations depend on both adult foster care and assisted living as critical components within the array of available long-term care options. Examples of these states include but are not limited to: Colorado, Maine, Oregon, Texas, and Washington.

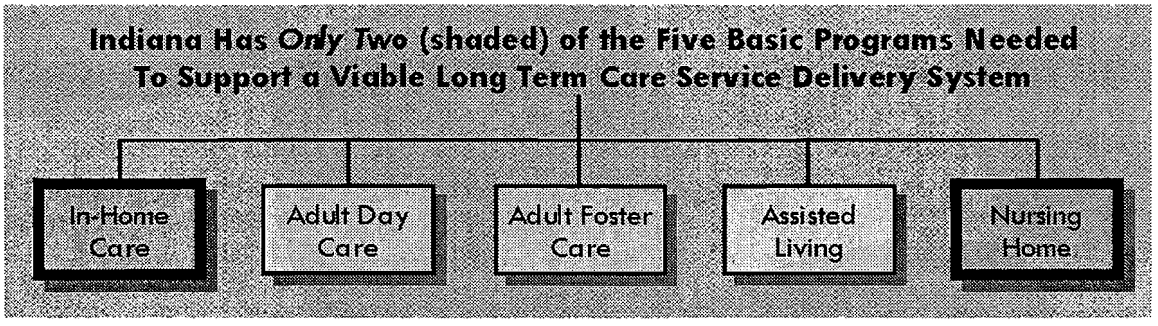
Adult Foster Care in Indiana

Indiana has no formally-established adult foster care provider base. There are reports of a small number of persons in the community who provide adult foster care-like services to private-pay individuals. However, there are no regulatory requirements for disclosure, reporting, licensure, survey, or oversight of these persons.

Of the five long-term care service settings needed to support a full array of long-term care service options, Indiana has available only two on a statewide basis: in-home care and nursing home care. (Please see Graph 4 below) Of the two, nursing home services are automatically available to all eligible Hoosiers, while services provided in a consumer's own home are available only on a limited basis and may require placement on a waiting list for an extended period of time. Therefore, even though nursing home care is the most expensive long-term care service option, it is fully funded, while in-home care and community residential services are not. This does not make good fiscal sense and is in direct contrast to the policies of other states such as Colorado and Oregon, which make community-based services and nursing home services equally available to all eligible consumers.

Like adult day care, adult foster care and assisted living are technically included as service options within Indiana's Medicaid Aged and Disabled Waiver, but they are available only on an extremely limited basis and collectively serve only a small number of persons.

Graph 4



The Indiana Medicaid Aged and Disabled Waiver currently has no consumers who utilize adult foster care and no providers enrolled to participate. This is partly due to the absence of a formal adult foster care provider presence in Indiana, but mostly to the lack of resources dedicated to development of an adult foster care program. Furthermore, since limited Medicaid Waiver slots are allocated on a statewide basis, there is no real opportunity to identify and match two or three consumers in one area with one adult foster care provider. As a result, the adult foster care service option is not likely to ever be utilized except in the rare circumstance where a consumer who receives a Waiver slot is able to identify a family member, friend, or relative who is willing and qualified to serve as an adult foster care provider and participate in the Medicaid Waiver Program, or when a consumer already lives in a privately-funded adult foster care home prior to becoming eligible for Medicaid and who is then able to negotiate a special arrangement with his/her adult foster care provider to remain in the home despite depletion of the consumer's personal finances.

Logistical Requirements

The only way that Indiana can add adult foster care services to its long-term care service delivery system is to develop the program from the ground-up. And while this seems to be a daunting assignment, this is exactly the approach taken by other states, including Washington, Oregon, and Texas. State policymakers and staff in those states have become so adept at adult foster care program development that they make themselves available as a resource to other states, both in an on-site capacity and by providing technical support over the telephone.

Adult foster care is widely accepted nationally as a necessary service option within a state's long-term care service delivery system. Nevertheless, the market in Indiana has not yet been developed. As a result, Indiana (like other states before it) faces a number of challenges. It must develop certification or licensure requirements, build a qualified provider base, build a consumer base, and establish a solid and reliable infrastructure that takes a "hands-on" approach throughout the design, development, implementation, and post-implementation phases.

Adult foster care also requires a dedicated quality assurance investment and approach like that developed for other community-based care programs. Carefully-designed quality assurance supports must include a targeted adult foster care Medicaid Waiver Program certification process that includes clear and comprehensive provider standards, on-site inspections of the physical home, frequent evaluations of consumers in the adult foster care setting, opportunities to collect and compile consumer feedback, and the authority to impose sanctions and corrective action plans for compliance failures. It is also important for these quality assurance functions to be supplemented by dedicated Adult Protective Services and State Long-Term Care Ombudsman staff.

There is, in fact, great need to formally develop an adult foster care program in Indiana. In 2001, Indiana ranked 10th highest among states in total number of nursing facility residents, and ranked 7th highest in the percentage of nursing facility residents as a percentage of the total population age 65 and over – 5.6%, compared to a national average of only 4.2%.[71] Moreover, 36.3% of all nursing facility residents in Indiana were classified according to the lowest levels of resource need.[72]

In 1999, the American Association of Retired Persons and the Indiana Home Care Task Force hired a nationally-recognized expert in adult foster care and long-term care service delivery, Mr. Richard Ladd, to develop an adult foster care implementation plan for Indiana's Medicaid-eligible aged and disabled population[73]. In summary, Mr. Ladd recommended that Indiana initiate a nine-month planning phase dedicated to adult foster care program development, and then implement a six month pilot in one geographic area before expanding the program statewide over a three-year period. Some of the logistical requirements would include the following:

- Timelines for planning and implementation will need to be established. Because of the complexities in designing and developing an adult foster care program, a pilot approach is recommended before expanding the program to go statewide.
- Determination of the types of residential services to be offered.
- Definition of the target population (i.e. elderly and physically disabled adults)
- Determination of the number of people to be served by geographic area.
- Determination of the number of providers needed.
- Determination of a funding source and cost-share formula.

- Design of the administrative structure, including the establishment of management (including data collection, analysis, and reporting), oversight, and quality assurance functions.
- Design of the field structure, including specialized case management, oversight, and quality assurance functions.
- Financial eligibility requirements will need to include 300% Supplemental Security Income standard.
- A multi-tiered reimbursement methodology based on 3 to 5 levels of care will be required.
- Determination of waiting list management and priority.
- An assessment and reassessment process and specialized case management (how performed, by whom, and caseload/number of staff needed) will need to be established.
- A unique quality assurance structure and process will be required. The quality assurance structure must fill the regulatory void with a unique certification process that includes clear and comprehensive provider standards, on-site inspections of the physical home, frequent evaluations of consumers in the adult foster care setting, and the authority to impose sanctions and corrective action plans for compliance failures.
- Quality assurance functions must be supplemented by dedicated Adult Protective Services and State Long-Term Care Ombudsman staff.
- Provider standards, administrative structure, and all certification requirements must be promulgated in administrative rule.
- A consumer marketing and recruiting approach must be developed and implemented.
- Staffing needs for development, implementation, and operation must be evaluated and then funded.
- Based on the established design parameters, a dedicated program within the Medicaid Aged and Disabled Waiver, or a new standalone Medicaid Home and Community-Based Services Waiver targeted to Adult Foster Care will need to be drafted and submitted for approval to the Centers for Medicare and Medicaid Services.

There is no doubt that development of an adult foster care program is a monumental and resource-intensive task, but one that is essential and invaluable in meeting the housing and service needs of persons who are elderly and disabled. It is important to note that the enormity of development and implementation has not deterred other states from moving forward. By 1996, 26 states reported that they had adult foster care programs that included older persons as residents[74].

An adult foster care program offers a realistic and cost-effective solution for state long-term care systems, as well as a flexible long-term care service option that can be used to support the changing needs of consumers in a community residential setting. Moreover, there is a wealth of experience in other states that can be tapped to facilitate a solid program design, with reasonable growth, and with safe and effective program administration and monitoring.

Policy Outcomes and Opportunities

Development of an adult foster care program was extensively studied by the late Governor O'Bannon's Commission on Home and Community Based Services (2002-2003) and was included in the Commission's June 30, 2004 Report (pages 36-37) as one of eight primary action steps assigned to the Indiana Family and Social Services Administration. The Commission considered the lack of publicly-funded adult foster care to be one of the most significant obstacles that Indiana faces in shifting the balance of long-term care service delivery in Indiana away from

institutional forms of care and toward less costly and more desirable care provided in the community.

Development and implementation of a viable adult foster care program within the Indiana Medicaid Waiver Programs can be expected to accomplish a number of long-term care rebalancing objectives. Specifically:

- Adult foster care will provide a new residential services option that does not presently exist;
- It will introduce a new affordable and accessible housing option that is desperately needed to meet the needs of Indiana's low-income elderly and disabled population;
- It will significantly expand placement options for transitioning nursing home residents back into the community;
- It will generate per person savings over time;
- It will grow the number of long-term care providers available to provide needed community-based services in the State;
- It will reduce unnecessary institutionalizations; and
- Most importantly, it will improve consumer health outcomes and quality of life.

Finally, implementation of an adult foster care program helps to satisfy some of the State's objectives in meeting the requirements of the *Olmstead* decision and to positively respond to the objectives presented in Indiana's Comprehensive Plan for Community Integration and Support of Persons with Disabilities (Indiana Family and Social Services Administration, June 1, 2001).

Program Success in Washington

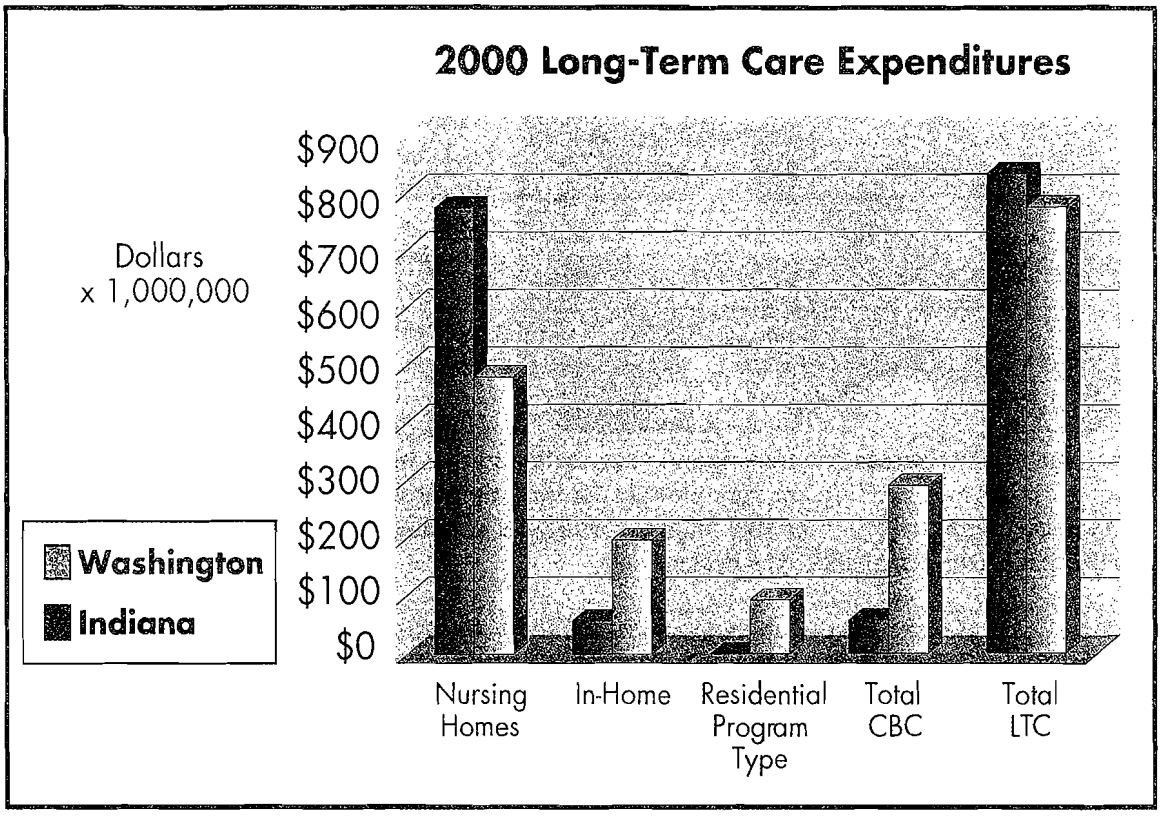
The State of Washington may be effectively compared with the State of Indiana since both share a number of characteristics that are relevant to long-term care services. Among other things, both states share a similar percentage of people age 65 and older who have disabilities and who live below the Federal Poverty Level, and both share a similar overall funding commitment for long-term care services.

Unlike Indiana, however, the State of Washington has in recent years invested heavily in expanding community-based services. Washington has invested heavily in in-home care, adult foster care, and assisted living in an effort to substantially reduce reliance on nursing homes.

Figure 5 on the following page provides a spending comparison between Indiana and Washington on long-term care services.[75] The dollars are in millions and are based on fiscal year 2000 expenditures. "CBC" refers to community-based care, and "LTC" refers to long-term care.

Figure 5 contrasts Indiana's significant investment in nursing home services with Washington's significant investment in community-based services. Moreover, Washington's community-based services include in-home care, adult foster care, and assisted living that are available to all eligible Medicaid consumers, while Indiana's community-based services primarily include only in-home care that is available to consumers on a limited basis only. Indiana has had little success with assisted living and has no adult foster care program.

Figure 5



Washington has for the past several years received national acclaim for its commitment to long-term care rebalancing, but especially for its success in developing and operating adult foster care and assisted living services through its Medicaid Home and Community-Based Services Waiver Program. Both of these community residential services provide desperately needed services with an affordable and accessible housing option for persons who are no longer able to remain in their own homes. Without an adult foster care and assisted living option, long-term care rebalancing cannot be achieved.

Case Study 3 - The choice to live at home

Since September of 1998, Bernie Nahrwold has been a client of Aging & In-Home Services (AIHS). She receives help through Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE). The help she has received has enabled her to remain in the home of her choice for the past several years.

Nahrwold's primary caregiver is her husband Bob. Recently, Bob has suffered some health ailments of his own, and the services the couple receives from AIHS have become much more important. "Bob takes very good care of me, but I also appreciate the help that comes in," Bernie said.

Through funding from the CHOICE program, the Nahrwolds benefit from a home health aide six hours a week and from a home aide for four hours a week. "We are very grateful for the help that we get," said Nahrwold. The health aide helps Bernie with things like bathing, while the home aide provides Homemaker services and helps to keep the Narhwold's home clean.

According to Bernie, she is very appreciative of the help she receives that enables her to stay at home. "I am very grateful, it helps Bob so much, especially now," she said.

The Narhwold's have two grown sons that are married, and have five grandchildren. The couple looks forward to time with family and is already excited about the upcoming holidays when everyone will be together.

Faith is something that has been very important to Bernie throughout her life. "The things I have accomplished, I have accomplished because of God," she said. "I always appreciate prayers."

"With the help I've received, I've had an amazing life."

"We consider it a success when people have been allowed to live out their lives at home due to in home services," said Diann Shappell, president of AIHS of Northeast Indiana. "This is a public policy issue of do we value the people who are in need? Does our society value that individual? Should our CHOICE and Medicaid dollars buy the best financial deal for taxpayers? With in-home services the answer in all cases is yes."

Assisted Living

Senate Enrolled Act 493 Provisions

Senate Enrolled Act 493 requires that the State make available assisted living services.

> "Section 5. The state shall provide access to the following long term care services that are appropriate and needed for an individual who is eligible for these services under this chapter: (4) Assisted living."

This provision is intended to establish a publicly funded assisted living program that will safely and cost-effectively meet the growing needs of Indiana's low-income elderly and disabled populations.

What Is Assisted Living and Why Is It Important?

While assisted living programs and regulatory requirements vary significantly among states, the Assisted Living Workgroup, established by the U.S. Senate Special Committee on Aging, developed the following general definition[76].

> "Assisted living is a state-regulated and monitored residential long-term care option. Assisted living provides or coordinates oversight and services to meet the residents' individualized scheduled needs, based on the residents' assessments and service plans and their unscheduled needs as they arise.
>
> Services that are required by state law and regulation to be provided or coordinated must include but are not limited to:
>
> - 24-hour awake staff to provide oversight and meet scheduled and unscheduled needs
> - Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
> - Health related services (e.g. medication management services)
> - Social services
> - Recreational activities
> - Meals
> - Housekeeping and laundry
> - Transportation
>
> A resident has the right to make choices and receive services in a way that will promote the resident's dignity, autonomy, independence, and quality of life. These services are disclosed and agreed to in the contract between the provider and resident. Assisted living does not generally provide ongoing, 24-hour skilled nursing."

Assisted living has been an expanding industry over the past several years, with the number of people using assisted living services having grown by nearly fifty percent between 1991 and

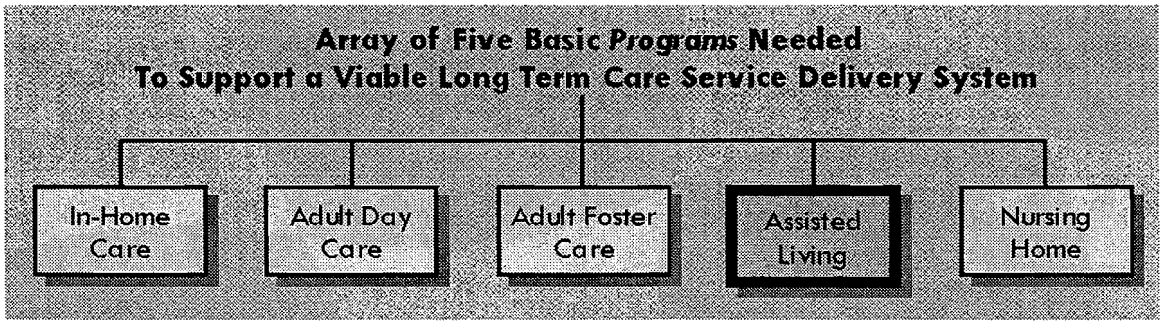
1999.[77] It holds particular appeal for persons who can no longer safely remain in their own homes but who do not seek the services of an institution. It currently, however, remains primarily a private market catering to persons of middle and upper incomes.

Regulation and licensure of assisted living services also varies greatly among states. When regulated by state law, assisted living may be identified and licensed as a separate service, or as a service within a broader community-based service or provider category. When not regulated at the state level, assisted living services may be provided through Medicaid Home and Community Based Services Waivers only if the services are governed by provider certification standards that are specifically established for the Waiver Program and are promulgated in state Medicaid Program regulation. Funding for assisted living may come from private paying residents, state programs for the elderly and disabled, and/or Medicaid through the Medicaid Home and Community Based Services Waiver Programs. Medicare does not cover assisted living.

Assisted living is a community residential services option that provides both affordable and accessible housing and necessary healthcare services in a convenient, apartment-like setting. It is an especially important service option within any state's long-term care service delivery system. This is because assisted living (like adult foster care) provides an essential placement alternative for consumers who are no longer able to remain in their own homes but who do not desire nursing home services, and for persons who are transitioning out of nursing homes and who no longer have a home in which to return.

Graph 5 below presents the array of five basic settings needed to support long-term care rebalancing. The first two, in-home and adult day care, represent the two complementary settings that promote the delivery of services within an individual's own home within the community. The third and fourth boxes represent *assisted living* and adult foster care, which are the two residential or supportive housing options within a non-institutional community care setting. Assisted living provides a combined housing with services option that does not presently exist for Indiana's low-income elderly and disabled populations. And finally, the fifth box represents nursing home care, which is the primary institutional service for people who are elderly and for people of any age who have physical disabilities and for whom alternative long-term care options may not be available.

Graph 5



Federal regulations authorize states to develop Medicaid-funded assisted living programs as a State Medicaid Plan option, and through its Medicaid Home and Community-Based Services Waiver Programs. When offered through the Medicaid Waiver Programs, assisted living may be included as a service within another adult waiver program, or as a separate, or stand-alone, waiver

that specifically targets eligible consumers who seek assisted living services and assisted living providers who are willing to participate in the program.

The existence of affordable and accessible assisted living and adult foster care services is especially critical as states develop programs designed to successfully transition nursing home residents back into the community. It is, in fact, the lack of housing with services options such as assisted living and adult foster care that severely hinders the ability of Indiana and other states to transition low-income nursing home residents back into a community setting and prevents consumers from reclaiming some form of community life after institutionalization. Transitioning programs have gained significant momentum in recent years as states struggle to meet their *Olmstead* and state-directed long-term care service initiatives. Furthermore, recognition of these *Olmstead*-related state responsibilities by the Centers for Medicare and Medicaid Services led to the approval in May 2002 of federal funding specifically dedicated to assist states in paying for one-time basic living expenses that are not normally covered by the Medicaid Program solely to assist in the transitioning of nursing facility residents back into the community.

And finally, it is important to note here that all states that are heralded for their "Best Practices" in providing long-term care services to low-income elderly and disabled populations depend on both assisted living and adult foster care as critical components within the array of available long-term care options. Examples of these states include but are not limited to: Colorado, Maine, Oregon, Texas, and Washington.

Assisted Living Services in Indiana

Indiana does not define assisted living specifically, but does offer a regulatory and licensure process for residential care facilities and includes them in a broader definition of "housing with services establishment", which is defined in Indiana Code 12-10-15-3 as follows:

> Sec. 3. (a) As used in this chapter, "housing with services establishment" means an establishment providing sleeping accommodations to at least five (5) residents and offering or providing for a fee: (1) at least one (1) regularly scheduled health related service; or (2) at least two (2) regularly scheduled supportive services; whether offered or provided directly by the establishment or by another person arranged for by the establishment. (b) The term does not include the following: (1) A comprehensive care facility licensed under IC 16-28-2. (2) A hospital licensed under IC 16-21. (3) A group home licensed under IC 12-17.4 or IC 12-28-4. (4) An establishment that serves as a shelter for battered women or other similar purpose. (5) Private homes in which the residents are related by kinship, law, or affinity with the person offering the services. (6) An organized condominium, cooperative, common interest community, or owner's association where at least eighty percent (80%) of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units.

There are 250 providers in Indiana that meet the definition of housing with service establishment (Indiana's broad assisted living definition)[78]. Of these, 140 are licensed as residential care facilities (410 IAC 16.2) with a capacity to serve 11,555 people[79] but who cater primarily to consumers and families who can afford to pay privately.

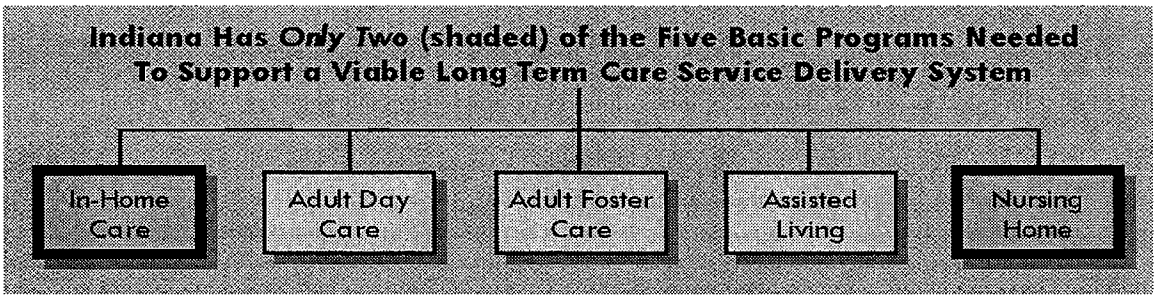
Despite having a significant commercial presence in Indiana, assisted living services are not widely available to Indiana's low-income elderly and disabled populations. Indiana's Medicaid Assisted Living Waiver was developed in 2001, but it serves only 71 consumers with 12 certified

providers.[80] The program has not yet been fully developed and is not available statewide. This is due primarily to the lack of administrative resources dedicated to development of this program, and not to lack of funding since the program was fully funded during the initial development and implementation stages. Originally targeted to serve 2,250 consumers within three years, the Waiver was recently renewed for an additional five years with approval to serve only 400 people. This reduction in program scope directly conflicts with the provisions of Senate Enrolled Act 493.

Of the five long-term care service settings needed to support a full array of long-term care service options, Indiana has available only two on a statewide basis: in-home care and nursing home care. (Please see Graph 6) Of the two, nursing home services are automatically available to all eligible Hoosiers, while services provided in a consumer's own home are available only on a limited basis and may require placement on a waiting list for an extended period of time. Therefore, even though nursing home care is the most expensive long-term care service option, it is fully funded while in-home care and community residential services are not. This does not make good fiscal sense and is in direct contrast to the policies of other states such as Colorado and Oregon, which make community-based services and nursing home services equally available to all eligible consumers.

Like assisted living, adult day care and adult foster care are included as service options within Indiana's Medicaid Aged and Disabled Waiver, but they are available only on an extremely limited basis and collectively serve only a small number of persons.

Graph 6



This limited application of assisted living facility services within the Indiana Medicaid Waiver Programs significantly hinders the State's ability to offer affordable and accessible non-institutional care to its low-income elderly and disabled citizens. This is because assisted living is a long-term, residential care service option that provides *both housing and services* for people who can no longer live safely in their own homes but who are not willing or ready to reside in a nursing home.

Logistical Requirements

As of October 2002, Indiana was one of forty-one states that had federal Medicaid approval to cover services in residential settings that included either assisted living or board and care licensing categories.[81] Since that time, however, program development and utilization of Medicaid-funded assisted living services in Indiana has been far below expectations.

The establishment of a dedicated Indiana Medicaid Waiver for Assisted Living is a significant accomplishment both in terms of meeting long-term care service delivery objectives and with respect to the creation of a solid framework that is essential for community-based services to grow. Nevertheless, there remains much more to be done with respect to consumer access/provider development, utilization, and successful outcomes for the State's nursing facility diversion and conversion initiatives.

Despite funding availability, the number of participants and applicants has been limited by the program's infrastructure, marketing, recruitment and retention success. There is, in fact, great need for expansion of this particular Medicaid Waiver Program. In 2001, Indiana ranked 10th highest among states in total number of nursing facility residents, and ranked 7th highest in the percentage of nursing facility residents as a percentage of the total population age 65 and over – 5.6%, compared to a national average of only 4.2%.[82] Moreover, 36.3% of all nursing facility residents in Indiana were classified according to the lowest levels of resource need.[83]

There are several logistical requirements that must be met in order to build upon and expand Indiana's Medicaid Assisted Living Waiver Program and foster and sustain rebalancing of Indiana's long-term care service delivery system. These requirements are briefly described below.

- There must exist a sufficient number of state staff who are dedicated to manage and operate the program on a full-time basis. State staff should be expanded as the program grows.
- Creation of a marketing strategy to recruit and retain providers.
- Development of comprehensive and up-to-date program enrollment and training manuals.
- Development of a timely consumer and provider enrollment process.
- Development of comprehensive provider standards.
- Availability and provision of nursing services within the assisted living program definitions.
- Competitive provider rates that are tiered according to 3-5 levels of service need.
- Development of an outreach strategy to identify, recruit, and enroll consumers.
- Collaboration with area agencies on aging.
- Provision of specialized case management that includes regular and as-needed on-site visits.
- Development of specialized and reliable quality assurance protocols.
- Program collaboration with Adult Protective Services and the State Long-Term Care Ombudsman Program.
- Program monitoring and reporting.
- Coordination of waiver slot expansions with nursing facility diversion and transition initiatives.
- Availability of start-up funds that may be needed to transition nursing home residents back into the community.
- Partnering with state and federal subsidized housing initiatives.

There are no doubt many approaches that can be taken to accomplish all of the logistical requirements necessary for establishing a successful assisted living program that provides critical housing and support services to Indiana's low-income elderly and disabled populations. Additionally, there is great value in supplementing these approaches with the assistance of staff in other states that have expertise in successful Medicaid-funded assisted living program development.

Policy Outcomes and Opportunities

Development of Indiana's Medicaid Assisted Living Waiver was extensively studied by the late Governor O'Bannon's Commission on Home and Community Based Services (2002-2003) and was included in the Commission's June 30, 2004 Report (pages 44-45) as one of eight primary action steps assigned to the Indiana Family and Social Services Administration. The Commission considered the lack of publicly-funded assisted living to be one of the most significant obstacles that Indiana faces in shifting the balance of long-term care service delivery in Indiana away from institutional forms of care and toward less costly and more desirable care provided in the community.

Futher development and expansion of a viable assisted living program within the Indiana Medicaid Waiver Programs can be expected to accomplish a number of long-term care rebalancing objectives. Specifically:

- Assisted living will introduce a new affordable and accessible housing option that is desperately needed to meet the needs of Indiana's low-income elderly and disabled population;
- It will grow the number of Medicaid-enrolled providers available to provide needed community-based services in the State;
- It will provide a desperately needed housing with services placement option for nursing home residents transitioning back to community life;
- It will reduce unnecessary institutionalizations; and,
- Most importantly, it will improve consumer health outcomes and quality of life.

Finally, implementation of an assisted living program helps to address the present shortage of affordable and accessible housing that creates a barrier for many seniors who seek community-based services. According to the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century,[84] there are nearly six times as many seniors with unmet housing needs as are currently served by rent-assisted housing. Waiting lists for many types of subsidized housing are long.

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Development of assisted living services will also satisfy some of the State's objectives in meeting the requirements of the *Olmstead* decision and to positively respond to the objectives presented in Indiana's Comprehensive Plan for Community Integration and Support of Persons with Disabilities (Indiana Family and Social Services Administration, June 1, 2001).

States with significant Medicaid-funded assisted living programs include: Arizona, Colorado, Florida, Georgia, Minnesota, New Jersey, North Carolina, Oregon, and Washington.

Program Success in Washington

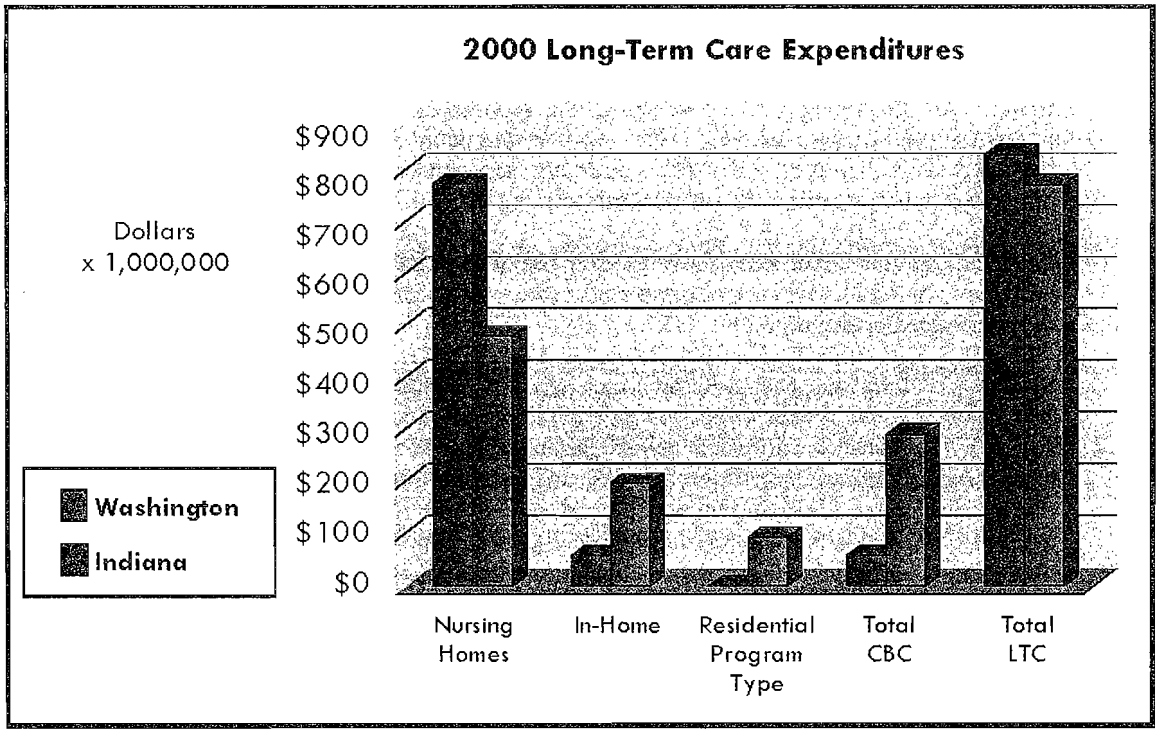
The State of Washington may be effectively compared with the State of Indiana since both share a number of characteristics that are relevant to long-term care services. Among other things, both share a similar percentage of people age 65 and older who have disabilities and who live below the Federal Poverty Level, and both share a similar overall funding commitment for long-term care services.

Unlike Indiana, however, the State of Washington has in recent years invested heavily in expanding community-based services. Washington has invested heavily in in-home care, assisted living, and adult foster care in an effort to substantially reduce reliance on nursing homes.

Figure 6 provides a spending comparison between Indiana and Washington on long-term care services.[85] The dollars are in millions and are based on fiscal year 2000 expenditures. "CBC" refers to community-based care, and "LTC" refers to long-term care.

Figure 6 contrasts Indiana's significant investment in nursing home services with Washington's significant investment in community-based services. Moreover, Washington's community-based services include in-home care, adult foster care, and assisted living that are available to all eligible Medicaid consumers, while Indiana's community-based services primarily include only in-home care that is available to consumers on a limited basis only. Indiana has had little success with assisted living and has no adult foster care program.

Figure 6



Washington has for the past several years received national acclaim for its commitment to long-term care rebalancing, but especially for its success in developing and operating assisted living services and adult foster care through its Medicaid Home and Community-Based Services Waiver Program. Both of these community residential services provide desperately needed services with an affordable and accessible housing option for persons who are no longer able to remain in their own homes. Without an assisted living and adult foster care option, long-term care rebalancing cannot be achieved.

Caretaker Support Program

Senate Enrolled Act 493 Provisions

Senate Enrolled Act 493 provides a number of specifications with respect to development of a caretaker support program. These specifications can be found in Article 10.5 Respite Care Services, Chapter 1. Caretaker Support Program, which provides the following:

> "Section 1. As used in this chapter, "caretaker" means an individual who: (1) provides ongoing care for an individual who (A) is at least eighteen (18) years of age; and (B) has special needs; and (2) does not receive money for the care provided under subdivision (a).
>
> Section 2. As used in this chapter, "special needs" means any of the following: (1) Alzheimer's disease or any related disorder. (2) Inability to perform at least two (2) activities of daily living. (3) Any other condition that the division determines by rule should be covered by this article.
>
> Section 3. The caretaker support program is established.
>
> Section 4. (a) The division of disability, aging, and rehabilitative services established by I.C. 12-9-1-1 shall administer the caretaker support program established under this chapter. (b) The division of disability, aging, and rehabilitative services shall do the following: (1) Adopt rules under I.C. 4-22-2 for the coordination and administration of the caretaker support program. (2) Administer any money for the caretaker support program that is appropriated by the general assembly.
>
> Section 5. An individual who is at least sixty-five (65) years of age and: (1) a caretaker; or (2) an individual with special needs being taken care of by a caretaker; is eligible for the caretaker support program.
>
> Section 6. Caretaker support program services include the following services administered by the area agencies on aging: (1) Information for caretakers about available services. (2) Assistance to caretakers in gaining access to the services. (3) Individual counseling, organization of support groups, and caretaker training to assist caretakers in making decisions and solving problems in the individual's role as caretaker. (4) Respite care to offer caretakers temporary relief from caretaker responsibilities.
>
> Section 7. The division shall develop and implement a client cost share formula for respite care services.

These provisions are intended to establish the framework needed to create and sustain a caretaker support program that will formally acknowledge and address on a statewide basis the needs of Indiana's caretakers who are providing care for someone who is elderly or disabled, or for those who are receiving care from an unpaid caretaker.

What Is A Caretaker Support Program and Why Is It Important?

Unpaid family caretakers provide the vast majority of the care and support that the frail elderly need to live independently in their own homes within the community. These caretakers may provide support through direct, hands-on care on a daily or regular basis, or from long-distances

by helping to identify and arrange for needed services that will be delivered by others. Nationally, nearly one out of every four households (22.4 million) is involved with caretaking of a person aged 50 and over. Seventy five percent of caretakers are women; most are daughters and most are married or living with a partner. Nearly one-fifth of unpaid caretakers spend over 40 hours per week providing care, with the average caretaking span covering 4.5 years.[86]

Dr. Donna Wagner (right), Director of Gerontology, Towson University and Julie Newland of Eli Lilly & Company addressed issues of caregiving, employee productivity, and business profitability at The Moving Forward Summit, November 15th, 2004, Indianapolis.

Family caretaking responsibilities often place undue hardship on the caretaker, creating extraordinary stress on the caretaker's physical and emotional well being. Caretaking responsibilities often require the individual to juggle his/her financial, professional, family and other personal responsibilities, which may be devastating for the caretaker, especially when there is little or no support or respite available. In economic terms, caretaking often interferes with outside employment, creating a situation where hours may have to be reduced, job/career changes may be required, or employment may be lost, either voluntarily or involuntarily. In sum, it has been calculated that caregivers lose an average of $659,000 in total wealth as a result of their caretaking responsibilities.[87]

Despite the expansive role that unpaid family caretakers play in the long-term care service delivery system, there is little recognition about their value or the implications of this caretaking relationship on society as a whole. It is estimated that there are over 27 million caretakers nationally, who are providing over 29 billion hours of care per year. If those hours would have been paid, they would represent over $257 billion in market value.[88]

Nearly one-fifth of unpaid caretakers spend more that 40 hours per week providing care, with the average caretaking span covering 4.5 years. Moreover, it has been calculated that caregivers lose an average of $659,000 in total wealth as a result of their caretaking responsibilities.

Until recently, federal law did not formally recognize the needs of family caretakers. That changed, however, when the 2000 United States Congress established The National Family Caregiver Support Program, which is authorized under the Older Americans Act and is administered by the United States Administration on Aging. The program offers formula and demonstration grants that allow states and other organizations to provide any or all of five basic services for family caregivers. These include:

1. Information to caretakers about available services;
2. Assistance to caretakers in gaining access to supportive services;
3. Individual counseling, support groups, and caretaker training to assist caretakers in making decisions and solving problems relating to their roles;
4. Respite care to temporarily relieve caretakers from their responsibilities; and
5. Supplemental services, on a limited basis, to complement the care provided by caretakers.

A caretaker support program is a program that makes available services and creates and supports policies that are designed to better meet the needs of the caretaker so that (s)he can maintain her physical and economic well-being while continuing to provide the caretaking support needed by a loved one.

At a minimum, caretaker support should include: information about available support services; assistance with accessing those and other services; training; respite; availability of affordable, dependable, and qualified providers to meet the health care and other support needs of the person for whom the caretaker is responsible; and reasonable flexibility by the caretaker's employer.

Most Medicaid waiver and state-funded programs do not recognize the heavy reliance that the programs place on family and informal caregivers in terms of accessing, coordinating and providing long-term care in the community without providing the supports necessary to sustain them in the caregiver role. It is for this reason that a proactive strategy for meeting the needs of unpaid family caregivers is essential in establishing a solid long-term care service delivery system for any state. Home and community-based services and programs that include the service components needed to sustain the caregiver relationship and better support the needs of both the caregiver and the loved one who is receiving the care will positively impact caregiver and care receiver quality of life, care delivery, independence and choice, employee productivity, and workforce shortage issues*.

Caretaker Support in Indiana

Indiana ranks fourteenth highest among states in the number of unpaid family caregivers. In the year 2003, it was estimated that Indiana had over 586,000 caregivers providing 628 million hours per year at an annual market value of more than $5.5 billion.[89]

This care delivery dynamic obviously has significant implications for Indiana, not only in terms of health care services and long-term care specifically, but also in economic terms that affect both private households and employers. It is a subject that is not very well understood, despite its extended implications for public assistance and the overall economic well being of the state. It is for this reason that The Generations Project has begun to study the economic implications for Indiana's economy and the impact of long-term care on employers and employees. Great care needs to be taken to embrace and preserve the family caretaking relationships from both a societal and an economic perspective, as well as to inform and build upon employers' understanding and appreciation of the human and financial value of investing in caretaking employees.

"Indiana ranks fourteenth highest among state in the number of unpaid caregivers. In the year 2003, it was estimated that Indiana had over 586,000 caregivers providing 628 million hours per year at an annual market value of more that $5.5 billion."

In a worst case scenario, failure to invest in the family caretaking relationship creates a situation whereby the family caretaker struggles to meet the needs of his/her loved one who is dependent upon the care provided, the caretaker's family, and employer. Without support, the loved one's care suffers, the caretaker's ability to manage the competing demands of his/her environment is

* The federal government estimates that by the year 2050 the United States will need three times as many paid long-term care workers as are employed today. (The Older Americans Act National Family Caregiver Support Program, "Compassion in Action", Executive Summary, September 2003, p. 7.

compromised, and her employment is threatened. Options then may include obtaining institutional care for the loved one at significant private and eventually public expense, termination or suspension of the caretaker's employment, or a combination of the two. When this occurs, all involved suffer in immeasurable personal and economic terms.

Caretaker support programs in Indiana have largely been developed through grants provided by the National Family Caregiver Support Program. These programs are administered by the sixteen area agencies on aging and vary by locality. Services focus on caretakers and care receivers who are over 18, and include a special focus on grandparents who are raising grandchildren. Program and service development remains in its early stages because of limited funding. The Indiana Association of Area Agencies on Aging has established a Professional Advisory Committee of Caregiver Coordinators, which works closely with state staff and has adopted statewide standards for the caretaker program, as well as strategies to improve program functions and processes.

The Indiana Medicaid Waiver Program complements the caretaker support program by covering respite care services that provide temporary support for the consumer during times when the caretaker is in need of rest or relief. Another complementary program, but one which has not yet been well developed in Indiana, is adult day care services. These services provide a regular daytime community service option that gives caretakers the opportunity to maintain employment, run errands, or receive respite time, while assuring that the frail elder or disabled person receives needed health and personal care and social interaction outside the home.

The Indiana Division of Disabilities, Aging, and Rehabilitation Services has developed a proposed rule, LSA Document #03-231, that was published in the July 1, 2004 *Indiana Register*. The purpose of the rule is to establish boundaries for the caretaker support program both in terms of Senate Enrolled Act 493 and the National Family Caregiver Support Program, and to provide for flexibility needed by the Division and the area agencies on aging to administer the programs locally.

Logistical Requirements

There are several logistical requirements that must be met in order to develop and expand Indiana's caretaker support program. These requirements are briefly described below:

- Establish and secure on-going state funds to support the state caretaker program created by the National Family Caregiver Support Program when grant funds are concluded.
- Work with the area agencies on aging to evaluate their individual successes with the National Family Caregiver Support Program and then develop a strategy for implementing the best approaches consistently within all area agencies on aging.
- Work with the area agencies on aging to develop a uniform set of outreach materials for families and caretakers.
- Develop and implement a client cost share formula for the state program.
- Complete the rule promulgation process.
- Develop outreach initiatives that build upon the partnership between state agencies and employers. This can be done through targeted mailings, development of other written materials, and enhancement of the web sites for the Departments of Workforce Development and Labor. Those efforts should be targeted to inform the state's business and industry sectors of caretaking issues as well as the effect and expense of caretaking on workforce recruitment, employment and retention.

- Provide guidance to the State's economic development team of the need to include family caretaker issues in the State's economic development plan.
- Acknowledge the service access issues that face working caretakers and work with area agencies on aging and other human service agencies to provide extended or adjusted hours of operation.
- Provide technical assistance to employers to help them address their employees' needs better.
- Expand telephone and in-person access to counseling, information, and referral. Recent studies have indicated that investment in this area plays the largest role in deferring institutional placement (Syracuse University, Mary Maines). This is being addressed through the Resource Center Grant funded by the Administration on Aging and the Centers for Medicare and Medicaid Services and administered by the Indiana Bureau of Aging and In-Home Services.
- Evaluate state family and medical leave acts to determine whether changes are needed to better respond to the needs of both family and non-family caretakers.
- Explore options to provide paid leave and fully paid extended health care benefits.
- Consider end-of-life needs in any state initiatives that are directed at caretakers and make existing state "living wills" or "advance directives" easily accessible to all state residents.

Policy Outcomes and Opportunities

Development and implementation of a statewide caretaker support program in Indiana can be expected to accomplish a number of long-term care rebalancing objectives. Specifically, it will provide needed support to the significant number of Hoosiers who are providing unpaid care for a friend or loved one, it will improve upon caretaker/employer relationships, it will improve upon the physical health and emotional well-being of the caretaker, it will improve upon the health outcomes of the care receiver, it will substantially delay nursing home placement[90], it will keep more unpaid caretakers engaged in the care-giving process and thereby reduce utilization of nursing home services, and most importantly, it will improve caretaker and care receiver quality of life.

In addition, further development of Indiana's caretaker support programs helps to satisfy some of the State's objectives in meeting the requirements of the *Olmstead* decision, and will positively respond to the objectives presented in Indiana's Comprehensive Plan for Community Integration and Support of Persons with Disabilities (Indiana Family and Social Services Administration, June 1, 2001).

Finally, development of a strong family caregiver support program depends not only on the availability of information, referral, training, and access to services by the caretaker, but also on the availability of respite care and adult day services, the latter of which has not yet been well-developed in Indiana. All three are essential for supporting and sustaining the unpaid caretaker in the prominent role that (s)he plays within the long-term care service delivery system.

States with significant caretaker support programs include: California, Delaware, Georgia, Nevada, New Jersey, North Dakota, and Pennsylvania.

Program Success in Pennsylvania

Pennsylvania's Family Caregiver Support Program is a program that is specifically targeted to reinforce the care that is provided by a family member to an elderly or disabled person in his/her own home. The Program uses specially trained social workers to provide information about long-term care services and supports and to design a care plan that best reflects the needs of the caregiver and family. Services that are available to all caregivers and persons who are receiving the supports, regardless of household income, include: care management; legal consultation; support groups, caregiver education and training; and counseling. Eligible caregivers may receive up to $200 per month to help with out-of-pocket expenses such as respite care and incontinence supplies. Additionally, eligible families may receive a one-time grant of up to $2,000 to purchase home modifications or assistive devices. The Family Caregiver Support Program serves approximately 3,500 families at any given time and about 6,500 families per year. Costs average approximately $2,900 per family for a full year of participation in the program.[91]

Quality Management

Senate Enrolled Act 493 Provisions

The framers of Senate Enrolled Act 493 expect that long-term care rebalancing in Indiana will occur with a solid quality management structure already in place, and that all new initiatives and program expansions will include necessary quality features.

The Act specifically provides for the following:

> Section 9. (b) An individual who receives Medicaid services through a Medicaid waiver shall receive the following: (1) The development of a care plan addressing the individual's needs. (2) Advocacy on behalf of the individual's interests. (3) The monitoring of the quality of community and home care services provided to the individual. (4) Information and referral services on community and home care services if the individual is eligible for these services.

Full compliance with Senate Enrolled Act 493 depends on a quality management infrastructure that is flexible enough to adapt to the shift in service delivery from institutional to community-based settings. Consumer rights and protections that are already in place for institutional services may need to be redefined, expanded, or otherwise modified to better accommodate the needs and preferences of a growing number of consumers in their own home settings. The long-term care quality management structure must be responsive to consumers in all long-term care settings.

Quality management requires both the traditional framework for service delivery that includes provider licensure, regulation, and certification standards, and a non-traditional but equally important focus on consumer involvement throughout the care and service planning process and consumer direction of services. Risk of vulnerability in a community-based setting is minimized by a combination of consumer independence and empowerment to self-direct care, good case management, strong program management and oversight, a timely and reliable problem resolution and emergency response protocol, and establishment of multiple avenues by which consumers can regularly provide feed-back. This may require a greater investment in case management services and an increase over time in the number of staff dedicated to quality management for community-based services.

What Is Quality Management and Why Is It Important

Quality management in long-term care service delivery has come to mean many things to many people. From a consumer perspective, quality management represents consumer choice, safety, independence, dignity and protection issues, emergency response, and provider qualifications and compliance with established standards. For institutional and community residential providers, quality management takes the form of survey and certification processes, and general compliance with provider standards. For the State, quality management means all those things and more, such as assurance in quality of service delivery, positive and improved health outcomes of beneficiaries, fiscal accountability, and program administration, monitoring and oversight.

Research does not reveal a common definition of quality management with respect to all forms of long-term care. Terms are often used interchangeably, and quality concepts are not clearly

delineated. Therefore, it may be helpful to organize a quality management discussion around several general concepts.

According to the Centers for Medicare and Medicaid Services, there are three main components of program quality.[92] These are:

1. Quality system design
2. Quality assurance
3. Quality improvement

The first, quality system design, provides a foundation for the others. By specifying methods for how monitoring activities will be carried out, it provides the framework by which quality assurance and improvement can occur.

All three components appear to embody the full scope of requirements and mechanisms necessary for assuring that consumer rights and preferences are protected and that all home and community-based services programs (regardless of funding source) include proper safeguards, meet accountability requirements and expectations, and maintain timely and thorough response capabilities. A brief review and discussion of each follows.

Quality System Design

A quality system design must identify and incorporate all action steps taken by consumers and providers from beginning to end. Beginning with eligibility and enrollment and ending with verification of the delivery of quality services in accordance with care and service plans, the system design should provide a clear and strong administrative infrastructure for assuring quality care and delivery of services and opportunities for quality improvement.

Ideally, the long-term care service delivery system utilizes a single point of entry by which information can be obtained, assessments of eligibility and need can be scheduled and performed, case management made available, and service delivery arranged. Indiana has received considerable recognition nationally for its single point of entry system, which employs its sixteen area agencies on aging to provide local access to local and state-wide long-term care programs for the elderly and persons of any age with physical disabilities.

Ideally, the long-term care service delivery system utilizes a single point of entry by which information can be obtained, assessments of eligibility and need can be scheduled and performed, case management made available, and service delivery arranged.

A consumer needs assessment serves as the core documentation source for the delivery and monitoring of services to the consumer. For Indiana Medicaid Waiver service eligibility, for example, the needs assessment must document limitations in at least three activities of daily living, requiring the level of services normally provided in a nursing home. In contrast, CHOICE Program eligibility requires limitations in at least two activities of daily limiting, placing the consumer at risk of losing his or her independence. It may be a separate determination process, or it may be combined with development of the consumer's plan of care.

Development of the consumer's plan of care should be based on the consumer's preferences, care and support needs (both formal and informal) and should describe the type and amount of services to be provided, as well as the type of provider who will deliver the services. It should be

comprehensive and describe the need for each service, regardless of funding source. It also should include a plan for how best to meet the consumer's changing needs, as well as consideration of any risk factors that threaten the on-going independence of the consumer.

The consumer's service plan should be based on a care plan that is jointly developed by the consumer and the area agency on aging case management staff. It should prescribe a formalized schedule for services to be provided and the specific engagement of fully trained providers who respect the consumer's prerogatives and authority to self-direct their care. It should address all services to be provided by all programs (and funding sources) to ensure maximum coordination, improve administrative efficiency, and eliminate duplication of services.

Updated program manuals and provider standards should be made available to all consumers, their family members, and providers. In addition, relevant orientation and training should be made available, and technical assistance provided whenever needed. Training and written materials must include criteria and standards for consumer self-direction, consumer rights, and quality management protections.

The quality assurance design must also incorporate a mechanism by which quality assurance issues and problems are funneled upward to allow for a comprehensive identification and assessment by higher-level program managers and planners. If designed properly, this will provide for the needed connection between local service planning and delivery and centralized oversight.

To better assist states with the quality management of their Medicaid Waiver Programs, the Centers for Medicare and Medicaid Services developed a Quality Matrix and Framework that was shared with states in August 2002. The Quality Matrix creates a conceptual framework for envisioning the desired outcomes of Medicaid Home and Community-Based Services Programs. Seven domains are defined, each with a series of sub-domains that include activities or policies in support of positive outcomes.[93] Other efforts have included Quality Conferences, development of Quality Tools for states, development of a quality Protocol for federal waiver reviews, and the availability of technical assistance through a National Contractor for Quality. All of these initiatives are focused toward the provision of additional federal resources and assistance to states without a reduction in state administrative authority.

Quality Assurance

Quality assurance focuses on the organization and operation of programs according to program requirements. It does not guarantee that quality of care is delivered, but does provide the foundation and optimal conditions for which quality care can occur. Quality assurance includes all of the actions necessary to verify a consumer's health and safety, assure that actual service delivery corresponds with the service and care plan, and to facilitate the implementation of corrective actions needed to immediately resolve deficiencies. It also includes a number of program management functions that assure program-wide accountability and efficiency. Functions are assigned at the local level where consumer interactions predominantly occur, and at the state level where overall program management occurs.

At the local level, quality assurance may include a periodic reassessment of need based on program criteria, as well as regular monitoring of the plan of care and service plan. Elements that must be present in both plans include: evidence of consumer participation in development, implementation and direction of the plans; evidence that plans are updated to respond to changes

in the consumer's health and support circumstance; and evidence that services delivered compare favorably with services prescribed.

Like quality design, quality assurance must highlight the role of case management. At the local level, case managers are responsible for completion of need assessments, development of plans of care and service, on-going monitoring and follow-up, and timely response to issues and problems as they occur. Case managers are required to have a 24-hour/7-day a week access number for emergencies. Similarly, at the state level, there must also exist a program-level quality assurance mechanism that reviews the quality and performance of all case managers, including assessment of qualifications and training, reasonableness of caseloads, and existence of the administrative supports and resources needed by them to provide quality work.

A comprehensive quality assurance process also includes an external review component, whereby a pool of quality assurance staff is specifically and solely dedicated to consumer safety and satisfaction and provider concerns and compliance. They perform desktop audits and on-site reviews, and may be assigned to evaluate the performance of all quality assurance mechanisms within the long-term care system.

There must also exist a formal consumer communication plan that is administered jointly at the local and state levels that may consist of satisfaction surveys, telephone and in-person interviews and small consumer/family group meetings, multi-tiered consumer complaint mechanism that consists of a 24-hour telephone hotline, and access and formal coordination with Adult Protective Services (APS) and the State Long-Term Care Ombudsman Program.

At the state level, a formal licensure and regulatory process normally exists for institutional, transportation, and community residential care providers, and home health and hospice agencies, but does not normally exist for non-traditional community-based providers like providers of home modifications, homemaker and companion services. These formal regulatory processes typically include the designation of a single state agency to establish standards for provider participation, to manage, approve and deny provider applications, to conduct regular on-site and desk-top reviews to ensure compliance with standards, and to impose sanctions and penalties to correct deficiencies.

Providers that are not formally licensed or regulated are normally subject to a program-specific certification process that should support the needs, preferences, and personal characteristics of a consumer in his/her own home setting. The certification process should include established standards that are described in state regulation, as well as reasonable methods to support consumer self-direction and to verify provider compliance. Compliance failures need to be documented and then followed-up with corrective action plans and sanctions.

Quality assurance processes and methods need to be coordinated with other state agencies responsible for licensure and provider compliance and with other programs to ensure that quality assurance gaps are filled and duplication of responsibilities is eliminated.

At the state level, long-term care quality assurance encompasses many program administration and oversight responsibilities. States must assure the federal government that the State Medicaid Agency retains administrative authority over the Medicaid Waiver Programs, regardless of which agencies have responsibility for other programs. State administrators are expected to maintain centralized responsibilities for: assuring consumer health and well-being; program monitoring and review (including sampling); overall financial accountability; data analysis (i.e. examination of utilization and service trends, and outliers); and obtaining regular stakeholder feedback.

Quality assurance is not a static process, but one that must be regularly modified to respond to issues and problems as they occur and to successfully meet the changing needs and preferences of consumers and providers.

Quality Improvement

The third component of a quality assurance system, known as quality improvement, is one that goes beyond normal quality assurance functions and formally addresses the resolution of wide spread or significant problems and improvement of existing health and performance outcomes.

Quality improvement may occur as a minor or major adjustment to a process or function, or as a special project. Common steps involved with quality improvement are as follows:

- Determine prevalence of problem
- Engage consumers and providers
- Identify barriers
- Identify available resources
- Identify intended outcomes

There are, without doubt any number of ways that quality management can be described and its components organized. What is important, however, is whether the quality system makes sense, whether it is easy to identify and adjust as issues arise, and whether it accomplishes the overall safety, quality of life, and performance expectations of the programs.

Quality design, assurance, and improvement programs are becoming increasingly prominent in their role within states' long-term care service delivery systems.

Quality Management in Indiana

As in most states, formal quality management responsibilities for non-institutional long-term care services are assigned to one state agency in Indiana, the Family and Social Services Administration. Responsibility for licensure and oversight of institutional and residential care providers and home health and hospice agencies is assigned to the Indiana State Department of Health. Responsibilities between the two agencies overlap and require coordination and collaboration.

Non-institutional providers enrolled in the Indiana Medicaid Waiver Programs are subject to certification standards established by the Indiana Family and Social Services Administration. Quality assurance is performed at two levels: locally by the sixteen area agencies on aging; and centrally by program staff within the Indiana Family and Social Services Administration.

Each area agency on aging serves as the State's case management agency and oversees the provision of community-based services. Case managers must make home visits at least once every ninety days, and reassessments are performed annually. Case managers use the State's automated assessment tool, Insite, to record and report their findings.

The Bureau of Quality Improvement Services, within the Indiana Family and Social Services Administration, works in collaboration with the Bureau of Aging and In-Home Services and conducts on-site reviews of area agency on aging operations, which includes a random review of participant files and visits to participants' homes. The purpose of these reviews is to evaluate case management functions and to verify that consumers' needs are being met and that quality services are being delivered as prescribed by the individual plans of care and service. The two Bureaus are currently negotiating a shift in responsibility where the Bureau of Quality Improvement Services will take on all quality assurance and improvement responsibilities. This change was made possible through a federal Quality Assurance grant.

The Quality Improvement Process (QIP) is a consumer survey component of the State's automated case management assessment and tracking system. It was developed under a grant from the Robert Wood Johnson Foundation and was designed and overseen by the Center for Law and Health at Indiana University. The survey is imbedded within Insite, Indiana's automated case management assessment and tracking system, and is administered to at least 5% of all program participants during annual reassessment. It provides information on various aspects of service delivery from the participant's perspective, including consumer choice, timeliness, respectfulness, consistency and task performance. Results of the QIP are used on an individual basis to identify and follow-up on serious incidents, as well as to provide feedback to providers on their performance.[94]

The State is also in the process of reviewing bids under a Request for Proposal (RFP) to develop a new software system to replace Insite. The new system is expected to be implemented sometime in 2005.

The Adult Guardianship, Adult Protective Services, and State Long-Term Care Ombudsman programs, also housed within the Indiana Family and Social Services Administration, provide the primary mechanisms for identifying and responding to allegations and confirmed incidents of adult abuse, neglect, and exploitation.

In state fiscal year 2002, the Indiana Adult Protective Services documented 15,536 calls for service that drew on 12,894 cases. Of those, 71% involved substantiated problems (21% were substantiated cases of neglect, 27% of abuse, 11% of exploitation, and 41% of self-neglect).[95]

Logistical Requirements

There are several logistical improvements and expansions that must be met in order to support the solid infrastructure of long-term care service delivery that is established by Senate Enrolled Act 493. These include:

- Establishment of a quality management protocol that is specifically dedicated to support the development and implementation of an adult foster care program in Indiana. This is essential, since there exists no formal adult foster care commercial industry in Indiana, and since it is a new, very different form of residential service. Fully trained quality assurance staff must be permanently dedicated to this program.
- Quality management for the Medicaid Waiver for Assisted Living must include dedicated staff familiar with consumer rights and provider certification standards and knowledgeable about the quality assurance issues posed by assisted living services. This too is a fairly new service within Indiana's Medicaid Waiver Programs and presents

issues and challenges that are different from those of institutional and other community-based services.

- As the long-term care programs and services expand, there needs to exist a formal evaluation of the number of additional Adult Protective Services and Ombudsman staff that are needed to fill the critical adult protection role.
- Once the evaluation of Adult Protective Services and Ombudsman staff is complete, additional funding may need to be requested and obtained.
- The State has just begun reviewing and compiling data received from a Request for Information (RFI) initiative that focused on case management. That information may be used to set standards for issues such as competency testing, training, and certification.
- There needs to be a renewed emphasis on expansion of the Adult Guardianship Program, which is provided through six organizations (four Area Agencies on Aging and two Mental Health Associations) in 24 counties. The Adult Guardianship Program is a program that makes available guardians to assist and help to direct the care of individuals who are unable to speak for themselves and who lack involved families.

Quality management is a very basic, yet infrequently discussed aspect of every state's long-term care service delivery. The reasons for this are unclear, but may stem from lack of administrative resources and funding, urgency to implement services, and improper designation of quality assurance as a post-implementation issue.

In addition to the features already mentioned, quality management must include consumer protections and an appreciation and understanding of consumer rights, preferences, and support of consumers who choose to self-direct their services.

Indiana has much of the quality assurance structure already in place to cover services in a private home or other residential setting. Development of an adult foster care program will, however, require a dedicated quality assurance staff to support the opportunities and challenges that a new service within the Indiana Medicaid Waiver Programs can bring. This is also true, although to a significantly lesser degree, for the Medicaid Assisted Living Waiver.

States that provide best practice models for quality assurance include: Colorado, Maine, Michigan, Minnesota, New Hampshire, New York, Ohio, Oregon, Pennsylvania, South Carolina, Vermont, and Wisconsin.

Program Successes in Oregon and Wisconsin

Oregon's Client Assessment and Planning System is an automated assessment and eligibility tool that determines an individual's need for assistance according to service priority levels and includes a number of quality management features. Specifically, it includes triggers that automatically generate a referral for a nurse assessment if certain health conditions are present as well as other referrals based on risk assessment. In addition, it collects information and produces monthly consumer need, utilization and cost reports required to manage all of the service programs administered by the single entry point, including the Medicaid Home and Community-Based Services Waiver Program, Oregon Project Independence and the Older Americans Act.[96]

Wisconsin's Family Care Program is a managed care approach to providing long-term care services to elderly and disabled persons on their Medicaid Home and Community Based Services Waivers. The Program fields a Consumer Outcomes Survey annually to a random sample of waiver participants. The survey generates an outcomes score that serves as a Quality of Life

indicator for each participant and a support score that measures the quality of Family Care services and supports. The State then shares the survey findings with the Care Management Organizations who coordinate and monitor waiver services in order to evaluate and improve quality of care, as well as to track changes in outcomes over time.[97]

Other Requirements in Senate Enrolled Act 493

Senate Enrolled Act 493 prescribes a number of other requirements that are important for long-term care rebalancing. All are intended to support and/or enhance the service delivery infrastructure.

CHOICE Program and Medicaid Waiver Coordination of Services

The Act intends for the CHOICE Program and the Indiana Medicaid Waiver Programs to be coordinated to the extent possible in order to create a seamless, consistent, and continuous delivery of services to support consumers as their long-term care needs and preferences change and regardless of funding source.

Senate Enrolled Act 493 addresses this in the following section.

> Section 7. (d)... the office shall discuss and review any amendment to the waiver required under this section with the board. (e)...the office shall apply to the United States Department of Health and Human Services to amend the waiver to include in the waiver any service that is offered under the community and home options to institutional care for the elderly and disabled (CHOICE) program established by IC 12-10-10-6. A service provided under this subsection may not be more restrictive than the corresponding service provided under IC 12-10-10...(h)...the office shall meet with the board to discuss any changes to other state Medicaid waivers that are necessary to provide services that may not be more restrictive than the services provided under the CHOICE program. The office shall recommend the changes determined necessary by this subsection to the governor.

Both Indiana's CHOICE and Medicaid Waiver Programs provide a solid framework for Indiana's long-term care service delivery system. Together, the two programs have provided essential community-based services and supports to tens of thousands of Hoosiers. Senate Enrolled Act 493 is intended to provide the additional authority and policy support needed to effectuate lasting change in Indiana.

Use of Volunteers

Senate Enrolled Act 493 prescribes the inclusion of volunteers within the long-term care service delivery system as follows:

> "Section 7. When possible, the office of the secretary of family and social services shall make use of volunteers and volunteer groups, including faith based groups, when executing its duties under this chapter.

A similar reference is included within the caretaker support program section (Section 8) and with respect to the establishment of a system of integrated services (Section 12).

The purpose of these provisions is to expand the network of informal community supports and grow the number of paid and unpaid caregivers within Indiana's long-term care service delivery system.

There are a number of volunteer programs that provide valuable assistance and support to elderly and disabled persons in the community.

Program Successes in Indiana. AngelWorx is a volunteer program sponsored by LifeStream Services, one of Indiana's sixteen area agencies on aging that helps people remain independent in their own homes. More than 800 volunteers of all ages, economic backgrounds and ethnic origin participate. Services include telephone and home visits, being a pen pal, providing respite care, shopping and performing other errands, performing yard-work and light housekeeping, performing home modification and repairs, and much more. LifeStream partners with Ball State University, Ivy Tech State College, and Indiana Wesleyan University to provide service-learning projects that pair gerontology program graduate students and nursing students with older adults. More than 400 elementary students adopted the program as part of their curriculum, high schools contribute a day of caring, and inner-city youth groups have become involved by completing group projects and becoming individual pen pals in the teen program. Local churches and other groups provide home maintenance that includes everything from handrail installation and ramp building to replacement of roofs. In 2003, volunteers donated 26,000 hours of their time at a monetary value of $430,040.[98]

LifeStream partners with Ball State University, Ivy Tech State College, and Indiana Wesleyan University to provide service-learning projects that pair gerontology program graduate students and nursing students with older adults.

Program Successes Nationally. The Administration on Aging administers the Senior Medicare Patrol Project grants under the Older Americans Act. The grants were established in 1997 and have been used to recruit and train retired professionals such as doctors, nurses, teachers, lawyers, and accountants, to work with Medicare and Medicaid beneficiaries in their communities. The purpose of the project is to educate beneficiaries on how to recognize and report suspected cases of deceptive health care practices, such as over-billing, overcharging, or providing unnecessary or inappropriate services.

Another program, the Senior Companion Program is part of Senior Corps, a network of national service programs that provide older Americans the opportunity to put their life experiences to work for local communities. Senior Companions must be healthy individuals age 60 and older with limited incomes who serve one-on-one with the frail elderly and other homebound persons who have difficulty completing everyday tasks. They assist with grocery shopping, bill paying, and transportation to medical appointments, and they alert doctors and family members to potential problems. Senior Companions also provide short periods of relief to primary caregivers.

Local non-profit organizations and public agencies receive grants to sponsor and operate Senior Companion projects. Community organizations that address the health needs of older persons work with the local Senior Companion Program projects to place and coordinate the services of the Senior Companion Program volunteers. These local partners – which include hospitals, area agencies on aging, and home health groups – are called volunteer stations. The stations' professional staff identifies individuals who need assistance and work with Senior Companion Program projects to place them with Senior Companions. In fiscal year 2001, 15,500 Senior Companions tended to the needs of more than 61,000 adult clients.[99]

Program Successes in Other States. In 1997, Minnesota began implementing a five-county demonstration program that utilizes trained volunteers in the quality measurement process. The purpose of the program is to provide an alternative approach to the state licensing process. Two-

person volunteer review teams evaluate all services provided to a consumer and identify exceptional practices and necessary improvements. By September 2001, 92 reviews had been performed and 53 providers had been licensed or re-licensed under the system. The program has enjoyed widespread provider support.[100]

Additional Waiver Slots

Senate Enrolled Act 493 includes the following Medicaid waiver slot requirement.

> "Section 8. (c)...The office also shall seek approval for twenty thousand (20,000) additional waiver slots at no additional cost to the state."

The purpose of the 20,000 additional Medicaid waiver slots is to give the State the ready capacity to address the needs and full array of care options for persons eligible for home and community-based services under the provisions of The Act.

Medicaid waiver slots represent the targeted number of persons whom a State may serve under a Medicaid waiver program. Slots must be formally requested by States and approved by the Centers for Medicare and Medicaid Services before a consumer may participate in any of the Medicaid Home and Community-Based Services Waiver Programs. The request for approval of additional slots is normally a simple process, but it can be quite time-consuming. Even when funding does become available, eligible consumers cannot receive Medicaid Waiver services unless the State has available a slot to put them in. Therefore, it is essential that the State have available a sufficient number of empty slots in order to resolve timing issues and eliminate administrative barriers that all too often either delay the delivery of community-based services to eligible consumers or create an undesirable and expensive pathway to the institutional care provided in a nursing home.

The financing provisions of Senate Enrolled Act 493 were written to provide the ability to fund slots as people are moved into home and community-based services utilizing the resources of the State's existing global, or aggregate, long-term care budget. The request for, and subsequent federal approval of the slots was not designed nor intended to increase overall expenditures; it does, however, provide the assurance that eligible waiver clients are able to receive critical services as needed.

System of Integrated Services

Senate Enrolled Act 493 establishes the framework needed to ensure the coordination and integration of all long-term care services, not only those that are publicly-funded or directed to persons with low-incomes.

> "Section 12. (a) Before December 31, 2003, the secretary of family and social services (I.C. 12-8-1-2) shall discuss with the community and home options to institutional care for the elderly and disabled (CHOICE) board established by I.C. 12-10-11-1, and with any other agency, volunteer, volunteer group, faith-based group, or individual that the secretary considers appropriate, the establishment of a system of integrated services, including: (1) transportation; (2) housing; (3) education; and (4) workforce development; to enhance the viability and availability of home and community based care. (b) The secretary shall report to the governor and the budget committee any recommendations for funding these services."

A comprehensive long-term care program embodies not only consumers and providers of service, but also a number of systems and processes. All of these must be thoroughly evaluated in terms of their mutual relationship and scope of overlap, and then carefully coordinated.

In Indiana and throughout the country, affordable and accessible housing and transportation are limited and often inflexible for meeting the special needs of persons who are elderly and disabled. This is due both to an historic separation between housing and services at the federal level and a resultant dearth of coordination between services and publicly-funded housing programs at the state and local levels. It is remarkable that these programs are so separate, given the interrelationship between them. While affordable and accessible housing is needed to meet basic shelter and living needs, health care and support services are required to sustain an individual's physical and mental health and ability to remain independent in living. A similar dynamic exists with health care services and publicly-funded transportation; consumers need affordable and accessible transportation to obtain basic medical care and medications, to go grocery shopping, and to maintain important social relationships with family and community. Lack of any of these basic necessities adversely influences the health, social, and economic outcomes related to the others. As a result, the overall success of long-term care service delivery is seriously impeded.

Integration of services also includes integration and coordination of the administrative processes that support determination of need, eligibility, case management, delivery of services, and quality assurance. This addresses the adequacy of staffing, availability of training, establishment of clear program guidelines and regulations, seamless funding, efficient and responsive program management, data collection and reporting, quality assurance and careful program oversight. Only when administrative obstacles are removed can services be fully integrated.

Senate Enrolled Act 493 identifies the basic components of a fully-integrated system and services and requires the Indiana Family and Social Services to engage in targeted initiatives that will positively influence the current disconnect between community-based services and supports, transportation, housing, education, and workforce development.

Program Successes in Colorado, New York State and New Hampshire. Colorado's Single Entry Point System serves the long-term care assessment needs of the elderly and people with disabilities. Medicaid policy and administration for both nursing facility and community-based services is set in one division. Single Entry Point (SEP) agencies in 25 local districts are contracted to provide functional assessments for Medicaid nursing facility services, Medicaid home health benefits provided for more than 60 days, five Medicaid Waiver programs, a Medicaid Research and Demonstration waiver for self-directed services, and two state-funded programs. The SEP agencies also provide case management, serve people who can pay privately for assessment and case management, and offer services on a sliding scale when funds are made available. In 2002, the Colorado Single Entry Point System served more persons with community-based care (29,960) than with nursing home care (15,592).[101]

The New York Medicaid Program provides long-term care services through partially-capitated managed care plans. One of its managed care contractors, Visiting Nurse Services (VNS) Choice, coordinates acute care and long-term care services covered by both Medicare and Medicaid through a comprehensive plan of care and a nurse consultant who serves as the case manager for the consumer across all settings and services. The program began in 1998 and serves approximately 2,600 people[102].

In New Hampshire, a public housing authority has adapted the assisted living model to public housing, where services are made available to persons who need subsidized housing and who need assistance with at least three activities of daily living. The program is targeted to a public housing building for older persons but also provides services to non-residents when funding permits. The program offers a variety of services, including: two meals a day, weekly laundry and housekeeping, personal care, transportation, personal emergency response systems, and an on-site nursing clinic once each week. The program is unique in that it provides a seamless transition of services for the residents between the housing agency program and the Medicaid Home and Community-Based Services Waiver as their needs change.[103]

Calculation of Persons in Need

Senate Enrolled Act 493 requires the State to identify, calculate, and report on the level of long-term care need, both met and unmet, in the State.

> "Section 13. (a)...the office of the secretary of family and social services (IC 12-8-1-2) and the area agencies on aging shall calculate the number of individuals who may reasonably need care under this act, including the following individuals: (1) An individual receiving home and community based services under the community and home options to institutional care for the elderly and disabled (CHOICE) program established by IC 12-10-10-6. (2) An individual on the waiting list to receive home and community based services under the CHOICE program. (3) An individual receiving home and community based services under a state Medicaid waiver. (4) An individual on a Medicaid waiver waiting list to receive home and community based services. (5) An individual who receives assisted living services or adult foster care services under a Medicaid waiver. (6) An individual residing in a health facility licensed under IC 16-28 who may be appropriately served in a home and community based setting. (b)...the secretary shall report the findings under subsection (a) to the governor, the budget committee, and the budget agency..."

Calculation of met and unmet service need is absolutely essential for short and long-term strategic planning purposes, including the establishment of policy priorities, as well as for determining overall program costs and cost-effectiveness.

In Indiana's long-term care system, there is no formal or regular process for specifically determining the number, level and scope of consumers who are in need of services provided by the Medicaid or CHOICE Program but who are not receiving the services. Program waiting lists are often drawn upon to make need projections, but their reliability is limited for several reasons:

- Indiana's Medicaid Waiver and CHOICE Program waiting lists consist primarily of persons who have independently sought information or services and been denied because of lack of funding. Since lack of funds historically has limited the outreach efforts of program managers, there are a significant number of low-income elderly and disabled Hoosiers who are not aware of available services and are therefore not on any of the waiting lists.
- Waiting lists for the Indiana Medicaid Aged and Disabled Waiver Program have historically been short or nonexistent. This is not because funding for the program has been sufficient, but because the financial eligibility for the program has been so strict (77% Federal Poverty Level) that few consumers can afford to meet their housing and basic living needs and meet Medicaid spend down requirements. Indiana's institutional bias does, however, make more expensive nursing home services available. Additionally,

Indiana's other Medicaid Waiver Programs utilize a more liberal income eligibility standard.

- Indiana's Medicaid Waiver and CHOICE Program waiting lists are believed to include duplicate names.
- Indiana's Medicaid Waiver and CHOICE Program waiting lists are managed locally by the area agencies on aging. A lack of standardized guidelines between and within both programs makes waiting list management inconsistent.
- Waiting lists are not routinely updated, therefore, they likely include consumers who had no option other than nursing home care or who died while waiting for services.
- Waiting lists are a source for aggregated information on the level and amount of services needed by consumers, but for reasons already noted this information is neither complete nor wholly accurate.

Despite their limitations, waiting lists have historically played an important role in assisting Indiana State policymakers in determining the level of resources needed to expand community-based services. They are not, however, in their current form an accurate proxy either for predicting the total number of low-income elderly and disabled persons with unmet needs, or for determining the extent to which persons who are already receiving services are having their needs met. This information is essential for program planning purposes both for the short-term and the long-term, since it provides the necessary tools for determining the full range of costs and savings that can be generated by long-term care system rebalancing. It not only eliminates the financial risk associated with implementing certain program and service initiatives, but it also provides policymakers with the means for better determining current and future program and service priorities.

Senate Enrolled Act 493 requires the identification and reporting of unmet need precisely for these purposes.

Consumer Rights and Protections

Senate Enrolled Act 493 also includes a number of consumer protections. These are:

> Section 9. (b) An individual who receives Medicaid services through a Medicaid waiver shall receive the following: (1) The development of a care plan addressing the individual's needs. (2) Advocacy on behalf of the individual's interests. (3) The monitoring of the quality of community and home care services provided to the individual. (4) Information and referral services on community and home care services if the individual is eligible for these services.
>
> Section 9. (c) The use by or on behalf of an individual receiving Medicaid waiver services of any of the following services or devices does not make the individual ineligible for services under a Medicaid waiver: (1) Skilled nursing assistance. (2) Supervised community and home care services, including skilled nursing supervision. (3) Adaptive medical equipment and devices. (4) Adaptive non-medical equipment and devices.

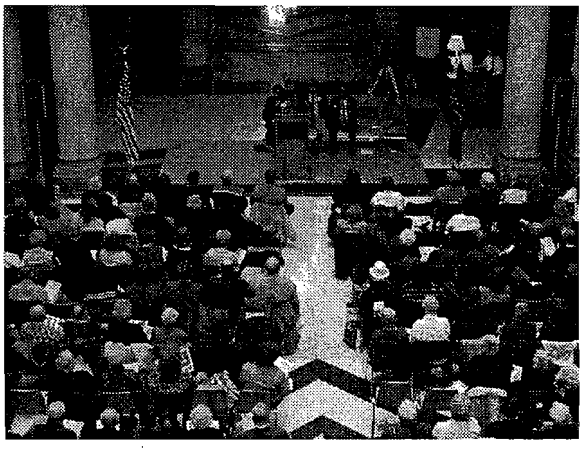
The consumer provisions in Section 9(b) are specifically included to protect the rights and prerogatives of citizens who use publicly funded long-term care services. Rebalancing is, by definition, not only an initiative that expands and improves information and access to services, but also one that is driven by consumer preference with respect to where, how, and by whom services are provided. Rebalancing places a real emphasis on consumer involvement in the

planning, service delivery, and monitoring process, including a regular evaluation of independence, dignity, and quality of life goals.

The consumer provisions in Section 9 (c) are specifically intended to preserve the rights of persons who have greater care needs and who can continue to have those needs met cost-effectively in a community-based setting. These protections are necessary to ensure that historically rigid policy interpretations within Indiana's Medicaid Program that have unnecessarily hindered a consumer's ability to receive needed care and supports in the community are not applied to the Medicaid Waiver Programs. For the same reasons, similar consumer protection language is contained in the CHOICE statute.

Case Study 4 - CHOICE & SEA 493; Contrasts in Implementation

In the past twenty years Indiana has seen the passage of two landmark laws to improve the availability, quality, and cost effectiveness of home and community based services. For persons needing long term care, these laws – CHOICE and SEA 493 – represented dramatic leaps in state policy and care possibilities. In both cases there were strong parallels in terms of the need, public mobilization, and politics that resulted in the passage of the acts. However, through the end of 2004, the implementation of the two laws revealed sharp differences.



1,200 people attended the 2003 Senior Rally Day at the State House in support of Senate Bill 493, a bill based on the systems change model developed by The Generations Project.

The CHOICE program came about as a result of a working alliance of the major senior citizen organizations with statewide general memberships. Also working within that alliance were most human service organizations including those representing persons with disabilities. These alliances were solidified in 1984 with the formation of the Indiana Health Care Campaign and later consolidated in 1986 with the establishment of the Indiana Home Care Task Force. They formed the basis for a cooperative and coordinated campaign to establish accessible and affordable state funded home health care services. Virtually all of the organizations that are formal members of The Generations Project today became members of the Indiana Home Care Task Force (Task Force) in 1986 and 1987.

By 1987, several health care trade associations joined the Task Force in supporting the recommendations of a legislative study commission to create a new system of state funded home health care. The commission was the General Assembly's initial response to the advocacy and public pressure generated by the member organizations of the Task Force. The hearings held by the commission provided a dynamic forum for education of the public and lawmakers regarding the benefits and components of home health care programs.

In the past twenty years Indiana has seen the passage of two landmark laws to improve the availability, quality, and cost effectiveness of home and community based services. For persons needing long term care, these laws – CHOICE and SEA 493 – represented dramatic leaps in state policy and care possibilities.

In late 1986, the commission issued its findings and with virtually unanimous formal support from organizations representing senior citizens, persons with disabilities, human service interests, and the health care industry (including nursing homes), these recommendations rolled through the 1987 state legislature with only one dissenting vote. The CHOICE legislation was signed into law that spring by Governor Robert Orr.

After its passage, both the Orr administration and later the Bayh administration met with consumer groups, area agencies on aging, and provider interests to effect the implementation of

CHOICE in Indiana. While those discussions were not easy, the law was implemented over time as passed by the legislature and as intended by senior citizen organizations and their allies in the Task Force. By the mid 1990s, the law was consistently rated by private experts and the federal government as one of the best state funded health care programs in the nation. More importantly, it received rave reviews by the individuals and families enrolled in the program.

Despite the success of the CHOICE program, it was and remains limited as a strictly state funded home health care program. CHOICE does not utilize Medicaid funding, rarely provides for alternative home and community based care residential options, does not equalize eligibility for home care with institutional care, and too rarely provides the means for individuals to transition from nursing facilities to home and community based care. Indiana clearly needed a publicly funded program to do all of these things. Huge waiting lists for home and community based care services proved that CHOICE, by itself, was not the answer. Furthermore, a better way to use Medicaid dollars to provide home and community based services was needed. The law designed to meet these needs was Senate Enrolled Act 493.

While CHOICE received national accolades for its structure and implementation, SEA 493 has, to date, only received such accolades for its structure. The law's final implementation remains an open question.

SEA 493 shared many of the same dynamics that led to the passage of the CHOICE program. It was a product of the Indiana Home Care Task Force, was unanimously supported by senior citizen organizations, and had deep support among professional provider interests. Like CHOICE, it was also endorsed by associations representing the nursing home industry.

Unlike CHOICE, the model for SEA 493 did not originate with a legislative study commission. Instead, it originated as a systems change model developed by The Generations Project. However, like the study commission of 1986, The Generations Project did provide the means to both develop the model and to educate the public regarding the need for comprehensive long term care change in Indiana.

Another parallel was the enthusiastic support of the General Assembly. SEA 493 was unanimously passed by both houses of the 2003 legislature and signed into law by Governor Frank O'Bannon.

Designed to leverage the system-wide financial and legal resources of Indiana's Medicaid system in support of home and community based care options, SEA 493 has a reach far beyond CHOICE while clearly resting on the foundation established by that program. However, the parallels between CHOICE and SEA 493 have largely ended with implementation. Twenty months since its passage, the major features of SEA 493 – including provisions dealing with income eligibility, alternative residential services, access to Medicaid dollars, and utilizing savings to expand home and community based services – have largely not been implemented.

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Recommendations and Conclusion

Senate Enrolled Act 493/Public Law 274 is a long-term care infrastructure law, the purpose of which is to eliminate any remaining program and service gaps that impede the further development of community-based programs in Indiana. The Act builds upon and formally partners the CHOICE and Indiana Medicaid Home and Community-Based Services Waiver Programs as the two primary pathways for delivering long-term care services to Indiana's low-income elderly and disabled populations.

The Act establishes funding parameters, accounting and reporting requirements, basic service and program components, and provides for a range of additional development and operational supports that are needed to foster growth, change, and improvement in long-term care and service delivery. By drawing upon the experience and successes of other states, the Act removes long-standing barriers to the provision of home and community-based care in Indiana and creates a full array of home and community-based services that can be used to cost-effectively and safely manage the care and support needs of Indiana's low-income elderly and disabled citizens.

Close to 200 citizens, advocates, and policy makers gathered at The Generations Project's Moving Forward Summit in November of 2004 to address how to speed the process of implementing SEA 493.

The Act was written from a consumer perspective and presumes their full involvement throughout the planning process and implementation and post-implementation phases of development. The Act provides the direction needed to make lasting change in Indiana, but bestows upon state policymakers the authority, flexibility, and responsibility for administration and oversight.

In order to achieve full compliance with The Act, state policymakers must redefine relationships with stakeholders and commit to working closely with consumers, legislators, and providers of long-term care services in Indiana. This is essential for ensuring that the State fully meets both the legal requirements of The Law and the needs of consumers and providers who rely on Indiana's long-term care service delivery system. Representatives of all stakeholder groups should be included throughout the discussion, planning, design, implementation and post-implementation phases. This may be best accomplished through the establishment of a technical planning and implementation team composed of state agency staff, all major consumer representatives, and representative providers.

All components of The Act must be implemented. Given the scope of effort involved with rebalancing Indiana's long-term care service delivery system, this is a large task that requires program planning and development of timelines. It is, however, a very reachable goal that has

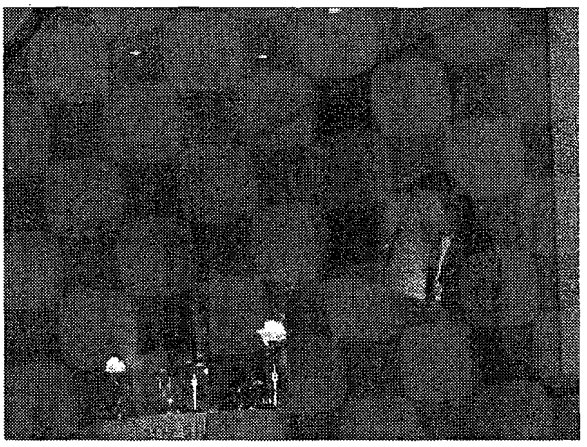
already been achieved in several states across the nation. Several specific recommendations that may assist with these efforts are as follows:

- The State should establish a Senate Enrolled Act 493 technical planning and implementation team that consists of a core group of state policymakers that have decision-making authority, prominent consumer leaders, and provider advisors. This Team should meet frequently and be dedicated to collaborative planning and timely implementation of all aspects of Senate Enrolled Act 493.
- Administration regulations for community-based services and all aspects of The Act should be developed by the State in close collaboration with consumers, and other stakeholders. Solicitation of input should not be limited to public hearings but should occur throughout the drafting and formal promulgation process.
- While all aspects of Senate Enrolled Act 493 should be implemented as timely and efficiently as possible, priority should be given to implementing the 300% Supplemental Security Income financial income eligibility threshold within the Aged and Disabled Waiver. Once funding becomes available to support additional waiver slots, this change should immediately reduce undesirable nursing home admissions (and therefore free up additional funds) but will also immediately impact the preservation of consumer housing.
- Priority should be given to implementing an aggressive deinstitutional, or transition, process in order to free up the funds available to support more consumers in community-based settings. This initiative has been supported with the award of a federal Nursing Home Transition Grant, but progress has been too slow to date.
- Priority should be given to the resolution of all outstanding issues related to self-directed care in order to expedite implementation. Since this initiative is funded with federal New Freedom Initiative grants, it is advisable to ensure that optimal use is made of available funds and technical assistance.
- Priority should be given to development of a viable assisted living and adult foster care service program. These service options are essential for meeting the needs of persons who are no longer able to live in a private home setting but who do not desire the more expensive services available in a nursing home and for successfully transitioning nursing home residents back into the community.
- Priority should also be given to securing the approval of the 20,000 additional waiver slots by whatever means necessary per the provisions of The Act in order to ensure the capacity that will be needed for the timely delivery of care.
- Finally, state policymakers should become immediately informed about the rebalancing initiatives that are currently occurring in other states in order to assist with the planning and full implementation of system rebalancing in Indiana.

Senate Enrolled Act 493 provides all the service and program features, timelines, and policymaking authority needed to rebalance Indiana's long-term care service delivery system. It does not (and should not), however, prescribe *how* rebalancing should be accomplished – *exactly how it should be designed, implemented, and later evaluated.* This is best left to a core team of technical and implementation specialists made up of state policymakers, leading consumer representatives, and provider advisors. These stakeholders should collaborate on an approach that optimizes available resources and selects best methods for implementing permanent and lasting change, while taking fully into consideration Indiana's existing systems and structures and drawing upon the best practices of other states.

There are several benchmarks that can be used to measure full compliance with Senate Enrolled Act 493 and complete success in rebalancing Indiana's long-term care service delivery system. Some of the more significant of these are as follows:

- The principles of client-driven and directed care are reflected at all levels of the state's system of long-term care services; from the hands-on delivery of services, to training, to state policymaking and planning with the CHOICE Board fully exercising its statutory prerogatives.
- The 300% Supplemental Security Income standard is implemented and incorporated in rule, eliminating Medicaid spend down for all Aged and Disabled Waiver clients and further abrogating Medicaid Program institutional bias.
- Community residential settings include a viable assisted living and adult foster care program that is affordable and available to Medicaid Waiver and CHOICE clients on a statewide basis.
- Money is allowed to follow the person who meets nursing home eligibility but who prefers to receive health care and other supports in his/her own home or other community residential setting at less cost.
- Medicaid Aged and Disabled Waiver and CHOICE clients are able to self-direct their care and fully supported in their efforts to do so.
- Nursing home utilization is significantly reduced (reduction in bed days) to reflect the increase in utilization of community-based services.
- The full scope of unmet need is identified and understood, and future program planning takes this fully into consideration.
- Waiver slots are immediately available to support program expansions as they occur.
- The role of caretakers and the effects on Indiana's long-term care service delivery system and economy are fully understood. The caretaker support program should reflect these dynamics.
- Nursing home providers are fully engaged in a program that helps them transition to community-based care. If successful, this will reduce the number of nursing facilities statewide and grow the number of available community-based service providers.
- The long-term care system of delivery is fully integrated with established relationships between human and social services, housing, workforce development and transportation. Success will be achieved when policymaking for all services is collaborative and common barriers are eliminated.
- Waiting lists for all long-term care services are consistently managed and are reliable determinants of unmet needs.
- Cost and savings formulae are established and accepted by all stakeholders, and agreed-upon measurements of progress are reported routinely and consistently to ensure that financial expectations of rebalancing are achieved.
- Volunteers and volunteer groups are formally incorporated into programs, and their contributions are regularly reported both in terms of societal and economic value.
- Consumer representatives are formally and permanently incorporated into the policymaking process, which takes fully into account the perspectives of all stakeholders.



Judith Becherer, the author of this report, presents her initial findings to those attending the November 2004 Moving Forward Summit in Indianapolis.

Senate Enrolled Act 493 not only provides state agencies with the authority needed to make critical changes to Indiana's long-term care service delivery system, but it also introduces a number of new opportunities for program and service collaboration, consideration of best practice models, and innovative funding and service delivery approaches. In so doing, the Act provides the framework for helping the State of Indiana meet its federal *Olmstead* decision requirements, respond to the recommendations of the late Governor O'Bannon's Commission on Home and Community Based Services (2002 - 2003), and meet the goals established by the Indiana Family and Social Services Administration in its Comprehensive Plan for Community Integration and Support of Persons with Disabilities (June 1, 2001).

Senate Enrolled Act 493 embodies the goals and objectives of legislators, state policymakers, consumers, community-based providers, and all Hoosiers; namely, to provide quality health care and supports to its most vulnerable, low-income elderly and disabled populations in the least restrictive and most desirable settings, while optimizing consumer dignity, independence and choice in the most efficient, safe, and cost-effective manner possible.

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Glossary

Adult Day Care Services, or Adult Day Services - Community-based, group day-time programs that include health, therapy and social services furnished in an outpatient setting on a regular basis for one or more days a week. Adult day care services are specifically targeted to meet the needs of elderly and disabled individuals who live in their own homes or some other residential setting and who desire to remain in the community, and close to their families.

Adult Foster Care - Refers to any family home or other facility in which residential care is provided in a home-like environment for compensation to three or fewer elderly persons or adults with physical and/or cognitive disabilities who are not related to the provider. Services include: room and board; supervision, personal care; homemaker; chore; attendant care and companion services; and medication oversight (to the extent permitted under state law). Adult foster care provides both affordable and accessible housing and necessary healthcare services in a small, community-based residential setting.

Assisted Living - A state-regulated and monitored residential long-term care option that provides or coordinates oversight and health care and support services to meet the residents' individualized scheduled needs. Services may include: access to 24-hour assistance; assistance with activities of daily living and instrumental activities of daily living; health related services; social and recreational services; recreational activities; meals; housekeeping and laundry; and transportation.

Bond Financing – A provision in Senate Enrolled Act 493 that provides a nursing home borrower with access to low interest rate capital markets through the issuance of tax-exempt revenue bonds. Proceeds from the loan may be used by eligible borrowers to fund construction/renovation projects, land acquisition for future project, acquisition of existing health facilities, refinancing of existing debt, working capital for start-up facilities and pay costs of issuance.

Caretaker Support Program, or Caregiver Support Program - A program that makes available services and creates and supports policies that are designed to better meet the needs of the caretaker so that (s)he can maintain physical and economic well-being of self while continuing to provide the caretaking support needed by a loved one. Support may include: information about available support services; assistance with accessing those and other services; training; respite; availability of affordable, dependable, and qualified providers to meet the health care and other support needs of the person for whom the caretaker is responsible; and reasonable flexibility by the caretaker's employer.

Cash and Counseling - A service model whereby personal care workers are selected, hired, trained, and paid for by the consumer with monthly cash payments deposited electronically into participants' bank accounts. A fiscal intermediary is available but not required. Several states use this model through one of the Independent Choices research and demonstration waiver initiatives.

Centers for Medicare and Medicaid Services – The federal agency within the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid Programs.

CHOICE - The acronym for Indiana's Community and Home Options to Institutional Care for the Elderly and Disabled Program.

CHOICE Program - Refers to Indiana's Community and Home Options to Institutional Care for the Elderly and Disabled program, which is a 100% state-funded program specifically intended to keep individuals out of nursing homes, to keep individuals from being forced into poverty by long-term care costs, and to maintain dignity, independence and choice with consumer-driven services. CHOICE provides services to Indiana residents who are age 60 and older, and to persons with disabilities of any age who are unable to perform two or more activities of daily living. CHOICE pays for a range of community-based services, including home health, attendant and personal care, chore services, transportation, adult day care, respite care, and more. CHOICE funds are available on a sliding scale according to income.

Client or Beneficiary – refers to a consumer who is eligible for, enrolled in, and/or receiving publicly funded, long-term care services.

Commission on Home and Community Based Services (2002-2003) – A commission established by the late Governor Frank O'Bannon composed of public officials and consumer and provider representatives to investigate and make recommendations for transforming Indiana's system of long term care into a system that utilizes a larger array of home and community based services.

Community-Based Services – refers to health care and support services provided to individuals in their private homes or other community residential service setting. This does not include institutional services.

Community-Residential Services – Health care and support services provided in an adult foster care home or assisted living facility.

Comprehensive Plan for Community Integration and Support of Persons with Disabilities (June 1, 2001) – The plan developed by the Indiana Family and Social Services Administration to comply with the U.S. Supreme Court's Olmstead decision.

Consumer - refers to persons who are in need of, eligible for, or receiving long-term care services. Within the context of this paper, most references to consumer mean persons who have low-income and are elderly and/or disabled.

Direct Pay Model - A service model whereby the consumer assumes responsibility for all functions. The consumer is the employer of record and handles hiring/firing, training, supervising, scheduling, and assumes payroll and tax responsibilities. The State of Kansas uses a variation of this model.

Divert – The process of keeping a person who has been determined eligible for nursing home care from entering a nursing facility through the provision of a home and community based long term care alternative.

Dual-Eligibles – Refers to 6-7 million Americans who have low-income and are elderly and physically disabled who qualify for both the Medicare and Medicaid Programs.

Fiscal Intermediary Model - A service model whereby personal care workers are selected, hired, and trained by the consumer, but responsibility for wages, payroll taxes, and worker's compensation insurance are assigned to a state agency or a third-party fiscal intermediary with whom the state contracts. The State of Florida uses a variation of this model through one of the Cash and Counseling Demonstration grants.

Global Long-Term Care Budget - Refers to public assistance budgets that combine funds for all long-term care services in one account, rather than to designate specific funding caps for specific types of service in separate long-term care accounts. This single appropriation structure provides the administrative flexibility needed to readily transfer funds among services as needed and according to program priority.

Home Health Care – A mandatory State Plan service within the Medicaid Program for persons entitled to nursing home care. Home health services are also an essential component within Medicaid Home and Community Based Services Waiver Programs and Indiana's CHOICE Program. Home health services include nursing, home health aides, medical supplies, medical equipment, and optional therapeutic services of physical therapy, occupational therapy, speech pathology, and audiology services.

Indiana Family and Social Services Administration – The Agency in Indiana that is responsible for administering the Medicaid Program, Medicaid Home and Community-Based Services Waiver Programs, and CHOICE Program. Also known as FSSA.

Insite – Indiana's automated long-term care case management assessment and tracking tool.

Institutional Bias – Federal and state long-term care program policies that render institutional care provided in nursing homes and intermediate care facilities for the mentally retarded/developmentally disabled more accessible and affordable for the consumer than less-expensive care provided in the community.

Institutional Services – Refers to services provided in a nursing home, intermediate care facility for the mentally retarded/developmentally disabled, or hospital. For purposes of this paper, institutional services available to persons who are elderly and non-developmentally disabled normally refer to services provided in a nursing home.

Integrated System of Service Delivery – Refers to the development of an integrated system of home and community based services that include transportation, housing, education and workforce development as authorized in Senate Enrolled Act 493.

Long-Term Care - Refers to healthcare and service supports that are provided in a private home, community residential, or institutional setting to persons who are unable to manage common activities of daily living because of disability, frailty, chronic illness, or mental incapacity. Services may include home health care, nursing, respite, homemaker, attendant care, home modifications, and other supports.

Medicaid – A jointly-funded state and federal program that provides health insurance coverage primarily to low-income elderly and disabled adults, pregnant women, and children who meet strict categorical and financial eligibility requirements. The Medicaid Program operates within broad federal guidelines but extends considerable authority to the states in determining what populations are eligible for services, service scope, coverage and payment rates, and administrative structure. It is administered at the federal level by the Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services, and at the state level by the Indiana Family and Social Services Administration.

Medicaid Home and Community-Based Waiver Program or Medicaid Waiver - Refers to federal authorization for states to "waive" certain basic Medicaid program requirements to allow

persons who are eligible for nursing home and other forms of institutional care to receive traditional and non-traditional long-term care services in their own home or other non-institutional community setting, providing they do so cost-effectively.

Medicare - A social health insurance program that is financed largely through payroll taxes and federally administered. It covers more than 35 million Americans who are elderly and non-elderly with disabilities. Basic services covered include: inpatient hospital, limited skilled nursing facility, hospice, and home health care. Prescription drug coverage will be added beginning in 2006. Supplemental services such as physician, outpatient hospital, lab tests, medical supplies, and home health are available through the voluntary purchase of premiums.

"Money Follows the Person" - Refers to a long-term care system rebalancing policy where funding is assigned to an individual, regardless of the setting in which services are delivered.

MR/DD - The abbreviation for persons who are mentally retarded and/or developmentally disabled. In this paper the reference that has generally been used is developmentally disabled.

Nursing Home – Federal regulation generally defines a nursing facility as an institution (or a distinct part of an institution), which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; rehabilitation services for injured, disabled, or sick persons; or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) that can be made available to them only through institutional facilities.

Office of the Secretary of the Family & Social Services Administration – Refers to the office of the chief administrative officer of the Indiana Family and Social Services Administration, the umbrella agency for most of the human service programs administered by the State of Indiana.

Olmstead v. L.C. (1998) – The U.S. Supreme Court decision establishing the right of persons with disabilities to receive home and community based care under defined circumstance through programs that are administered by states.

President's New Freedom Initiative – A nationwide initiative to remove barriers to community living for people of all ages with disabilities and long-term illnesses. It represents an important step in working to ensure that all Americans have the opportunity to learn and develop skills, engage in productive work, choose where to live and participate in community life. It was announced by President Bush on February 1, 2001 and followed up by Executive Order 13217 on June 18, 2001.

Quality Assurance – Refers to the second component of a quality management system, which establishes the process of looking at how well a medical service is provided. The process may include formally reviewing health care given to a person, or group of persons, locating the problem, correcting the problem, and then checking to see if what you did worked.

Quality Improvement – Refers to the third component of a quality management system, which goes beyond normal quality assurance functions and formally addresses the resolution of wide-spread or significant problems and improvement of existing health and performance outcomes. Quality improvement may occur as a minor or major adjustment to a process or function, or as a special project.

Quality Improvement Process, or QIP – Indiana's consumer survey component of the State's automated case management assessment and tracking system. The survey is imbedded within Insite, Indiana's automated case management assessment and tracking system, and is administered to at least 5% of all program participants during annual reassessment. It provides information on various aspects of service delivery from the participant's perspective, including consumer choice, timeliness, respectfulness, consistency and task performance. Results of the QIP are used on an individual basis to identify and follow-up on serious incidents, as well as to provide feedback to providers on their performance

Quality Management - A function or process that includes three main components: quality system design, quality assurance, and quality improvement.

Quality System Design – Refers to the first component of a quality management system, which provides the framework that specifies the methods for how quality assurance and improvement activities will be carried out.

Rebalancing - Refers to state and federal efforts to shift the focus and delivery of long-term care services away from traditional institutional forms of care like nursing homes, and toward health care and support services that are selected and directed by consumers and that can be provided in their own homes or other community-based residential settings.

Self-Directed Care, or Consumer-Directed Care - A service delivery model that gives consumers and/or their families the right and the authority to develop service and support plans that reflect their wishes and preferences and to choose some or all of the following: who will provide their care; training, hiring, and firing of the person selected; service scheduling; purchasing and supervising the service; and possibly directing the payment of personal assistance and other support providers.

Senate Enrolled Act 493/ Public Law 274-2003 (The Act) - Refers to a public law that was created by the 2003 Indiana General Assembly. It establishes the broad administrative authority and the programmatic and service foundation needed to *rebalance* Indiana's long-term care service delivery system from one that is based on traditional, institutional forms of care like nursing homes, to one that favors healthcare services and supports that can be selected and directed by Hoosiers and provided in their own homes and other community residential settings. All provisions of The Act are now effective.

Spousal Impoverishment Protections - Refers to the Medicaid financial eligibility requirements of a married couple when one person requires long-term care services normally provided in an institution and the other spouse does not. Since 1988, states have been mandated to allow married couples who were faced with separation due to the institutionalization of one spouse to protect a certain amount of assets and income for the non-institutionalized spouse. At that time, spousal impoverishment protection was also made a state option for Medicaid Home and Community Based Services Waiver Programs, which are designed to serve persons who are at risk of needing, or who require institutional care.

Stakeholder - Refers to persons who have an interest or stake in Indiana's long-term care service delivery system. Stakeholders include: consumers and their families, consumer advocates/representatives; providers and provider representatives; and state policymakers.

Supplemental Security Income - Supplemental Security Income (SSI) is a Federal income supplement program managed by the Social Security Administration and funded by U.S. Treasury

general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people who have little or no income by providing monthly cash payments to meet basic needs for food, clothing, and shelter. The basic SSI amount is the same nationwide, however many states, including Indiana, add money to the basic benefit.

System change model – In the context of this report, a draft model for changing the design and structure of publicly funded long term care services in Indiana.

The Act - Refers to Senate Enrolled Act 493/Public Law 274-2003.

Transition – The process of moving from a nursing home or another form of institutional care to a home and community based form of long term care.

Unmet Need - Refers to the number of persons who have long-term care needs but who are not receiving any or all of the services that they require.

Endnotes

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Exhibit M
Select Joint Commission on Medicaid Oversight
August 12, 2010

August 12, 2010

Testimony of Paul Chase, Associate State Director for Public Policy, AARP Indiana Before the Select Joint Commission on Medicaid Oversight

Good afternoon. My name is Paul Chase. I am the Associate State Director for Public Policy for AARP Indiana. AARP is a non-profit, non-partisan membership organization that works to improve the quality of life for people age 50 and older. AARP has over 836,000 members in Indiana alone.

We appreciate the opportunity to provide testimony regarding challenges facing Indiana's Medicaid Aged and Disabled Waiver program, and how those problems are worsened by the Administration's decision to cut funding for the CHOICE program by 15% for FY 2011.

It is not clear how this cut will apply. While we oppose any cut to this vital home and community-based program, at the very least this cut should not apply to the $12.9 million annual intergovernmental transfer for Medicaid Aged and Disabled Waivers.

AARP initially raised concern when the Administration decided to cap enrollment in A & D Waivers in December 2009, less than half-way through FY 2010. At the June, 2010 CHOICE Board meeting it was reported that there were 2,569 people on the A& D Waiver waiting list. That number has grown since then, as you will hear from the Indiana Association of Area Agencies on Aging.

Our concern is that at a time when every dollar matters, this approach is actually increasing the cost of long-term care services to the state.

This is because people who qualify for A & D Waiver services are also eligible for nursing home care. And unlike waivers, nursing home care is an entitlement. With a 15% cut in CHOICE services, and a waiting list for waiver services that is roughly twice as large as the total number of A & D Waiver slots budgeted for the entire FY 2011, more and more individuals are being forced into nursing homes, as will be more fully discussed by the Indiana Association of Area Agencies on Aging.

Data from the Division of Aging reflect the cost-effectiveness of waiver services. Its Financial Review report for FY 2009 documents a monthly per-person saving of $730 for Medicaid A & D Waiver as opposed to nursing home expenditures. That amounts to a per-person annual savings of $8,760.[1]

It is my understanding that CMS regularly approves requests from states to increase the number of Medicaid Aged and Disabled Waiver slots beyond what was originally projected.

[1] The cost-effectiveness of the CHOICE program is even more dramatic. According to the CHOICE Annual Report for SFY 2009, the average cost per month for a CHOICE client was $423.81, compared to the average cost per month of a client in a nursing facility of $4,575.89, for an overall per-person yearly savings of $49,825, of which $18,470 is the state's share.

In other words, the lack of sufficient A & D Waiver slots to address current and future demand is not due to federal restrictions. Instead, it is due to Indiana's unwillingness to ante up additional state dollars to pull down federal matching dollars.

On the other hand, this is exactly what our state is now doing for every wait-listed individual who goes into a nursing home, and at a significantly greater cost. Moreover, the state cannot place a cap on the number of nursing home enrollments.

In summary, while we are hopeful the 15% reduction in available CHOICE dollars does not affect the $12.9 million amount that is used to purchase additional A & D Waivers, the state must allocate sufficient dollars to pull down federal matching dollars and eliminate the waiting list for waiver services.

AARP's 2009 publication entitled "Across the State's" ranked Indiana 48th in the percentage of Medicaid expenditures for home and community-based services in 2007.[2] Our current approach will only take us further in the wrong direction in balancing our long-term care system.

Respectfully submitted,

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[2] The ranking was established by first separating out older adults and adults with physical disabilities from other long-term care populations.

Indiana Association of Area Agencies on Aging

Testimony on Long Term Care Services
Medicaid Oversight Commission

August 12, 2010

Good afternoon and thank you for this opportunity to comment on Indiana's Medicaid Aging & Disabled Waiver and CHOICE Programs. Both programs are critically important long-term care programs that allow older adults and people with disabilities to remain affordably and safely in their own homes rather than accessing costlier facility-based care.

My name is Kristen LaEace, and I am the CEO of the Indiana Association of Area Agencies on Aging, representing Indiana's 16 Area Agencies on Aging that manage long-term care services for people of all ages in each of Indiana's 92 counties. You have as part of your package an Indiana map that indicates the AAA serving your constituents by county, including your local AAA's contact information. You should feel free to contact your AAA at any time regarding your own questions or concerns, or those of your constituents.

Joining me is Michelle Prendergast, a Care Manager and Team Leader from CICOA Aging and In-Home Solutions, the Area Agency that services Central Indiana. She will be able to answer specific questions you may have about how Area Agencies manage A&D Waiver and CHOICE for home- and community-based services. She can also speak to the direct impact of the recent A&D Waiver limitations and cuts to CHOICE on our neighbors that she serves daily.

According to the FSSA's CHOICE FY 2009 Annual Report, the "typical" CHOICE client was female, age 85 years or older and living alone. She would have had circulatory, nervous or muscular impairments and was unable to perform three or more critical activities of daily living, or ADLs. The A&D Waiver also requires a minimum of three ADL's. Importantly, this level of impairment is the same level of impairment that qualifies consumers for nursing facility care.

Also according to the annual report, the average annual cost for a CHOICE consumer was about $5,000, compared to the average annual cost of a nursing facility consumer of about $55,000, representing an annual yearly savings $50,000, of which the state's share is $18,500. Total state CHOICE expenditures for FY 2010 were $47,000,000.

One may argue that nursing facility consumers are more medically needy than A&D Waiver and CHOICE consumers. However, with the current limitations on both A&D Waiver and CHOICE, AAAs are finding clients that might normally be served more cost-effectively at home are now being driven into nursing homes. Data bears this out. In the first half of 2009 when Waiver and CHOICE services were more readily available, AAAs statewide conducted 27,667 screenings for nursing home admissions. In the first half of 2010, in which Waiver services were limited and AAAs prepared for CHOICE cuts, AAAs statewide conducted 30,282 screenings, a 9.5% increase.

Using the savings calculations described above, the state may have realized a $130,750,000 savings, of which $48,377,500 can be estimated as the state share.

Exhibit N
Select Joint Commission
on Medicaid Oversight
August 12, 2010

Further, every Indiana AAA now reports waiting lists for both A&D Waiver and CHOICE services. Statewide, as of this past Tuesday, AAAs report there were 4027 of our neighbors waiting for A&D waiver services, and 4,388 of our neighbors waiting for CHOICE. This data is available through the Division of Aging's own case management system. A breakout of this data by AAA is included in your hand out, so that you may gain some sense of the number of your own constituents that are waiting for services.

Both CHOICE and the A&D Waiver are important parts of the state's continuum of long-term care services. CHOICE is required to be a resource of last resort. CHOICE applicants must also submit A&D Waiver applications in the event they may be Medicaid eligible. In the past several years, AAAs statewide have implemented an enhanced model of services called Aging and Disability Resource Centers, or ADRCs. An important component of an ADRC is Options Counseling, in which AAA staff educate consumers and their families regarding ALL available long-term care options, including those which are available on a private-pay basis, are available through existing medical and long-term care insurance policies, may be provided by a relative or neighbor, or are available as the result of local, state and federal support including CHOICE, Medicare and Medicaid. AAA staff then facilitate a family's decision making process regarding the best options for their loved-one.

Through this counseling model, AAAs truly amplify and extend Indiana's investment in both CHOICE and A&D Waiver. Families tap services available through volunteer and private-payor sources before even accessing them.

While the typical CHOICE client may be a frail older adult, CHOICE and Medicaid Waiver serve Hoosiers of all ages. In 2009, of the 9,200 CHOICE participants, 420 of them were children ages 18 or younger. 1,800 were adults under the age of 60.

Importantly, unlike Medicaid Waiver services, CHOICE does not require a consumer to impoverish themselves to access services. While there are no income restrictions for eligibility, CHOICE consumers may have no more than $500,000 in assets, and CHOICE requires a cost share for anyone over 150.0% of the Federal Poverty Level. Over 350.0% of poverty, CHOICE consumers pay 100.0% of the cost of their in-home services, though they still receive both case management and a lower rate for their in-home services.

The impact of these eligibility guidelines is tremendously important for enhanced consumer self-sufficiency. Consumers that have CHOICE support are able to use their own resources to address emergencies to keep their homes intact, such as fixing a roof, furnace or other home safety concerns that might otherwise pose a health hazard or render their own homes uninhabitable.

In conclusion, the result of the current limitations of both A&D Waiver and CHOICE is that Hoosiers are being forced into nursing facility care rather than being able to stay in their own homes, at a significantly greater cost to taxpayers. We hope to work with you in the upcoming Indiana General Assembly to remedy this imbalance.

Indiana Association of Area Agencies on Aging

Testimony on Long Term Care Services
Medicaid Oversight Commission

August 12, 2010

Data collected as of Tuesday, August 10, 2010, from the Indiana Division of Aging "Insight" case management and reporting system.

	CHOICE Waitlist as of 8/10/2010	A & D Waiver Waiting List as of 8/10/2010	PAS Total Cases 1/1/2009-6/30/2009	PAS Total Cases 1/1/2010-6/30/2010
Area 1	179	313	2,156	2,651
Area 2	1044	681	2,947	3,009
Area 3	354	202	2,739	3,150
Area 4	234	143	1,532	1,494
Area 5	172	76	1,258	1,394
Area 6	426	294	1,817	2,344
Area 7	138	61	1,146	1,416
Area 8	265	980	7,079	7,302
Area 9	81	65	891	939
Area 10	37	62	696	722
Area 11	150	120	733	936
Area 12	9	61	648	655
Area 13	191	94	1,067	1,121
Area 14	514	519	802	819
Area 15	377	124	558	592
Area 16	217	232	1,598	1,738
TOTAL	**4,388**	**4,027**	**27,667**	**30,282**

2,615 = PAS screenings increase, first half of 2010 over first half of 2009.

Mitchell E. Daniels, Jr., Governor
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Anne Waltermann Murphy, Secretary

"People helping people help themselves"

FSSA Office of Communications and Media

Communications Policy Statements

Exhibit O
Select Joint Commission on Medicaid Oversight
August 12, 2010

Policy on Media Representation:

Employees and contractors of the Family and Social Services Administration should refer all media inquiries to Marcus Barlow, Director of Communications and Media. It is in the best interest of FSSA and those we serve to maintain a consistent, clear voice to our stakeholders and to the public. So, if you are contacted by a member of the media, contact Marcus before releasing any information at Marcus.Barlow@fssa.IN.gov or (317) 234-0197.

Policy on Communicating with Legislators:

Employees and contractors of the Family and Social Services Administration should refer all inquiries from legislators, legislative staff, the Legislative Services Agency or lobbyists on FSSA legislative and policy matters to the appropriate FSSA division director. The director will then contact FSSA's legislative director. This policy is simply to ensure that FSSA speaks with a consistent voice on FSSA's legislative and policy matters.

Policy on Public Record Requests:

Employees and contractors of the Family and Social Services Administration that receive public records requests should forward those requests to the appropriate FSSA division director, to director of the Office of Communications and to FSSA's General Counsel. The Office of the General Counsel will direct the appropriate response. This policy is to ensure that FSSA responds within the appropriate time, manner and in compliance with Indiana state law.

Written and Electronic Information:

Virtually all communications between and among employees and contractors of the Family and Social Services Administration are public record. This may include, but is not limited to e-mail, memorandums, postings on the state Intranet and SharePoint sites. As public record, any of these items could be disclosed to the public. Please use appropriate judgment in deciding the content of these communications.

Similarly employees and contractors who participate in online public forums and social media sites (such as blogs, message boards, Facebook, MySpace, Twitter, LinkedIn), when responding as an employee or representative of FSSA, are advised to use appropriate judgment in deciding the content of these communications.

FSSA/OCM Rev. 07/16/2010