

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 MINUTES¹

Meeting Date: September 21, 2010
Meeting Time: 10:00 A.M.
Meeting Place: State House, 200 W. Washington St.,
Senate Chamber
Meeting City: Indianapolis, Indiana
Meeting Number: 2

Members Present: Rep. William Crawford, Chairperson; Rep. Charlie Brown; Rep. Timothy Brown; Rep. Suzanne Crouch; Sen. Patricia Miller; Sen. Ryan Mishler; Sen. Luke Kenley; Sen. Sue Errington; Sen. Vi Simpson; Sen. Connie Sipes.

Members Absent: Rep. Don Lehe; Rep. Peggy Welch.

The second meeting of the Commission was called to order by Rep. William Crawford, Chairperson, at 10:15 AM. Chairperson Crawford announced changes to the order of the agenda and commented that the afternoon session on public assistance issues should be abbreviated since few complaints regarding the operation of the hybrid eligibility system have been received. He asked the Family and Social Services Administration to include in their comments any anticipated increased cost related to the implementation of the hybrid eligibility system. Chairperson Crawford introduced the long-term care topic for the morning explaining that presenters were asked to address factors that prevent or impede the delivery of high quality care in the nursing facility system.

Long-Term Care Facility Issues

State Department of Health Update on Health Facility Evaluation & Quality Measures
Mr. Terry Whitson, Assistant Commissioner on Health Care Regulatory Services, reviewed the information contained in the slide presentation and other material distributed. (See Exhibits A, B, and C.) He responded to Commission questions regarding the inappropriate

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.

placement of Alzheimer patients, the desirability of setting minimum nursing facility staffing requirements, consistency of survey results, nursing facility staffing turnover rates, and survey deficiency statistics.

Department of Insurance Update on the Long-Term Care Insurance Program and the Community Living Assistance Services and Supports (CLASS) Act

Ms. Robyn Crosson, Chief Deputy Commissioner, provided the Chairperson with a packet of long-term care insurance promotional materials. (See these materials at Exhibit D and at: http://www.in.gov/iltcp/files/What_You_Should_Know_5-2009.pdf and http://www.naic.org/index_ltc_section.htm for "A purchaser's Guide to Long Term Care Insurance".) Ms. Crosson explained that long-term care insurance does not cover medical services and that policies are purchased from an insurance agent - the Department of Insurance (DoI) does not sell insurance. The price of a policy depends upon the insured's age, gender, and health status, and the policy remains in force as long as the premium is paid. She added that individuals may obtain information regarding long-term care insurance through the State Health Insurance Assistance Program (SHIP). The SHIP provides free, unbiased insurance advice to seniors and pre-retirees statewide. The DoI also administers the Indiana Long-Term Care Insurance Program, also referred to as the Partnership Program. Ms. Crosson reviewed activities undertaken to promote awareness of long-term care insurance, the advantages of Partnership policies, and the level of sales of qualifying policies sold under the Partnership Program. She stated that 48,218 policies have been sold, 37,965 policies are in force, 67 individuals have exhausted benefits under the policies, and 40 have moved to Medicaid-provided services. There is no information available regarding the number of nonqualifying long-term care policies sold or in force in the state.

Ms. Crosson explained that at present, little is known about the requirements for implementation of the CLASS Act provisions within the Affordable Care Act (ACA). The provisions of CLASS do not become effective until October 2012, and the federal Health and Human Services Administration has not dealt with the subject yet. She explained that CLASS is an employer payroll deduction program - not an insurance program and that DoI does not have statutory authority since CLASS is not an insurance product. The CLASS program has no underwriting, has no upper payment limits, and persons who are not insurable could contribute and participate. She added that regulations for the program have yet to be developed and that the statute requires that the funding for the program must last for 75 years.

Commission discussion followed regarding the need to encourage younger individuals to purchase long-term care insurance and whether the Partnership asset protection includes reciprocity with other states.

FSSA Update on Health Facility Medicaid Reimbursement

Ms. Faith Laird, Director, Division on Aging, briefly described the Medicaid case-mix reimbursement system for nursing facilities, reviewed the Phase II changes to the case-mix reimbursement system, and how those changes provide incentives to provide quality care. She discussed potential Phase III changes, provided an update on the Closure and Conversion Fund, and defined the amount of additional revenue that could be generated by maximizing the Quality Assessment Fee (QAF). (See Ms. Laird's written remarks in Exhibit E and a summary of the case-mix reimbursement system in Exhibit F.)

Attorney General's Office, Health Facility Complaint Investigation and Adjudication Process

Mr. Dave Miller, Legislative Liaison, and Mr. Allen Pope, Director, Medicaid Fraud Division, reviewed the complaint and investigation process within the Attorney General's Office. Mr. Pope emphasized that the AG's Office does not have the authority to impose sanctions; cases are referred to county prosecutors, licensing boards, the CNA registry, or the federal

Health and Human Services Office. Attorney General Greg Zoeller presented four recommendations for legislative or regulatory action. (See Exhibit G.)

Commission questions and discussion followed regarding the Attorney General's recommendations.

Mr. Scott Tittle, President, Indiana Health Care Association, referred the Commission members to the material distributed and explained what documents were included. (See Exhibit H.) He discussed health facility economic impacts, reviewed statistics, staffing, and training issues.

Mr. Jim Leich, President /CEO, IN Association of Homes & Services for the Aging, pointed out that the Medicaid reimbursement system is an important public policy tool. He reviewed the history of the case-mix reimbursement system and the QAF as steps in the process of rewarding nursing facilities that provide quality patient care. He also discussed staffing and training issues. (See Exhibit I for Mr. Leich's written testimony.)

Mr. Vince McGowan, Chairman, Hoosier Owners and Providers for the Elderly, answered Commission questions regarding the posting of staffing hours, staffing standards, and CNA turnover.

Chairperson Crawford requested written quality improvement suggestions from the nursing facility representatives by the end of September.

The Commission recessed at 1:10 PM. Rep. Crawford reconvened the Commission at 2:10 PM.

Long-Term Care Provisions under the Affordable Care Act

Mr. Roger Auerback, representing AARP, reviewed the provisions of the CLASS Act and other long-term care provisions within the ACA. (See the slide presentation at Exhibit J.) During his testimony, Mr. Auerbach clarified that under Indiana spousal impoverishment provisions, applicants for home and community-based services already have parity with applicants for institutional services. Mr. Auerbach also distributed Exhibit K to Commission members.

Ms. Robyn Grant, United Senior Action, discussed staffing levels in nursing facilities. (See Ms. Grant's written comments in Exhibit L.)

Administration of Public Assistance, Eligibility Determination

Eligibility Modernization Project Update

Ms. Anne Murphy, Secretary, FSSA, reviewed public assistance enrollment statistics and the applications backlog. She suggested that the hybrid eligibility appeared to be the driving factor in decreasing backlogged cases at a time when enrollments were increasing. Secretary Murphy reviewed statewide system performance statistics presented in her slide presentation. (See Exhibit M.) She also discussed the roll-out time table and process of implementing the hybrid eligibility system. (See Exhibit N.) Secretary Murphy discussed employee training, application options available under the hybrid system, call center operations, and disability applications. She reviewed the SNAP error rates and remarked that FSSA staff and long-term employees are due the credit for the improved performance.

Commission discussion followed. Rep. Crouch and Rep. Riecken distributed letters to the Commission regarding the improvement in performance due to the hybrid system. (Exhibits O & P) Commission questions followed regarding why the roll-out of the hybrid could not be done faster, metrics for modernization and previous performance, the cost of the contract,

litigation with IBM, status of Healthy Indiana Plan enrollments, Indiana Client Eligibility System (ICES) replacement and cost, and the level of uncompensated care in the state.

Privatization of Social Services: An Examination of Health Care

Ms. Tia Kolasa and Ms. Katie Harris, students from the Department of Social Work at Valparaiso University presented a paper prepared by the Senior Social Policy Class. (See Exhibit Q.) Chairperson Crawford recognized the members of the class in attendance.

Ms. Teresa Torres, Director, Everybody Counts, presented a video containing an interview with Joey, a young man with disabilities who went to Colorado to receive services that were unavailable to him in Indiana.

Mr. Fred Gilbert, retired caseworker from Allen County, commented on aspects of the modernized system that he thought were improvements and weaknesses of the technology. He recommended starting the conversion of client records in the remaining nonmodernized counties before implementation of the hybrid system and suggested that funds be used to hire more state caseworkers, as state employees will make the system work best.

After discussion, Rep. Crawford announced that the next meeting of the Commission would be Monday, October 25, 2010, at 10:00 AM. The Commission will consider for recommendation draft legislation and the draft final report. There being no further business, the meeting was adjourned at 4:00 PM.



Indiana State
Department of Health

**Health Facility Evaluation
and Quality Improvement**

September 21, 2010

"The Indiana State Department of Health supports Indiana's economic prosperity and quality of life by promoting, protecting, and providing for the health of Hoosiers in their community."

Outline

- **Nursing Home Evaluation Process and Quality Measures**
- **Healthcare Quality Improvement Initiatives and Their Outcomes**

Previous Next

Indiana Nursing Home Evaluation Process and Quality Measures

Previous Next

Overview of Long Term Care Facilities

Previous Next

Overview of Indiana Long Term Care Facilities

Long Term Care Facility Types

- Comprehensive care facility – nursing home
 - Skilled nursing facility (SNF)
 - Nursing facility (NF)
 - Non-certified comprehensive care (State only)
 - Residential care beds
- Residential care facility
- Assisted living facility
- Intermediate care facility for the developmentally disabled (ICFDD) – group home

Previous Next

Overview of Indiana Long Term Care Facilities

Number of Indiana Long Term Care Facilities

- Certified comprehensive care facilities (nursing homes) – 502 facilities
- Non-certified comprehensive care facilities - 3
- Comprehensive care facilities with residential care beds – 110
- Freestanding residential care facilities – 109

Source: ISDH Data September 2010

Previous Next

Overview of Indiana Long Term Care Facilities

Indiana Long Term Care Beds

- Certified comprehensive care facilities (nursing homes) – 48,636 comprehensive care beds
- Certified comprehensive care facilities with residential care beds – 8,256 residential care beds
- Non-certified comprehensive care – 1165 comprehensive beds
- Non-certified with residential beds – 304 residential care beds
- Freestanding residential care facilities – 8,861 residential beds
- Total residential beds: 17,421 beds

Source: ISDH Data September 2010

Previous

Next

Survey Process and Findings

Previous

Next

Overview of Nursing Home Survey Process

Survey Frequency

- State licensing and federal certification surveys conducted every 9-15 months – Indiana has met that standard
- State and federal complaint survey conducted for all complaints based on a priority tier – Indiana has met that standard

Previous

Next

Overview of Nursing Home Survey Process

Number of Nursing Home Surveys Completed (2009)

- Number of Annual Licensing / Certification Surveys (2009) – 533
- Number of Complaint Surveys (2009) – 1,459
- Number of Annual Life Safety Code Surveys (2009) – 533

Source: CMS Casper Report

Previous

Next

Indiana Nursing Home Survey Findings

Most Cited Deficiencies (2010)

- F282: Services provided by qualified persons in accordance with care plan – 43% of providers
- F323: Facility is free of accident hazards – 33%
- F272: Comprehensive assessments – 33%
- F514: Clinical records – 29%
- F157: Inform of significant changes – 28%
- F441: Infection control – 25%

Source: CMS Casper System

Previous

Next

Indiana Nursing Home Survey Findings

Most Cited Immediate Jeopardies (2010)

- F323: Facility is free of accident hazards – 5
- F224: Facility prohibits abuse, neglect – 3
- F441: Infection control – 2
- F225: Facility does not employ persons guilty of abuse – 2
- F314: Pressure ulcers – 2
- F223: Residents right to be free from abuse – 2

Source: CMS Casper System

Previous

Next

Indiana Nursing Home Survey Findings

Outcomes: Deficiency free surveys

- 2005: 47 facilities
- 2006: 47 facilities
- 2007: 51 facilities
- 2008: 59 facilities
- 2009: 57 facilities
- 2010: 66 facilities (through Sept. 13)

Source: CMS OSCAR quarterly reports

[Previous](#)

[Next](#)

Indiana Nursing Home Survey Findings

Outcomes: Deficiency free surveys (% of facilities with no deficiencies)

	<u>Indiana</u>	<u>Region V</u>	<u>National</u>
• Q4 2006:	10.60%	n/a	8.20%
• Q4 2007:	11.70%	10.41%	8.30%
• Q4 2008:	10.78%	9.09%	7.60%
• Q2 2009:	12.25%	8.77%	7.83%

Source: OSCAR quarterly reports

[Previous](#)

[Next](#)

Indiana Nursing Home Survey Findings

Outcomes: Immediate jeopardy findings

- 2006: 91 – Indiana 3rd highest
- 2007: 106 – Indiana 5th highest
- 2008: 76 – Indiana 13th highest (68 surveys)
- 2009: 46 – Indiana 17th highest (35 surveys)
- 2010: 25 (through September 13)

Source: CMS CASPER data

[Previous](#)

[Next](#)

Indiana Nursing Home Survey Findings

Outcomes: Immediate jeopardy findings (% of facilities with IJ)

	<u>Indiana</u>	<u>Region V</u>	<u>National</u>
• Q4 2006:	4.50%	n/a	2.20%
• Q3 2007:	5.64%	3.36%	2.17%
• Q2 2008:	5.08%	3.75%	2.58%
• Q2 2009:	2.77%	3.23%	2.89%

Source: OSCAR quarterly reports

[Previous](#)

[Next](#)

Indiana Nursing Home Survey Findings

Average Number of Deficiencies Per Survey

	<u>Indiana</u>	<u>Region V</u>	<u>National</u>
• 2006:	1.7	1.5	1.5
• 2007:	2.7	2.4	2.0
• 2008:	3.0	2.5	2.1
• 2009:	2.7	2.5	2.1
• 2010:	2.5	2.2	2.0

Source: OSCAR quarterly reports through Sept 13, 2010

[Previous](#)

[Next](#)

Indiana Nursing Home Survey Findings

Data Variability Between States

- Percent of surveys timely completed
- Whether state citing all deficiencies
- Whether citing associated tags

[Previous](#)

[Next](#)

Indiana Nursing Home Survey Findings

Differences in Surveys Between Provider Types

- Acute Care
 - Compliance based on status at time of survey
 - Regulations based on facility policy
- Long Term Care
 - Compliance determination goes back to previous annual survey
 - Regulations based on descriptive requirements

Previous

Next

Indiana Nursing Home Survey Findings

Reporting of Survey Findings

- ISDH Nursing Home Consumer Report
 - All survey reports and plan of corrections will be added in 2010 to Consumer Report
- CMS Nursing Home Compare

Previous

Next

Healthcare Quality Issues Identified Through the Survey Process

Common Root Causes

- Appropriate admissions / placement
- Timely and accurate assessments
- Care transition and coordination
- Staff education, training, & sufficiency
- Negative health care culture

Previous

Next

Healthcare Quality Issues Identified Through the Survey Process

Quality of Care Issues

- Pressure ulcers
- Healthcare associated infections
- Medication errors / patient safety
- Falls / wandering
- Behavior management
- Abuse and neglect

Previous

Next

Health Care Staffing

Previous

Next

Staffing

Staffing Initiatives

- Leadership Conference
Staffing Strategies
September 17, 2009 (funded by Civil Money Penalty Fund)
- Staffing Study of Long Term Care Facilities (funded by the ISDH Civil Money Penalty Fund)

Previous

Next

Staffing

2009 Long Term Care Staffing Study

- Number of administrator changes per facility over past three years – 2.5
- Number of director of nursing changes per facility over past three years – 2.8

Previous

Next

Staffing

2009 Long Term Care Staffing Study

- Turnover rate for Registered Nurses (RN) – 74.1% (46% nationally)
- Turnover rate for LPN – 67% (43% nationally)
- Turnover rate for certified nurse aides (CNA) – 98.1% (64% nationally)

Previous

Next

Staffing

ISDH Senior Staffing for Survey Program

- Three Division Directors (Acute Care, Health Care Education, Long Term Care) and all seven long term care area supervisors are new within the past three years

Previous

Next

CMS Quality Indicator
Survey System

Previous

Next

Health Care Survey System

Survey Program Quality Improvement

- Implement CMS Quality Indicator Survey (QIS) system
 - Kick-off for QIS system occurred in August 2010
 - Training of surveyors for QIS surveys to begin in January 2011

Previous

Next

ISDH Healthcare Quality Improvement Initiatives

Previous

Next

Goals

- Promote health care quality and health literacy through educational initiatives
- Increase public awareness and focus on a state health issues
- Protect the public through oversight of quality of care provided by health care facilities

Previous

Next



Healthcare Quality Improvement Principles

Principles for Improvement

- Summarize evidence into checklists
- Identify and mitigate local barriers to implementation
- Measure performance
- Ensure all patients reliably receive the intervention

Previous

Next

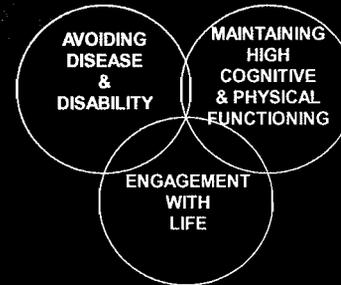
Healthcare Quality Competing Interests



Previous

Next

SUCCESSFUL AGING Rowe & Kahn, 1998



Previous

Next

Quality Improvement Themes

- Evidence-based
- System-based
- Incorporate care coordination principles
- Incorporate assessment tools
- Incorporate culture change principles
- Include patient and family centered care principles
- Measurable outcomes
- Plan for continuity after the initiative

Previous

Next

Indiana Health Care Quality Improvement Initiatives

Survey-based Initiatives

Survey-based Initiatives

- **CMS Special Focus Facility Program**
 - Adding a facility in October 2010
 - Will be five special focus facilities
 - Funded by CMS and state funds
- **ISDH Consultant Program**
 - Offered to facilities with substandard quality of care findings
 - Funded through ISDH Civil Money Penalty Fund
- **CMS Critical Need Nursing Home Project (Through Quality Improvement Organization – Health Care Excel)**
 - Pilot program for 4-5 facilities in northwest Indiana
 - Funded by CMS grant to Health Care Excel

Previous Next

Indiana Health Care Quality Improvement Initiatives

Addressing Immediate Jeopardy Level Deficiencies

Improving Survey Findings

The Challenge

- In 2007, Indiana had the 5th highest number of immediate jeopardy findings on nursing homes surveys

Previous Next

Improving Survey Findings

Quality Improvement Activities

- Monthly meetings with provider associations to review findings
- Quarterly meetings with advocate organizations to discuss quality of care concerns
- Collaborative quality improvement initiatives with healthcare organizations

Previous Next

Improving Survey Findings

Quality Improvement Activities:

- CMS and ISDH consistency workgroups
- Review of all immediate jeopardy findings by provider associations
- ISDH implemented a biweekly long term care newsletter in January 2008 (funded through ISDH Civil Money Penalty Fund)
- Implemented collaborative healthcare quality improvement initiatives

Previous Next

Indiana Nursing Home Survey Findings

Outcomes: Immediate jeopardy findings

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Source: CMS CASPER data

Previous Next

Indiana Nursing Home Survey Findings

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(% of facilities with IJ)

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Source: OSCAR quarterly reports

Previous

Next

Indiana Health Care Quality Improvement Initiatives

Indiana Healthcare
Leadership Conferences

Healthcare Quality Leadership Conferences

- Joint conferences for long term care providers, organizations, associations, and surveyors
- Two conferences per year
- Each conference covers one topic
- Conferences serve as kick-off for quality improvement initiatives
- Funded through the ISDH Civil Money Penalty Fund

Previous

Next

Healthcare Quality Leadership Conferences

Previous Conferences

- June 2007: Falls
- October 2007: Pressure ulcers
- March 2008: Restraints and behavior management
- September 2008: Emergency preparedness
- March 2009: Incontinence
- September 2009: Staffing
- March 2010: Healthcare Associated Infections

Previous

Next

Healthcare Quality Leadership Conferences

Planned Conferences

- Alzheimer's and Dementia Care – October 14, 2010
- Nutrition and Hydration – March 31, 2011
- Abuse and Neglect – Fall 2011
- Patient Safety / Medical Errors – Spring 2012

Previous

Next

Healthcare Quality Leadership Conferences

Conference Checklist

- Attend conferences
- Use information and resources to develop education and training program in facility
- Implement quality improvement project in facility
- Celebrate quality accomplishments

Previous

Next

Indiana Health Care Quality Improvement Initiatives

Indiana Pressure Ulcer Initiative

Indiana Pressure Ulcer Initiative

Participating Facility and Agencies

	Phase 1	Phase 2	Total
• Home Health / Hospice	27	13	40
• Hospitals	41	7	48
• Nursing Homes	94	62	156
• Totals	162	82	244

Funded through ISDH Civil Money Penalty Fund

Indiana Pressure Ulcer Initiative

- Indiana incidence of pressure ulcers in long term care facilities
 - Q4 2003 – 9.5% (Ranked 36th in US)
 - Q4 2004 – 9.2%
 - Q4 2005 – 8.6%
 - Q4 2006 – 8.4%
 - Q4 2007 – 8.1%
 - Q4 2008 – 8.3% (Ranked 36th in US)

Source: CMS GPRA Data

Indiana Pressure Ulcer Initiative

Initiative Components

- Three In-person Learning Sessions
- Toolkits
- Six Online education modules – www.in.gov/isdh/24558.htm
- Consumer brochure

Indiana Pressure Ulcer Initiative

Initiative Outcomes: Pressure Ulcer Rates for all Indiana Nursing Homes

- Q1 2008: 8.5% (34th)
- Q4 2008: 8.3% (36th)
- Q1 2009: 8.0% (29th)
- Q2 2009: 7.6% (28th)
- Q3 2009: 7.3% (26th)

Source: CMS GPRA Data

Indiana Pressure Ulcer Initiative

Initiative Outcomes: Number of Nursing Home Residents with a Pressure Ulcer

- Q1 2008: 2992
- Q3 2008: 2867
- Q4 2008: 2899
- Q2 2009: 2618
- Q3 2009: 2506
- Q4 2009: 2664
- Q1 2010: 2574 - 14% Statewide Decrease from Q1 2008

Source: CMS GPRA Data

Indiana Pressure Ulcer Initiative

Initiative Outcomes: One Year Cost Savings for Indiana Nursing Homes

- 300-400 fewer pressure ulcers per quarter
- Average cost of over \$10,000 per pressure ulcer to heal
- For 300 residents, savings of over \$12 million in one year

Source: CMS GPRA Data

[Previous](#) [Next](#)

Indiana Pressure Ulcer Initiative

Initiative Outcomes: One Year Cost Savings for One Unit of One Hospital

- 2008: 14 pressure ulcers with some stage 3 or 4
- 2009: 0 pressure ulcers
- Average cost of over \$30,000 per pressure ulcer to heal
- For 14 patients at one hospital, savings of over \$420,000 over one year

Source: CMS GPRA Data

[Previous](#) [Next](#)

Indiana Pressure Ulcer Initiative

Pressure Ulcer Deficiencies

<u>Year</u>	<u>Deficiencies</u>	<u>Immediate Jeopardies</u>
• 2007	195	18
• 2008	186	5
• 2009	157	4
• 2010	96	2 (to Sept. 13)

Source: CMS CASPER Data

[Previous](#) [Next](#)

Indiana Health Care Quality Improvement Initiatives

Indiana Healthcare Associated Infection Initiative

Indiana Healthcare Associated Infection Initiative

Infection Control Deficiencies

<u>Year</u>	<u>Deficiencies</u>	<u>Immediate Jeopardies</u>
• 2009	170	0
• 2010	137	2 (to Sept. 13)

Source: CMS CASPER Data

[Previous](#) [Next](#)

Indiana Healthcare Associated Infection Initiative

Healthcare Associated Infections

- Catheter associated bloodstream
- Catheter associated urinary tract
- *Clostridium difficile*
- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Surgical site
- Ventilator associated pneumonia

[Previous](#) [Next](#)

Indiana Healthcare Associated Infection Initiative

Indiana will focus on two infections

- Catheter associated urinary tract infections
- *Clostridium difficile* infections

Previous Next

Indiana Healthcare Associated Infection Initiative

Goals of Initiative

- Develop a state infection plan
- Develop and implement an infection surveillance system
- Implement a prevention initiative focusing on two of the infections

Previous Next

Indiana Healthcare Associated Infection Initiative

Participating Facilities

- Ambulatory Surgery Centers - 3
- Dialysis (ESRD) Clinics - 2
- Home Health and Hospice Agencies - 13
- Hospitals - 48
- Nursing Homes - 134

Previous Next

Indiana Healthcare Associated Infection Initiative

Initiative Funding

- Centers for Disease Control and Prevention (CDC) Grant
- ISDH Civil Money Penalty Fund

Previous Next

Indiana Health Care Quality Improvement Initiatives

Reducing Restraints
CMS GPRA Target

Restraint Reduction in Nursing Homes

CMS GPRA Restraint Data

- Q4 2003: 6.2% (27th rank)
- Q4 2004: 5.8% (26th)
- Q4 2005: 5.8% (30th)
- Q4 2006: 5.4% (30th)
- Q4 2007: 4.4% (32nd)

Source: CMS GPRA Data

Previous Next



Restraint Reduction in Nursing Homes

Quality Improvement Activities

- ISDH Leadership Conference on Restraint Reduction in March 2008 (funded by ISDH Civil Money Penalty Fund)
- Quality Improvement Organization (QIO) focus on restraint reduction (funded by CMS)

Previous

Next

Restraint Reduction in Nursing Homes

CMS GPRA Restraint Data

- Q1 2008: 4.0% (32nd rank)
- Q2 2008: 3.6%
- Q4 2008: 3.1% (27th)
- Q1 2009: 2.8%
- Q4 2009: 2.3% (22nd)
- Q1 2010: 2.2%

Source: CMS GPRA Data

Previous

Next

Other Civil Money Penalty Fund Quality Improvement Initiatives

- **Alzheimer's and Dementia Care Initiative**
 - Development of 10 education modules
 - Creation of Alzheimer's and Dementia Certification Program
 - Provided scholarships
- **Bladder Scanner Study for Incontinence Care**

Previous

Next

Quality Improvement Initiatives in Progress

- **Aide Curriculum Review Project**
- **Healthcare Quality Resource Center**
- **Implementation of New Regulations**
 - Life safety code
 - Infection control – Sept 2009
- **Implementation of MDS 3.0**
- **Care Transition and Coordination**

Previous

Next

Indiana Health Care Quality Improvement Initiatives

Medical Error Reporting System

Indiana Medical Error Reporting System

- Based on National Quality Forum's 27 (now 28) reportable events
- In 2002 NQF identified 27 events that are serious, largely preventable, and of concern to the public and providers
- Indiana was the second state to use these reporting standards

Previous

Next

Indiana Medical Error Reporting System

Most Reported Events

- Stage 3 or 4 pressure ulcers acquired after admission
- Retention of a foreign object in patient after surgery
- Surgery performed on the wrong body part
- Death or serious disability associated with a medication error

Previous

Next

Indiana Medical Error Reporting System

Outcomes

- Pressure ulcer data as top reportable event resulted in Indiana Pressure Ulcer Initiative and decrease in pressure ulcers
- Increased awareness of medical errors
- Allocation of resources to patient safety
- Increase in number and activity of state and regional patient safety coalitions

Previous

Next

Indiana Health Care Quality Improvement Initiatives

Patient Protection and
Affordable Care Act
- Long Term Care Initiatives

Affordable Care Act Initiatives

Affordable Care Act Includes Nursing Home Quality Improvement Activities

- Facilities required to implement a Quality Assurance & Performance Improvement Program (QAPI)
- Posting of survey reports and plan of corrections on consumer-oriented Website
- Disclosure of ownership

Previous

Next

Affordable Care Act Initiatives

Affordable Care Act Includes Nursing Home Quality Improvement Activities

- CMS Nursing Home Compare to include criminal violations
- Improved reporting of staffing
- Sanctions for inadequate notice of facility closure
- Reduced civil money penalties for some self-reported deficiencies

Previous

Next

**Indiana State Department of Health
Health Care Quality and Regulatory Commission**

**ISDH Presentation to
Joint Select Commission on Medicaid Oversight
September 21, 2010**

- I. Nursing Home Evaluation Process and Quality Measures
 - A. Overview of Long Term Care Facilities
 - B. Survey Process and Findings
 - The ISDH continues to complete all licensing and certification surveys within regulatory timeframe
 - Number of deficiency free surveys has increased since 2007 and Indiana is above national average for deficiency free surveys
 - Immediate jeopardy level deficiencies were 3rd highest in U.S. in 2006. With a collaborative project, the number decreased by 60% and below national average in 2009.
 - Number of deficiencies per survey have decreased for past two years
 - C. Reporting of survey findings
 1. ISDH Nursing Home Consumer Report
 - Indiana was one of the early states to create health care facility consumer reports
 - The ISDH will be adding survey reports and plan of corrections to the online consumer reports by end of 2010
 2. CMS Nursing Home Compare
 - D. Healthcare quality issues identified through survey process
 - Appropriate admissions, timely and accurate assessments, care transition and coordination are three common root causes of deficiencies
 - Significant quality of care issues include pressure ulcers, healthcare associated infections, and falls / patient safety
 - E. 2009 ISDH Nursing Home Staffing Study
 - Long term care turnover rates for nurses in Indiana facilities is 74%
 - Long term care turnover rates for certified nurse aides is 98%
 - Number of administrators in a three year period averages 2.5 and director of nurses 2.8
 - The staffing study was funded with the Civil Money Penalty (CMP) Fund
 - F. CMS Quality Indicator Survey System (QIS)
 - QIS is a system intended to increase consistency in the survey process
 - Indiana began preparations in August 2010 and will begin training and implementation of the QIS System in January 2011

II. ISDH Healthcare Quality Improvement Initiatives

A. Survey-based Initiatives

1. Special Focus Facilities
 - The ISDH will be adding a special focus facility in October 2010 for a total of five special focus facilities
2. Consultant Program
 - The consultant program is available to all facilities with substandard quality of care violations and funded by the CMP fund
3. Critical Need Nursing Home Project
 - CMS awarded a grant to the state Quality Improvement Organization to create a pilot collaborative program to assist 4-5 critical need facilities in northwest Indiana

B. Indiana Immediate Jeopardy Improvement Project

- The ISDH developed a collaborative project with provider associations to address immediate jeopardy deficiencies
- The number of immediate jeopardy deficiencies has decreased by 60% and the Indiana rate is now below the national average

C. Indiana Healthcare Leadership Conferences

- The ISDH has provided seven conferences on healthcare quality issues
- The conferences are funded by the CMP fund

D. Indiana Pressure Ulcer Initiative

- The ISDH developed a large collaborative pressure ulcer initiative
- The nursing home pressure rate decreased from 8.5% to 7.3%
- The decrease results in a cost reduction of \$12 million per year for nursing homes and another \$12 million in hospitals
- The Initiative was funded by the CMP fund

E. Indiana Healthcare Associated Infection Initiative

- The Initiative is focusing on a reduction of *Clostridium difficile* and catheter associated urinary tract infections
- The Initiative includes nearly 200 facilities and is funded by a CDC grant and the CMP fund

F. Indiana Restraint Reduction Initiative

- Indiana nursing homes have reduced the restraint rate from 4.0% in 2008 to 2.2% in 2010

G. Indiana Medical Error Reporting System

- The Medical Error Reporting System has resulted in an increased number of patient safety coalitions and showed a decrease in pressure ulcers

H. Affordable Care Act Nursing Home Initiatives

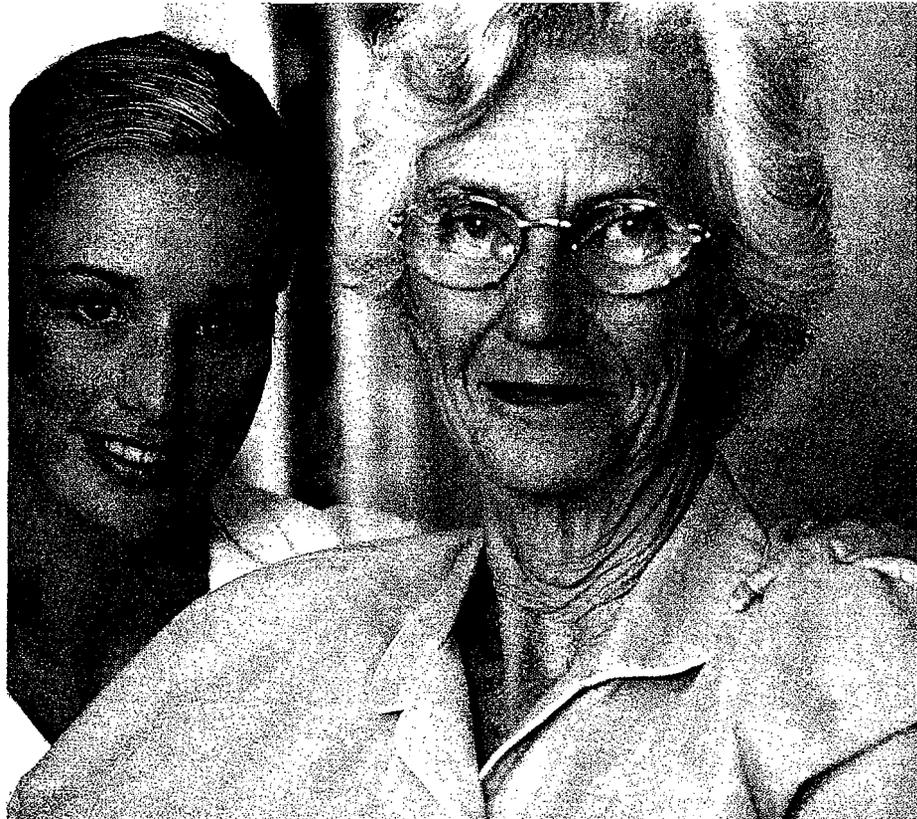


Exhibit C
Select Joint Commission on
Medicaid Oversight
September 21, 2010

Pressure Ulcers,
often called bed sores,
are preventable.

PREVENT PRESSURE ULCERS.
KNOW THE FACTS. TAKE ACTION.



Indiana State
Department of Health

The Facts

What is a pressure ulcer?

A pressure ulcer is a painful injury, usually caused by constant pressure that limits the skin and underlying tissue. The friction caused by sliding down in a bed or chair also can injure the skin, leading to a pressure ulcer.

Why do pressure ulcers develop?

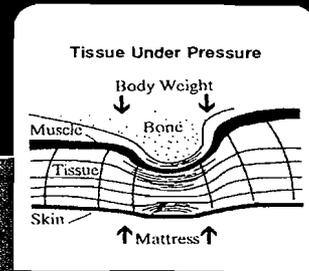
Excessive pressure narrows or blocks the blood vessels that supply the skin with nutrients and oxygen. If pressures are not relieved, the tissue dies and a pressure ulcer forms.

Where do pressure ulcers develop?

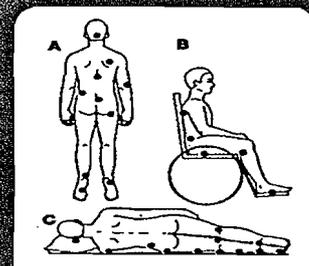
Pressure ulcers develop on the body where bony areas seem to stick out, such as the tailbone, hips, heels, knees, shoulders, back of head and ears.

Who is likely to develop pressure ulcers?

People who can't move by themselves, have an incontinence problem or are unable to ask for help are more at risk for not being able to develop pressure ulcers.



TISSUE UNDER PRESSURE



PRESSURE ULCER LOCATIONS ON BODY

act of a Pressure Ulcer

Areas of a pressure ulcer are not necessarily painful to the patient.

Pressure ulcers can cause pain, infection, damage to muscle and bone, and even death.

A pressure ulcer may prevent you from sitting or lying in your preferred position.

Care can be time-consuming and uncomfortable. Pressure ulcers may take a long time to heal.

A pressure ulcer may limit your daily activities. You may not be able to move around like you used to or do the things you enjoy.



STAGE 1 - HIP



STAGE 2 - BUTTOCKS



STAGE 3 - KNEE



STAGE 4 - HIP

How Can You, Your Family and Friends be Partners in Care?

Help the care team know your pressure ulcer risk. If caregivers how well you move about, use the toilet, bath, eat, and drink. Difficulty with these activities increases your risk for pressure ulcers.

Share information about yourself. Let caregivers know your daily routines, favorite foods, drinks, and activities. This information helps caregivers prevent pressure ulcers in a way that will work for you. For example, if you have to lie in the same position for two hours to prevent pressure ulcers, what do you need to entertain you?

Be active in planning your care. A care plan sets the goals for your care, including preventing pressure ulcers if you are at risk. At a care plan meeting, you, your family member or friend, and the care team discuss what is important to you. For instance, do you want to be taken to the toilet at night or would you rather wear an absorbent brief that protects your skin while you sleep?

Help your caregivers know your turning and repositioning schedule and remind caregivers, if necessary. Be sure you are getting enough to eat and drink.

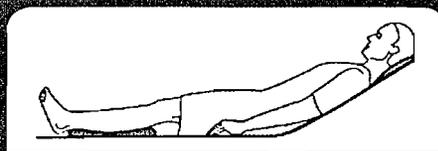


Addressing Risk: Do the CORE FOUR!!

1 Inspect your skin daily. Look for reddened or discolored areas. Tell your caregiver if you find one.

2 Minimize pressure

- Use safe positions in bed and chair.
- Ask for pressure-relieving devices in your bed and chair (if necessary).
- Ask for help to change positions.
 - At least every 2 hours or more often when lying down.
 - Every hour when sitting.
- Lean yourself every 15 minutes in a chair if you can.
- Ask your caregiver not to drag you across sheets or seats, especially if injuries to the skin.



The bed should be raised no more than 30 degrees.

3 Stay clean and dry. Ask for help to the bathroom or to get cleaned up right away when incontinent or if you sweat a lot.

4 Eat nutritious meals and drink plenty of fluids. Talk about your dietary needs with your care team professionals.

ion Steps

- the core four.
- the care team know your pressure ulcer risk.
- re information about yourself.
- ctive in planning your care.
- o your caregivers. Let them know what is working and not working.
- ak up!! Ask questions. Get help with concerns.
- re this brochure with your family and friends.

Copyright © 2009, Indiana State Department of Health

VENT PRESSURE ULCERS.
W THE FACTS. TAKE ACTION.

Pressure Ulcers,
often called bed sores,
are preventable.



Indiana State
Department of Health

For further information about:

- Medicare
- Medicare Supplement Insurance
- Long Term Care Insurance and the Indiana Long Term Care Partnership Program
- Help for low income Medicare beneficiaries

Call:

1-800-452-4800

1-765-608-2318

**STATE HEALTH INSURANCE
ASSISTANCE PROGRAM**

www.medicare.in.gov

The State Health Insurance Assistance Program (SHIP) is a free, unbiased counseling program provided by the Indiana State Department of Insurance

SHIP will answer your questions, or will refer you to the appropriate agency or a local **SHIP** site for personal assistance.



**The
Spousal Impoverishment
Protection Law**

(07/2010)

UNDER THE SPOUSAL IMPOV

WHAT HAPPENS TO INCOME?

<u>Personal Income</u>	<u>Jointly Owned Income</u>
<ul style="list-style-type: none">* Income in your name remains your own. (Social Security, Pension, etc.).* Income from assets in your name remains your own.<ul style="list-style-type: none">• The spouse at home may keep all of <i>his/her</i> personal income.	Income from assets owned by both spouses is counted by Medicaid as jointly-owned income. Jointly-owned income is divided in half, with each spouse getting a half.
The spouse in the nursing home must use his/her income to pay for nursing home care, but may keep a personal needs allowance of \$52 per month.	

Once the income has been split, if the spouse at home gets less than **\$1,823** (Effective 7/2009) each month when adding the personal income plus his/her share of the joint income) he/she may keep part of the nursing home spouse's income in order to bring his/her total up to at least **\$1,823**. (Effective 7/2009) If the spouse at home has living expenses that are very high, he/she may appeal to keep more of the nursing home spouse's income, bringing him/her up to a maximum of **\$2,739** (Effective 1/2010) per month. Appeals are handled at the Division of Family and Children Services.

If the spouse's personal income plus his/her share of the joint income is more than **\$2,739** (Effective 1/2010) per month, he/she does not get to keep any of the



LET'S LOOK AT HARRY & SALLY:

Harry is no longer able to take care of Sally at home. She is being admitted to a long term care facility. They own \$100,000 in countable assets and their total monthly income is \$1,600.

Harry may keep all of his income (checks made out in his name, plus his half of the income that is jointly owned). Remember, if Harry's income is lower than **\$1,823** a month, then he can keep part of Sally's income.

Checks made out in **Sally's** name, plus her half of the jointly owned income, is considered hers and should be used to pay for her care. Medicaid would pay any remaining costs for her care.

ERISHMENT PROTECTION LAW

WHAT HAPPENS TO ASSETS?

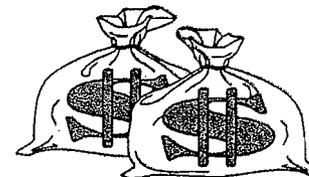
Most assets are considered by Medicaid as joint assets between a husband and wife; it doesn't matter in whose name they are placed.

What amount of the couple's assets is the spouse at home able to keep?

MAXIMUM - half of all countable assets, up to a total of \$109,560

MINIMUM - at least \$21,912

A person may appeal to keep more assets.
Figures effective January 1, 2010



WHAT ABOUT THE COUPLE'S HOME?

The home is not counted as an asset when the applicant, spouse, or dependent children live in the home. Special rules apply when siblings or adult children live in the home (*The home is always counted if no one intends to live there*).

WHAT ASSETS ARE "COUNTABLE"?

Some examples of assets that are countable are: checking accounts, savings accounts, CD's, stocks, bonds, mutual funds, revocable trusts, cash value of life insurance policies, and IRAs.

Example: (from Harry and Sally)

Half of Harry and Sally's countable assets amount to \$50,000. Since \$50,000 is less than the maximum allowed amount under this law (maximum is \$109,560), then Harry is able to keep all of his portion of the assets.

Sally and Harry would need to spend Sally's \$50,000 down to \$1,500 before Medicaid would begin to help pay for her nursing home costs.

Protection under the Spousal Impoverishment law applies to nursing home care, and under the Medicaid Aged and Disabled Waiver, for in-home and community-type care services

CAUTION! Transferring of assets: Persons who transfer assets to get Medicaid help, may wait longer before Medicaid will help pay for nursing home costs. Other penalties may also be applied.

Have you ever wondered...

- ~ What would happen if your spouse was not able to live at home due to poor health or confusion?
- ~ Would you have to spend all of your resources to pay for your spouse's nursing home care?

NO!

Spouses of nursing home residents have **protection** from losing all **income and assets** in order to pay for the nursing home spouse's care

How do you find out more?

1. Review this brochure for a brief explanation of the Spousal Impoverishment Protection Law.
2. Call **SHIP** or your local Office of Family and Children (Medicaid) to ask questions.
3. Contact the Office of Family and Children, when your spouse enters a nursing home, to complete a resource assessment form (also called a "snapshot"). The assessment will help you find the total value of combined finances and will help decide the amount of assets the spouse at home may keep. You must show proof of all assets owned.
4. Contact the Senior Law Project office nearest you or an elder law attorney.



Taking care of tomorrow
is just good policy

Thank you for your interest in the **Indiana Long Term Care Insurance Partnership Program** (also known as the **Indiana Partnership Program**). Hoosiers are fortunate because we have many choices when it comes to purchasing long term care insurance. These choices include, but are not limited to the following:

- **IN Partnership** policies or traditional long term care insurance policies
- Federally tax-qualified OR non-tax qualified policies
- Comprehensive coverage or Facility only coverage

We hope the enclosed materials (explained below) will help you understand the **Indiana Long Term Care Partnership Insurance Program**. We recommend you read these materials thoroughly.

1. **Companies that offer the Indiana Partnership Long Term Care Insurance policies.** This list provides you with the names of the insurance companies that sell both **Indiana Partnership** policies and traditional long term care insurance policies. The list shows the types of **Indiana Partnership** policies each company offers, as well as the company's financial stability rating from three different reporting services. You can use the phone number to contact the company for additional information or for assistance in locating an agent in your area.
2. **Consumer Bulletin on Tax-Breaks for Long Term Care Insurance.** This bulletin explains the Federal tax breaks available for owners of tax-qualified long term care insurance policies, as well as the Indiana tax deduction for owners of Indiana Partnership long term care insurance policies

3. **What You Should Know About Long Term Care – The Most Commonly Asked Questions About the Indiana Long Term Care Insurance Program.** This booklet answers basic questions about the need for and cost of long term care and about the Indiana Long Term Care Insurance Program. The unique benefit of Medicaid Asset Protection found only in **Partnership** policies is also explained.
4. **Self-Assessment Guide for Long Term Care Insurance.** This is a planning document to help you explore factors that affect your decisions about long term care and purchasing long term care insurance.
5. **Nursing Home Resident with a Spouse at Home.** This information pertains to married couples. It explains the Spousal Impoverishment Protection Law. This is a law that allows the spouse at home to keep some of the couple's resources and still qualify the nursing home spouse for Medicaid assistance.
6. **A Shopper's Guide to Long Term Care Insurance.** This booklet explains long term care insurance policies and its features including shopping tips.

Should you have any questions about the information in this packet, please contact the **Partnership Office** at **317/232-2187** or toll free **866-234-4582**. Also, visit our website at www.longtermcareinsurance.in.gov.

**Companies with Indiana Partnership Long Term
Care Insurance Policies (8/2010)**

INSURANCE COMPANY	TELEPHONE NUMBER	*POLICY TYPES	AM BEST	MOODY'S	STANDARD & POOR'S
Bankers Life and Casualty Co.	888-282-8252	TQ Comprehensive TQ Facility-only	B	Baa3	BB-
Cuna Mutual Group	800-443-6003	TQ Comprehensive	A	Not Rated	Not Rated
Genworth Life Insurance Co.	800-456-7766	TQ Comprehensive TQ Facility-only	A	A1	A
John Hancock Life Insurance Co.	800-377-7311	TQ Comprehensive	A++	Aa1	AA+
Massachusetts Mutual Insurance Co.	800-272-2216	TQ Comprehensive TQ Facility-only	A++	Aa1	AAA
Metropolitan Life Insurance Co.	800-308-0179	TQ Comprehensive TQ Facility-only	A+	Aa2	AA-
The Prudential Insurance Co. of America	800-732-0416	TQ Comprehensive	A+	Aa3	AA-
State Farm Mutual Automobile Insurance Co.	866-855-1212	TQ Comprehensive	A++	Not Rated	AA
United Teacher Associates Insurance Co. (Group policies only)	800-258-7041	TQ Comprehensive	A-	Not Rated	Not Rated

TQ = meets standards for federal tax breaks

Comprehensive = includes coverage for nursing facility care & home and community care

Your best resource for specific policy information is your local certified Indiana Partnership agent. When calling the insurance companies, you will be referred to a local Indiana Partnership agent.

Rating Scales and Definitions

<u>A.M. Best</u>	<u>Moody's Investment Service</u>	<u>Standard & Poor's</u>
A++ Superior	Aaa Exceptional	Secure Range:
A+ Excellent	Aa Excellent	AAA Superior
A Excellent	A Good	AA Excellent
A- Very Good	Baa Adequate	A Good
B++ Very Good	Ba Questionable	BBB Adequate
B+ Fair	B Poor	Vulnerable Range:
B Fair	Caa Very Poor	BB May be adequate
B- Marginal	Ca Extremely Poor	B Vulnerable
C++ Marginal	C Lowest	CCC Extremely vulnerable
C+ Poor		
C- Under State supervision		
D Under State supervision		
E In liquidation		
F In liquidation		
S Rating suspended		

Rating Modifiers:

g Group
 p Pooled
 v Reinsurance
 u Under review

Modifiers:

1=High end generic category
 2=Middle of generic category
 3=Low end generic category

Modifiers:

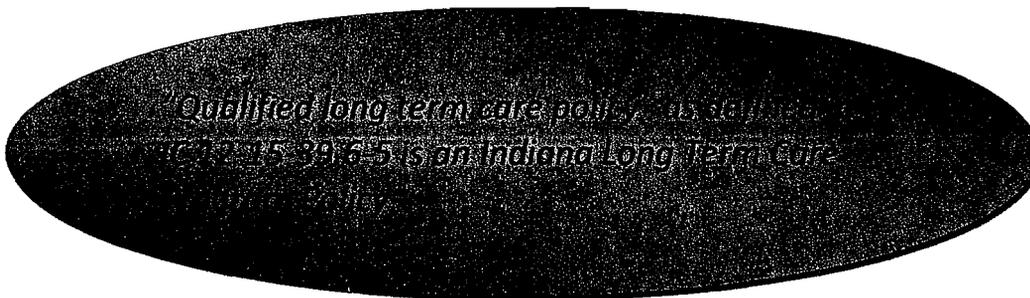
Plus (+) or Minus (-): Relative standing within major rating category

Since company ratings can change, you are encouraged to check your local library or the internet for the most current ratings.

State Tax Deduction for Indiana Partnership Policyowners

Indiana residents who pay premiums for Indiana Partnership long term care insurance policies can receive a state tax deduction beginning with tax year 2000. Governor O'Bannon signed the law authorizing this new deduction on May 13, 1999. The language of this law can be found at IC 6-3-1-3.5(a)(16) and states:

“For taxable years beginning after December 31, 1999, subtract an amount equal to the portion of any premiums paid during the taxable year by the taxpayer for a qualified long term care policy (as defined in IC 1215-39.6-5) for the taxpayer or the taxpayer’s spouse, or both.”



To know if the policy is an Indiana Partnership policy, look for the following box of information on the outline of coverage, the application, or the front page of the policy:

THIS POLICY {CERTIFICATE} QUALIFIES UNDER THE INDIANA LONG TERM CARE INSURANCE PROGRAM FOR MEDICAID ASSET PROTECTION. THIS POLICY MAY PROVIDE BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE INDIANA LONG TERM CARE INSURANCE PROGRAM.

Example of the state tax deduction: Mrs. Smith owns an Indiana Partnership policy and pays \$2,100 in premium during the year. On her Indiana tax return, she can take all \$2,100 as a deduction. If Mrs. Smith’s income is \$50,000, then her return would look something like:

\$50,000	-	Income
Minus 2,100	-	Partnership policy premium paid during the year
Minus <u>1,000</u>	-	Exemption for self
\$46,900	-	State taxable income
Times <u>.034</u>	-	State tax rate
\$ 1,595	-	State tax

If the amount of state tax she paid during the year and withheld on her W-2 is greater than the state tax, then she would qualify for a refund. Her Indiana Partnership policy premium deduction reduced her state tax by \$71 (\$2,100 X .034) for that tax year.

Exception for the self-employed: If Mrs. Smith in the above example was self-employed and her Indiana Partnership was federally tax-qualified, and she took \$940 on her federal return, she would only be able to deduct the difference on her state return.

	\$2,100	-	Premium paid during the year
Minus	<u>940</u>	-	Federal deduction taken
	\$1,160	-	Amount she can deduct on her Indiana tax return

Please read the Indiana State Tax Instruction Booklet for more information.

The 2010 Self-Assessment Guide For Long Term Care Insurance

A JOINT PUBLICATION BY:

SHIP

State Health Insurance Assistance Program

And

Indiana Partnership Long Term Care Insurance Program

Both of the Indiana state Department of Insurance

The Self-Assessment Guide for Long Term Care Insurance may be reproduced, but only as a complete document. For permission to use individual pages, contact SHIP or the Indiana Long Term Care Insurance Program.

State Form 45870 (1/2010)

PLEASE NOTE:

Indiana Long Term Care Insurance Policies have asset protection options however, **asset protection does not include income protection.** When an individual applies for Medicaid:

For transactions made **before February 8, 2006:**

- Medicaid looks back 3 years from the date of application (5 years for trusts), to see whether any assets were transferred **for less than fair market value.**

If it is determined that a less than fair market value transfer has taken place, the applicant will not be eligible for Medicaid for a specific time period based upon the dollar amount of the transfer. After this penalty period, the applicant may re-apply for Medicaid.

For specific guidelines contact Medicaid through your local Department of Family Resources. Area phone numbers and/or internet addresses may be obtained by calling **SHIP at: 1-800-452-4800.**

The Self– Assessment Guide for Long Term Care Insurance

This guide will not provide an exact answer to what you should do, but it can help you ask the right questions and make the best decision for your situation. The guide may be completed by you alone, with a SHIP Volunteer Counselor, or with an insurance agent or other professional. You may want to work through the guide with family members so these important issues can be discussed and considered.

Traditional Long Term Care Insurance

Long term care insurance policies are becoming more popular and more widely used by individuals to pay for some or all of their long term care expenses. This guide will help you think about your chances for needing long term care and the reasons you may want to buy a policy. Long term care insurance is not appropriate for everyone. Whether or not you should buy a policy will depend on your age, health status, overall retirement objective and income.

Indiana Long Term Care Insurance Program

The Indiana Long Term Care Insurance Program gives Hoosiers an option for long term care insurance. Indiana Partnership policies contain a unique state-added benefit of Medicaid asset protection. By purchasing an Indiana Partnership policy, you will protect your assets as the policy pays out for your care. The amount of assets you protect will depend on how much coverage you buy and use. Should you ever need care beyond the limits of your policy, Medicaid would act as your safety net. Your income would go towards your care, but you would not have to spend all of your assets. **For information on the Indiana Long Term Care Partnership Program, call 1-866-234-4582, or visit the Program's website at: www.longtermcareinsurance.in.gov**

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (**SHIP**) has certified volunteer counselors across Indiana to help persons, in their own communities, with their senior-related health insurance questions and concerns. Counselors can help answer your questions about:

- MEDICARE * MEDICAID * MEDICARE MANAGED CARE
- MEDICARE SUPPLEMENTAL INSURANCE *LONG TERM CARE INSURANCE

For materials on the above topics, to get help with questions you may have, or to locate the nearest SHIP site for individual assistance, call **1-800-452-4800** . You may also visit us on the Internet at: **www.in.gov/idoi/ship**

You are under no obligation to share the answers of this guide with anyone else, including your SHIP counselor or an insurance agent!

Name: _____

Date: _____ Current Age: _____

THE NEED FOR LONG TERM CARE

1.

AGE AND GENDER

The need for long term care increases as you get older. If family members have lived to ages over 85, there is a good chance you may live as long or longer. Living longer increases your chances for needing long term care. If family members have lived to younger ages than 85, advances in medical technology may allow you to live to be over age 85.

Women tend to live longer than men. They are therefore more likely to develop a disabling chronic condition and/or to live alone, which increases their likelihood of needing long term care at some point in their lives.

a. To what age did your parents live? _____

b. To what age have other family members lived (siblings, grandparents, etc.)?

2.

LIVING ARRANGEMENTS

For elderly persons living alone, with few friends or family members living close by who could provide assistance, chances of needing nursing home care at some point in their lives are increased. If home health care is considered as an option, the person will usually need someone at their home or nearby, to help them when the home health care aides or nurses are **not** available.

a. Do you live alone, with spouse, adult children, friends or relatives, or other?

b. Are your adult children or other family and friends available to provide care for you should you need it? Do your children live close by?

c. Would your children or other family members be willing and able to provide this care?

3.

HEALTH HISTORY

The need for long term care usually results from a disabling chronic condition (such as diabetes, arthritis, heart condition, stroke, emphysema or other respiratory problems,

Alzheimer's or cancer). These conditions may be related to your family history or to health risk factors you may have (smoking, overweight, high blood pressure). If you currently have a serious chronic health condition, insurance companies may not insure you.

a. General health condition (excellent, good, fair, poor):

b. List medication/s and purpose:

c. Major surgeries or illnesses which resulted in hospitalizations in the past 5 years:

d. Family history of chronic illness (diabetes, heart disease, arthritis, Alzheimer's, Parkinson's disease, cancer, etc.):

e. Do you have any health or life style factors that may put you at risk of needing long term care (smoking, overweight, high blood pressure, mental health problems)?

f. Are you currently unable to perform activities of daily living without help from others? If yes, you probably will not be able to purchase a long term care insurance policy. Common activities of daily living are: bathing, dressing, transferring (i.e. moving from bed to chair), toileting, and eating.

If you presently have a chronic disabling condition or are unable to perform activities of daily living,

PLEASE GO TO PAGE 10, "OTHER OPTIONS" SECTION.

PERSONAL PREFERENCES

4.

Your feelings and preferences are important to consider, in determining whether to purchase long term care insurance.

a. How do you feel about your adult children or others providing financial support for you?

b. How do you feel about relying on help from your adult children or others in order to remain in your home should you need such help?

c. How do you feel about living with your adult children or others?

d. What is your attitude about receiving Medicaid, should you need it?

e. How important is it to leave an estate to your children or others?

f. Is there a specific nursing home you would like to use should you need long term care?

g. How important is it for you to have a single room should you need nursing home care? The rates for single rooms are higher than the rates for double rooms. Having a LTC policy may help pay towards this cost.

h. What are your specific concerns or priorities? Why are you looking into long term care insurance at this time?

i. Are you planning to live in another state? If you buy an Indiana Partnership policy, **it will pay insurance benefits in others states**. However, should you move to another state and need care beyond the limits of your policy and turn to the Medicaid program in that state, only Indiana's Medicaid program and any other state with a reciprocal agreement* with Indiana's Medicaid will honor the asset protection earned through your policy.

* States having a reciprocity agreement with Indiana may offer total asset protection, or protection only on a dollar-for-dollar basis.

INCOME

Are you currently receiving SSI (Supplemental Security Income) or Medicaid?

Yes ___ No ___

IF YOU ANSWERED YES, LONG TERM CARE INSURANCE IS NOT AN OPTION

Monthly Income

- | | |
|--|-----------------|
| a. Wages | \$ _____ |
| b. Social Security | \$ _____ |
| c. Pension | \$ _____ |
| d. IRA, Annuities | \$ _____ |
| e. Interest/Dividends | \$ _____ |
| f. Rental Income | \$ _____ |
| g. Other Income | \$ _____ |
| h. TOTAL INCOME (add 'a' through 'g') | \$ _____ |

Monthly Expenses

- | | |
|--|-----------------|
| a. Mortgage/Rent | \$ _____ |
| b. Household (utilities, telephone, home maintenance, insurance) | \$ _____ |
| c. Food | \$ _____ |
| d. Clothing | \$ _____ |
| e. Auto (loan payment, gas, insurance, maintenance) | \$ _____ |
| f. Medical Expenses and Insurance Premiums | \$ _____ |
| g. Taxes (estimated income and property) | \$ _____ |
| h. Miscellaneous (recreation, etc.) | \$ _____ |
| i. TOTAL EXPENSES (add 'a' through 'h') | \$ _____ |

Income Left Over

Total Income - Total Expenses = Income Left Over \$ _____

Will the income you have left over be enough to pay your long term care insurance premiums? Yes _____ No _____

You will need to talk with a long term care insurance agent to find out the policy premiums for the specific coverage you want to b

FINANCIAL CONSIDERATIONS

ASSETS

Medicaid considers assets as **exempt** or **non-exempt**. **Non-exempt** assets are usually counted by Medicaid, when eligibility is being determined. **Exempt assets are not counted.**

The numbers in parenthesis () refer to details found on the next page.

Type of Asset

**Usually NOT Counted
By Medicaid**

**Usually COUNTED
By Medicaid**

a. Bank Accounts, Money Markets		\$ _____
b. Certificates of Deposit		\$ _____
c. Stocks, Bonds		\$ _____
d. IRAs, other retirement plans (2)	\$ _____	\$ _____
e. Cash Value of Life Insurance (3)	\$ _____	\$ _____
f. Burial Trusts (4)	\$ _____	
g. Equity Value of Home, If owned (current market value minus remaining mortgage and liens) (5)	\$ _____	
h. Equity Value of Income Producing Property (current market value of rental or commercial property minus mortgages and liens) (6)	\$ _____	
i. Equity Value of Other Property (current market value of second home, land, etc., minus mortgages and liens) (7)		\$ _____
j. Personal Property (8)	\$ _____	\$ _____
k. Autos, Recreational Vehicles (9)	\$ _____	\$ _____
l. Series EE or I U.S. Savings Bonds (10)		\$ _____
m. Total Assets (add lines 'a' through 'l')	\$ _____	\$ _____

CAUTION! Medicaid eligibility is complex. Consult your local Office of Family and Children, an attorney familiar with Medicaid law, or your local Legal Services Organization (free or reduced cost assistance). **You can find these numbers in your local telephone directory.**

Assets that are not counted by Medicaid may change, based on future changes in federal or state laws.

- (1) For married couples, the Spousal Impoverishment Protection Law provides some asset protection when one person enters a nursing home and their spouse is at home. For more information, please refer to page 12 of this guide, or call **SHIP at 1-800-452-4800** for a brochure.
- (2) **IRA's** owned by either spouse are usually **counted** by Medicaid. The \$ value of an IRA is the total IRA amount minus any penalties for early withdrawal of the IRA account. **Other types** of retirement funds (pensions, annuities, disability plans, profit sharing plans) **would be counted** if the person has the option of withdrawing a lump sum, even if not yet eligible to receive payments. However, a retirement fund is **not counted** if employment must end to receive payments.
- (3) The cash surrender value of life insurance is not counted if the death benefit (face value) of all policies totals \$10,000 or less, and the beneficiary is one's estate or the funeral home. This does not include term life insurance. The \$10,000 limit is reduced by any amount that is in an irrevocable funeral trust.
- (4) **Burial or funeral trusts** are not counted if irrevocable, regardless of their value, as long as the dollar amount is tied to specific funeral/burial services.
- (5) The home is **not counted** when it is the principal residence for the applicant, the applicant's spouse or children (if the children are under age 21 or are disabled or blind). The home is **not counted** until none of the above persons intend to or are able to live there. Special rules apply when siblings or adult children live in the home. For further details, contact either your local Office of Family & Children or an attorney familiar with Indiana Medicaid law.
- (6) Income producing property (i.e. rental property, farms) is **not counted** if it produces more income than it costs to keep it (taxes, mortgage, etc.).
- (7) Other real property (real estate) **is counted** and must be offered for sale or rent at current market value. Real estate in the name of the spouse at home is **not counted**.
- (8) Household goods (furniture) and personal effects (clothing/jewelry) are **not counted**. Collections, (coin, stamp, etc.) **are counted**.
- (9) One vehicle, regardless of value, is **not counted** if used for: applicant's employment, medical treatment, or the vehicle has been modified to accommodate a disability. Other wise, \$5,000 of the current market value of one vehicle is **not counted**. One car (of any value) for the spouse at home is **not counted**.
- (10) Series EE or Series I U.S. Savings bonds **are counted as assets**.

Medicaid has the right to be repaid for medical expenses provided. This payment would be made by the recipient's estate upon their death. Currently, Medicaid does not recover from the spouse's estate, unless the spouse also becomes a Medicaid recipient. Medicaid does not recover assets protected by Indiana Partnership policies.

DO YOU FIT UNDER ANY OF THESE CRITERIA?

1. You are **single**, your income (minus your medical expenses) is **less than \$674** and **counted assets** are less than **\$1,500**.

You are **married**, your income (minus your medical expenses) is **less than \$1,011** and **counted assets** are **less than \$2,250**.

If **either** of the above is true, then **you are probably eligible for Medicaid now**, and you need to visit your local Office of Family and Children.

2. You have a **disabling health condition** or you are **over age 84**.

3. Your **countable assets** are less than the cost of one year in a nursing home (around \$40,000), or based on your "left over" income (see p.5), paying for long term care insurance premiums would be difficult or result in a significant change in your life style, or any future premiums would also result in these situations.

If you meet any of the above criteria, long term care insurance may not be for you.

SKIP TO THE "OTHER OPTIONS" SECTION ON PAGE 10.

LONG TERM CARE INSURANCE POLICY BENEFITS TO CONSIDER

INSURANCE OPTIONS: Indiana residents have a choice of traditional long term care (LTC) insurance or Indiana Partnership policies.

1. There are three different options for purchasing LTC insurance. Indiana Partnership policies offer two options: nursing home only or a combination type policy. Which type of LTC coverage do you prefer?

**Combination Nursing Home
with Home And Community Care**

Nursing Home only

**Home and Community Care Only
(which may include home health care, adult daycare,
Respite care and homemaker services)**

2. **Daily Benefit:** You choose the amount of benefit you want the policy to pay towards the daily cost of your care.

A. What is the daily cost of nursing home care in your area? Call and ask two or three nursing homes in your area.

B. **Co-insuring Capability:** The lower the daily benefit selected, the lower the premium. You need to decide what portion of the daily cost of care you would be able or are willing to pay.

Will your “**left over income**” (on p.5) cover \$10, \$20, \$30 or more a day for the cost of care? _____

If the above answer is **yes**, are you willing to pay this amount in order to lower the cost of your premium, for lower daily benefits? _____

What would you like your daily benefit to be (based on answers to 2a and 2b)?

3. The cost of care in a nursing home **will increase** over the years **due to inflation**. An option you can buy to protect against this increase is **inflation protection**. Inflation protection will increase your policy's daily benefit and reduce the amount you will pay out in the future. Inflation protection **must** be included in Indiana Partnership policies.

Do you want inflation protection? Yes _____ No _____

4. **Elimination Period:** You choose how many days you must wait after you are admitted to a nursing home before your policy will begin paying for your care.

Your choices are: **0, 20, 30, 60, 90, 100, 180, and 365 days.**

The 365-day option is not available with Indiana Long Term Care Insurance Policies.

(0 days = most expensive premium. 100 days = least expensive premium.

You will have to use your resources (such as income, interest, or assets) to cover the cost of care during the elimination period. To determine your costs during this time, choose a daily nursing home cost from 2a above, multiply it by the number of days you choose for the elimination period.

Example:

(daily nursing home cost) X (# of elimination days) = (your cost)

5. Nursing homes may request one month payment in advance, at admission. Insurance companies pay on a reimbursement basis. This means it could be **30-60 days** after you enter a nursing home, (plus any days under your policy's elimination period) before your policy begins to pay. Therefore, you will need enough money to cover these initial days of care.

Example: 60 days x daily cost of care (from 2a, page 9) = _____

6. Insurance **will not** cover all of your LTC expenses. For example: policies **typically do not** cover prescription drugs. Plan to have extra money to pay for items not covered in the policy.

7. **Maximum Benefit:** This is the **total number** of days or total dollar amount the policy will pay. Choices include a specific number of days (or years), lifetime coverage, or a specific \$ amount.

What would you like for your maximum benefit? _____

OTHER OPTIONS

SELF INSURING

This option is most appropriate for persons who are able to invest income and assets over a number of years to cover the costs of long term care. You may wish to speak with a financial consultant or advisor.

RELIANCE ON MEDICAID

- a. Persons with limited income and assets **should not** purchase LTC.
- b. Persons who do not have or cannot get health insurance (possibly due to a health condition) may wish to consult an attorney familiar with Medicaid Law.
- c. To apply for Medicaid services, call your local Office of Family and Children.

RETIREMENT COMMUNITIES

- a. Continuing Care Retirement Communities offer a range of levels of care from independent apartments to nursing home care. The monthly fee is based on the level of care received.

- b. Life Care Retirement Communities require a person to pay an entrance fee and a monthly fee. Some communities refund all or part of the entrance fee upon death or if the person moves out of the community. The monthly fee does not change even if the person moves into the nursing home. However, it may increase each year due to inflation.
- c. For more information, look under “**retirement communities**” in the yellow pages.

**HOME EQUITY
CONVERSION MORTGAGES**

- a. Also called **reverse mortgages**, home equity conversion mortgages allow homeowners of 62 years of age or older to borrow against acquired home equity. They receive a loan to generate income to pay for LTC services, LTC insurance premiums, or to help with any other living expenses.
- b. The borrower retains full ownership of their home. There is no repayment of the loan until the person and/or their spouse no longer lives in the home (due to a move, admission to a nursing home, sale, or death).

Information about lenders and those loans may be obtained by contacting your local **Housing and Urban Development office** or at the **HUD internet site**:

www.hudhcc.org/agencies/indiana.txt

COMMUNITY SERVICES

- a. Many communities offer services for seniors. These services can range from assistance with home health care to community-based services, such as: adult day care, meal sites, transportation services, etc.
- b. Funding for these services is generally provided by: Older Americans Act, Social Service Block Grant, Medicaid Waiver, Community and Home Options to Institutional Care for the Elderly (CHOICE), etc.
- c. Eligibility requirements may be based on: age, income, need for medical assistance, or any combination of these.
- d. For more information about community services available in your area and/or eligibility requirements, contact your local **Area Agency on Aging** at **1-800-986-3505**.

Should you have questions about Long Term Care Insurance, Medicare, Medicare Supplemental Insurance, or Medicaid, call your local SHIP site, or call: 1-800-452-4800, or visit us at

www.in.gov/idoi/ship

The Spousal Impoverishment Protection Law

The Spousal Impoverishment Protection Law occurred in 1989. Its purpose is to protect spouses of nursing home residents from losing all their income and assets to pay for the nursing home spouse's care. The law allows the spouse living in the community to keep some assets and income and still be able to get Medicaid assistance for the nursing home spouse.

ASSETS

The spouse at home can protect up to half of the couple's countable assets at time of admission to the nursing home up to **\$109,560** but not less than **\$21,912 in 2010**. Some examples of assets that are **countable** are: cash, checking accounts, savings accounts, CD's, stocks, bonds, money market funds, mutual fund shares, revocable trusts, cash value of life insurance policies, savings bonds, and IRA's.

The nursing home spouse's share should be used towards his/her nursing home care until his/her assets have been reduced to **\$1,500**. Medicaid will then assist in his/here care.

PERSONAL INCOME

Income in your name remains your own (Social Security, Pensions, etc). The spouse at home may keep all of his/her personal income. If the spouse at home's income is less than **\$1,823** per month, then he/she can keep part of the income of the nursing home spouse's income to bring the spouse at home's income up to **\$1,823**. (Changing in July, 2010) If the spouse at home has living expenses that are very high, he/she may appeal to bring the spouse at home's income up to **\$2,739** (01/2010).

JOINTLY-OWNED INCOME

The spouse in the nursing home must use most of his/her income to pay for nursing home care. The nursing home spouse's income will pay first, then Medicaid will help with nursing home costs. The nursing home spouse may keep a **personal needs allowance of \$52** per month.

Income from assets owned by both spouses is **counted by Medicaid as jointly-owned income**. Jointly-owned income is divided in half, with each spouse getting a half.

Exhibit E
Select Joint Commission on
Medicaid Oversight
September 21, 2010

Testimony for SJCMO on September 21, 2010

Thank you Rep Crawford and members of the SJCMO. I am Faith Laird, Director of the Division of Aging and I am pleased to be able to present today some data that we believe will respond to requests made by Rep Crawford regarding the nursing facility case mix reimbursement system. This will include a description of the Case Mix (CM) reimbursement system as it functions with the Phase II changes incorporated, how that may change with the implementation of Phase III in the future, and how Phase II and III provide incentives to improve NF performance as it relates to quality. I will also give you an update on the Closure and Conversion Fund, and lastly discuss the additional revenue that could potentially be generated if the quality assessment was maximized. Before I get into the CM system, I would like to refresh your memories about what led to Phase II. In 2007 and 2008, the Division of Aging began reviewing the cost report data after nursing facilities had received the initial Quality Assessment (QAF) payments. If you recall, although the QAF was passed by the legislature in 2003, the plan was not approved by CMS until 2005, so lump sum payments equivalent to about \$100M per year were made beginning in late 2005; payments for '03 and '04 as well as '05. It became evident as then director Megan Ornellas reviewed this cost report data, that quality had declined although revenue had increased significantly. That led to the consideration of what could be done from a reimbursement standpoint to provide financial incentives for good care, while at the same time stop paying an enhanced rate, or at least reduce the enhanced rate, to those facilities that were scoring the worst in terms of quality performance. After many months of modeling and discussions with nursing home providers, a proposed rule was prepared, and as you may recall this Commission met almost 1 year ago to consider the recommendation of the proposed rule that was known as Phase II. State law prevents changes to the nursing facility reimbursement system without the recommendation of the SJCMO, and as you may recall the rule was recommended by this commission on a vote of 10-1. I came across a news article a few days ago from the Indy Star, published the day after that October meeting. It referred to this rule as *groundbreaking*. I hope that you share my sentiments that it was so nice to see Indiana described as doing something "groundbreaking" when so often we are accused of lagging behind. We were aware at that time that there were only 8-9 states that had undertaken any kind of a P4P initiative, and that Indiana's approach was somewhat unique. So we commend the commission for supporting this step towards improving care in Indiana's nursing facilities. That rule did become final, CMS approved the State Plan Amendment, and it was implemented on January 1.

You have been provided a summary of the case mix Medicaid rate setting system that was prepared for us by our rate setters, Myers and Stauffer LLC; Keenan Buoy is present with us today to clarify any questions you may have. First of all I would remind you that prior to a case mix system of reimbursement, facilities were reimbursed based on whether a resident fit into one of two categories, either skilled or intermediate. The case mix system creates multiple categories of reimbursement, ranging from a very low needs resident to one who has highly skilled, very acute care needs. These categories are called Resource Utilization Groups or RUGs. The residents are placed into one of these groups by a process that begins with the completion of the Minimum Data Set or the MDS. We have been using the MDS version 2.0 for approximately 12 years and the latest version, MDS 3.0, after many delays, goes into effect this October 1. After the MDS is completed by facility personnel on every resident, both initially as well as quarterly, annually and at any significant change of condition, that information is sent electronically to the Federal and State government entities. The *primary* purpose of the MDS is for the planning and delivery of care for each individual resident based on the information gathered. For states that use this information for reimbursement, as we do in Indiana, it is then extracted for our rate setters who use the data to modify the direct care component of the case mix system.

As seen in the diagram, there are four basic components to the CM system: Direct, Indirect, Administrative, and Capital.

The Direct care component is what it sounds like: it pays for nursing services. It is based on facility costs and it is case mix adjusted based on the average acuity of each facility's residents. While it is subject to an overall component ceiling, it is exempt from the Maximum Allowable Increase cap. This was a change that was effective with Phase II implementation as an encouragement, removing all negatives to a facility to increase staffing hours.

The Indirect Care component includes care that is not nursing: dietary, social services, laundry and plant operations; again based on facility costs and subject to an overall component ceiling. The direct and indirect care components have a profit add-on payment that is used to incentivize facilities to keep costs down; it is paid to providers whose costs are below the ceiling and the amount of the payment is tied to the facility's individual report card score. Basing this on the RCS was a component of the Phase II changes as another incentive to improve quality.

The Administrative component reimburses for general and administrative costs such as Administrator and other management salaries. With the implementation of Phase II this was changed from a strictly cost based method to a “price”, based on the median allowable cost of all facilities in the state. This was done in an effort to control the rapid growth in management salaries that had been witnessed following the implementation of the QAF.

The Capital component pays for the use of the facility and equipment based on a fair rental value system. It is a statewide price per bed. Property taxes and insurance are also reimbursed under the capital component and all are subject to the overall component ceiling. This component also has a profit add-on provision if costs are below the ceiling and are variable based on the facility’s RCS—another quality incentive provision of Phase II.

The Therapy component is considered a separate component as costs for Physical, Occupational, Speech and Respiratory therapies are reimbursed as a direct pass through, and not subject to the overall rate ceiling and are exempt from the maximum allowable increase cap.

The Quality Assessment Fee add-on reimburses for the costs of the quality assessment fee. The Medicaid portion of each facility’s QAF costs are reimbursed as a direct pass-through, which is not subject to an overall component ceiling.

Then come the **quality add-on** components: Report Card Score, facilities that have Ventilator units (serving more than 8 ventilator dependent residents, and the Special care Unit add-on for facilities who meet the qualifications for having a special care unit for residents diagnosed with Alzheimer’s or other related dementias, While each of these quality add-ons existed in the case mix system prior to Phase II, there have been some modifications. Each of these add-ons is *not* based on costs, and except for the Special Care Unit add-on, they *are* exempt from the maximum allowable increase (MAI). If you earn them, you get them, in total.

Report Card Score: Prior to Phase II, every facility received an additional payment based on their RCS; from \$1.50 per patient day for facilities in the lowest quartile (with the highest scores thus the poorest care), to \$2 for the next quartile, \$2.50 for those in the quartile with the next best scores to the highest reward of \$3 ppd for those with the lowest scores, thus performing the best as determined by the survey process. With the implementation of Phase II, the maximum payment is increased to \$5.75 ppd for all facilities ranking in the top quartile, those facilities with the lowest, or best, scores. The facilities in the lowest quartile will receive NO add-on, and those in between will receive a graduated add-on based on their individual scores. Not only

does this almost *double* the reward for good performance, it provides for a more equitable reward for all those in between. I am happy to report that we believe we have already begun to see the impact of Phase II by a drop in the average report card score by about 11 points.

The Ventilator Unit add-on has no new qualifying criteria but was increased from \$8.79 to \$11.50 per day which is paid for all residents in the facility, an increase of almost \$3 per patient per day. We have 5 facilities that care for ventilator dependent individuals and these facilities have large investments in equipment as well as highly trained staff.

The Special Care Unit or Alzheimer's add-on is the last of the quality component add-ons and it too has been updated and the reimbursement increased. Facilities that have Alzheimer's or Dementia Units are determined annually and the add-on has increased from \$10.80 per day to \$12 for each Alzheimer's patient being cared for. Because this information had not been updated since 2003, some new facilities since then have SCU's that are now receiving this add-on—bringing the total to 174 SCU facilities. Also some facilities have closed their dementia units and are therefore no longer receiving this add-on.

The Medicaid rate paid to each facility is the sum of all these rate components.

I have referred to some of the changes in the system created by the implementation of Phase II. There are a couple of other provisions that were incorporated to assist us in achieving the State's goal of balancing the long term care reimbursement system, expanding home and community based options and of providing care in the most appropriate and least restrictive setting whenever possible. The minimum occupancy for facilities with more than 50 beds has been increased to 90% from 85%, hopefully encouraging inefficient facilities to either close or convert the facility to another use. The rule change also reduced the value of certain RUG categories that will apply prospectively and only for new resident admissions, thus encouraging facilities to either not admit or to appropriately discharge residents in the lowest needs categories to a more appropriate HCB setting.

You also requested information on how Phase III or any other efforts will be used to serve as incentives to improve Nursing Facility quality. While the responsibility for the regulatory process, including on site surveys of facilities to verify compliance with state and federal regulations and also imposition of any subsequent penalties, lies with the ISDH as previously presented by Terry Whitson, FSSA will continue to look for ways to improve nursing facility performance from the reimbursement perspective. Before Phase II was even in place, we had

begun work on Phase III. A workgroup had been formed in 2008 under my predecessor, Megan Ornellas, to consider other avenues or methodologies to pay for improved performance. Sometimes called “pay for performance” or “value based purchasing”, the goal is the same. Beginning in February of this year, we expanded on the initial work of this group and are considering what, if any, changes should be made to the quality component. Often heard during the Phase II discussions was a concern that the survey process, which determines the RCS, was a flawed or an incomplete methodology to pay nursing facilities for quality. We, as a Division, recognized that it wasn’t a *perfect* way, or the *only* way, to measure or pay for quality. But it was a valid way and had been used for an add-on since the effective date of the QAF in 2003. The group that is currently refining the old and considering new components upon which to base the payment is known as the Clinical Expert Panel and were selected for their clinical expertise. We have Provider representation in nurses and administrators, advocacy representation from USA, AARP and the State Ombudsman office, we have educators and researchers from the field of gerontology and we have representation from ISDH and from FSSA, both Aging and OMPP as well as reimbursement expertise provided by Myers and Stauffer representatives. They have met faithfully on a monthly basis with some subcommittee work as well. They have reviewed mountains of resource documents and studied P4P or VBP from multiple states. The following components have been considered:

CMS Quality Indicators or Quality Measures; direct care staffing including hours per patient day, turnover and retention of direct care staff; tenure of administrators and directors of nursing; qualifications of Medical Directors and time spent by them on Medical Director duties in the facility. They have considered satisfaction surveys of residents, families and staff. They have talked about differentiating between quality of care vs. quality of life, e.g., should facilities be rewarded for implementing culture change programs; *and* the RCS which is now the only component. Some of these provisions are going to be recommended for Phase III and others will be held for future modifications. I am very impressed with the work of this group—a look at quality from some very experienced and qualified professionals. We will be finalizing the recommendations of the CEP in the next 2-3 months and then we will convene the provider associations, Aging and OMPP to develop the final product in preparation for developing a proposed rule. At this point in time the expectation is that the new quality measures with Phase III will supplement the RCS as the tools to determine the Medicaid reimbursement mechanism to incent improved quality.

Lastly, unless you would like me to stop now, I can update you on the status of the CCF and deal briefly with potential maximization of the QAF.

CCF: The CCF is a residual fund that results after reimbursing facilities by virtue of the CM reimbursement formula. While it has been designated to use to either close Medicaid nursing facilities or to convert them to HCBS such as AL, Adult Family care, or Adult Day Services, there has been little to no interest shown by providers in participating in this program. The current balance in the Closure and Conversion fund is \$27.8M. Expenditures from this fund include:

- a disbursement of \$512,610 to McCurdy Health Care Center for conversion from a Nursing Facility (NF) to an Assisted Living Facility (Riverwalk Village) participating in the Assisted Living Medicaid Waiver program.
- A transfer of \$10.5M at end of SFY10 to offset the state's portion of a negative variance in *nursing facility* expenditures in excess of \$40M. FSSA representatives met with providers who agreed with this transfer.

Maximization of QAF: There has been discussion involving providers, FSSA and some legislators about the possibility of increasing the assessment on nursing facility providers in order to generate additional dollars to be used similarly to the current assessment. If the quality assessment was maximized (5.5% of Medicaid revenue) it would generate approximately \$46.6M in additional state dollars.

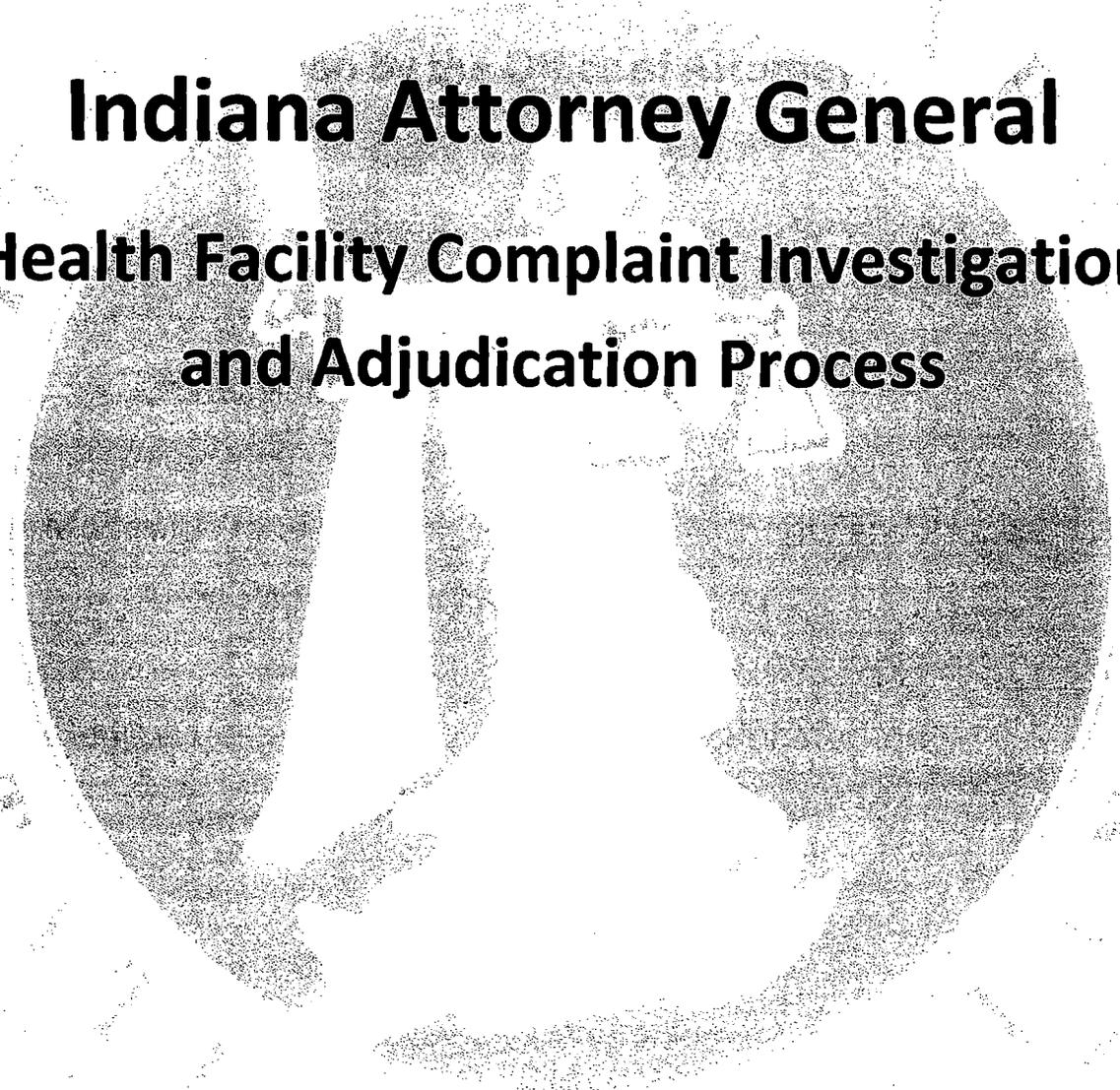
Questions?

Summary of Case Mix Medicaid Rate Setting System

Exhibit F
Select Joint Commission on
Medicaid Oversight
September 21, 2010

A. <u>Direct Care Component</u> <ol style="list-style-type: none">1. Reimburses nursing services2. Case mix adjusted based of the acuity of residents in the facility3. Rate based on each facility's costs, subject to caps4. Profit add-on payment available if cost < ceilings; profit % varies depending on ISDH Report Card Score
B. <u>Indirect Care Component</u> <ol style="list-style-type: none">1. Reimburses dietary, laundry, housekeeping, plant operation and social services2. Rate based on each facility's costs, subject to caps3. Profit add-on payment available if cost < ceilings; profit % varies depending on ISDH Report Card Score
C. <u>Administrative Component</u> <ol style="list-style-type: none">1. Reimburses general and administrative services2. Rate based on statewide "price" not provider costs
D. <u>Capital Component</u> <ol style="list-style-type: none">1. Fair rental value system based on statewide price per bed reimburses for the use of facility and equipment2. Reimburses property taxes and insurance based on each facility's costs*3. Fair Rental value plus cost* are subject to caps4. Profit add-on payment available if cost < ceilings; profit % varies depending on ISDH Report Card Score
E. <u>Therapy component</u> <ol style="list-style-type: none">1. Reimburses Medicaid physical therapy, speech therapy, occupational therapy and respiratory therapy services2. No component caps
F. <u>Quality Assessment Fee (QAF) add-on component</u> <ol style="list-style-type: none">1. Reimburses Medicaid quality assessment fee costs2. No component caps
G. <u>Nursing Home Report card score add-on component</u> <ol style="list-style-type: none">1. Additional reimbursement based on quality measures2. Not cost based3. Reimbursement can range from \$0.00 to \$5.75 per resident day based on each facility's ISDH Report Card Score
H. <u>Ventilator add-on component</u> <ol style="list-style-type: none">1. Additional reimbursement for providing care to more than eight (8) ventilator-dependent residents2. Not cost based3. Reimburses \$11.50 per Medicaid resident day
I. <u>Special Care Unit (SCU) add-on component</u> <ol style="list-style-type: none">1. Additional reimbursement for operating a special care unit providing care to residents with Alzheimer's disease or dementia2. Not cost based3. Reimburses \$12.00 per Medicaid day for residents in special care unit
J. <u>Total Medicaid Rate = Sum of all rate components above</u>

Exhibit G
Select Joint Commission on
Medicaid Oversight
September 21, 2010



Indiana Attorney General
Health Facility Complaint Investigation
and Adjudication Process

SELECT JOINT COMMISSION MEDICAID OVERSIGHT

Presentation by the Office of Attorney General

September 21, 2010

Overview of Attorney General Regulatory Role

- **David Miller, Deputy Attorney General**

Medicaid Fraud Control Unit (MFCU) Authority and Process

- **Allen Pope, Deputy Attorney General**

Medical Licensing and Consumer Protection Authority

- **David Miller, Deputy Attorney General**

Recommendations

- **Greg Zoeller, Attorney General**

The Medicaid Fraud Control Unit

Jurisdiction

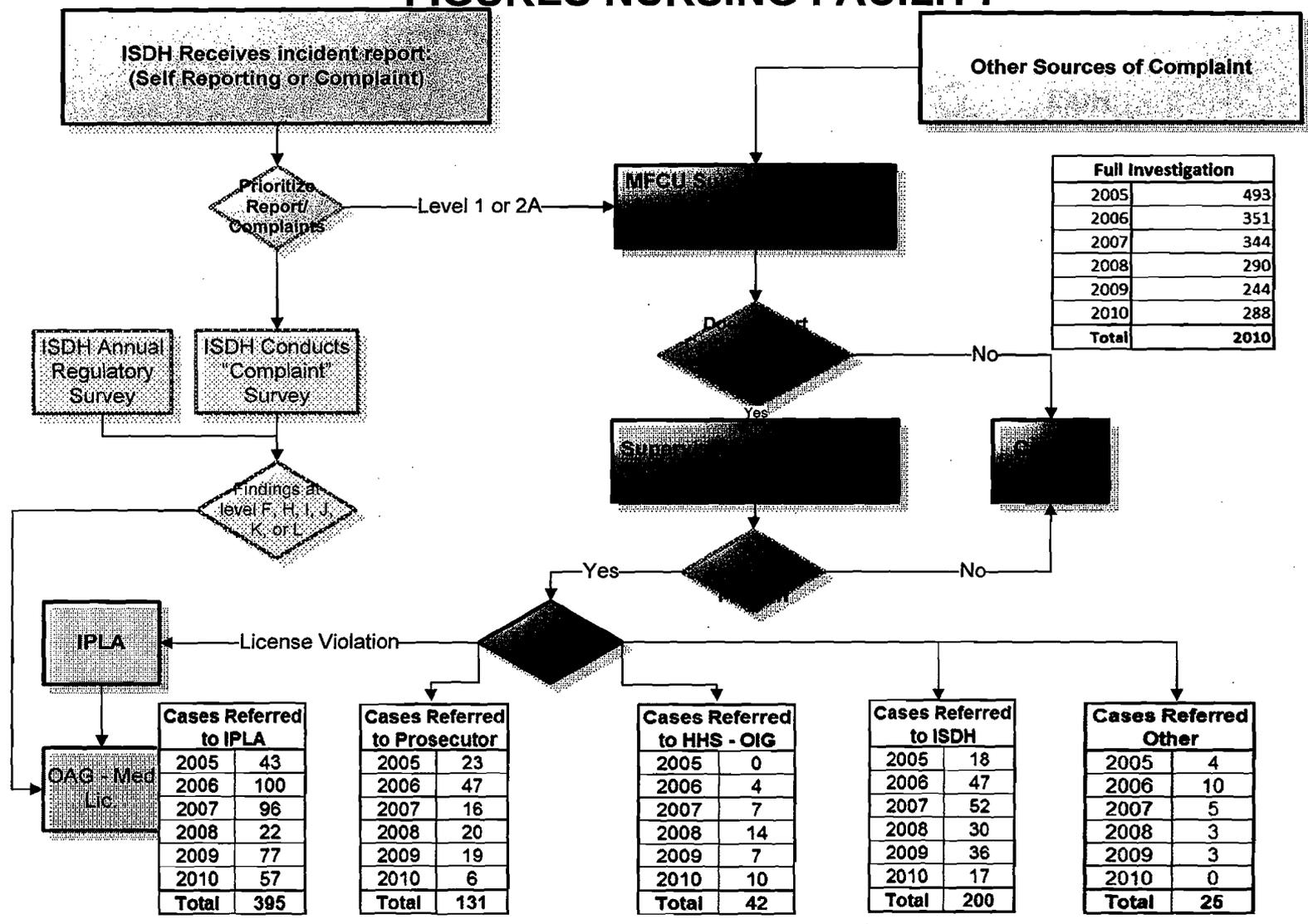
- **Medicaid-Provider Fraud**
- **Theft of Patient Funds**
- **Abuse of Medicaid Patients**
- **Neglect of Medicaid Patients**
- **Theft of Drugs**

See IC 4-6-10-1

Staff

- **47 Total**
 - **10 Attorneys**
 - **25 Investigators**
 - **3 Auditors**
 - **2 Information Technology Professionals**
 - **7 Other**
- **MFCU Abuse and Neglect Investigators have an average of 18.4 years of law enforcement experience.**
- **The MFCU has two Nurse Investigators, one with 22 and one with 24 years of professional experience.**

MFCU CASE WORKFLOW AND FIGURES NURSING FACILITY



Full Investigation	
2005	493
2006	351
2007	344
2008	290
2009	244
2010	288
Total	2010

Cases Referred to IPLA	
2005	43
2006	100
2007	96
2008	22
2009	77
2010	57
Total	395

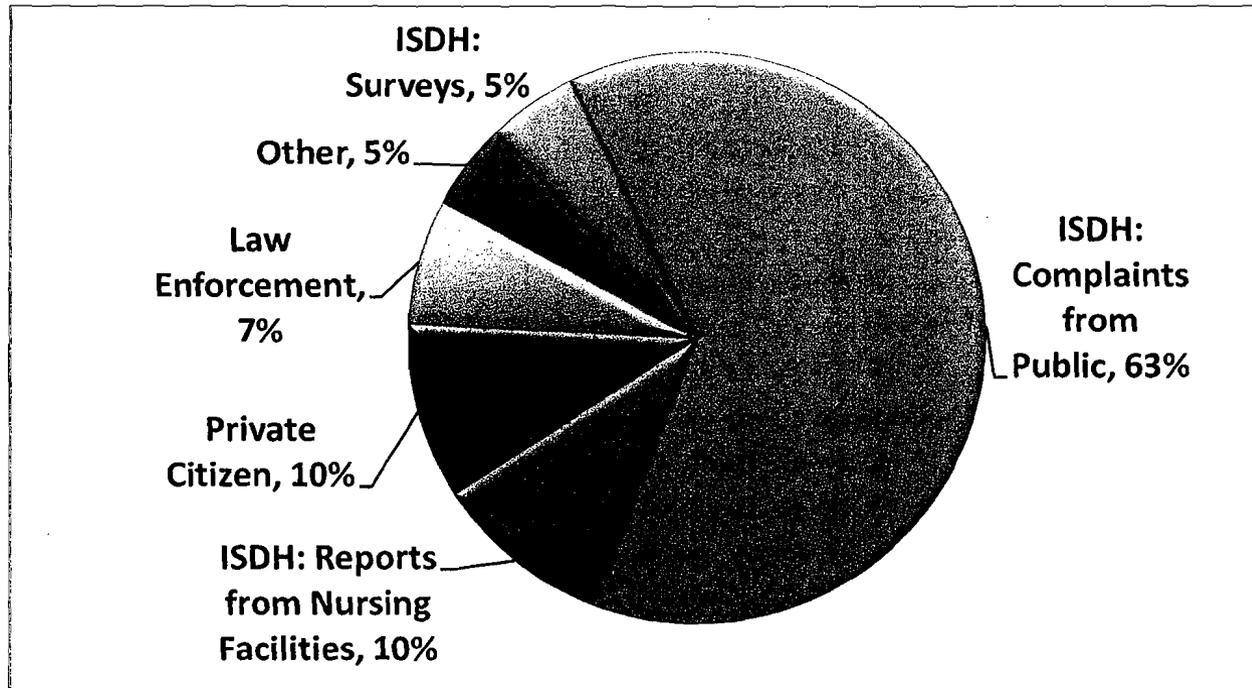
Cases Referred to Prosecutor	
2005	23
2006	47
2007	16
2008	20
2009	19
2010	6
Total	131

Cases Referred to HHS - OIG	
2005	0
2006	4
2007	7
2008	14
2009	7
2010	10
Total	42

Cases Referred to ISDH	
2005	18
2006	47
2007	52
2008	30
2009	36
2010	17
Total	200

Cases Referred Other	
2005	4
2006	10
2007	5
2008	3
2009	3
2010	0
Total	25

Sources



Referrals

Assigned	2005	2006	2007	2008	2009	2010	Total
Prosecutor	23	47	16	20	19	6	131
HFA Licensing Board	7	18	14	4	15	5	63
Nurses Board	36	78	81	18	59	51	323
Other Boards	0	4	1	0	3	1	9
Boards: Total	43	100	96	22	77	57	395
CNA Registry	18	47	52	30	36	17	200
Exclusion Requests	0	4	7	14	7	10	42
Other Referrals	4	10	5	3	3	0	25
Totals	88	208	176	89	142	90	793

MEDICAL LICENSING HEALTH FACILITY WORKFLOW AND FIGURES

Complaints Passed from IPLA (Includes MFCU Forwarded Complaints)			Complaints From Public			Surveys from ISDH		
40.0%	HFA	Nurses	42.3%	HFA	Nurses	17.7%		
2005	26	163	2005	26	115	2005	27	
2006	19	183	2006	18	101	2006	64	
2007	28	124	2007	12	103	2007	103	
2008	10	58	2008		111	2008	24	
2009	19	59	2009	4	110	2009	37	
2010	6	57	2010	5	72	2010	28	
Total	108	531	Total	65	612	Total	283	

Medical Licensing Investigation

Has a licensing violation occurred?

YES

**Medical Licensing Litigation:
Work Case and Submit to Relevant Board**

HFA
Board Designee:
Review and
Recommendation

Nursing Board
Board Designee:
Review and
Recommendation

IBM Board Hearing

IBM Board Hearing

Informal Board Meeting

Formal Board Action

Informal Board Meeting

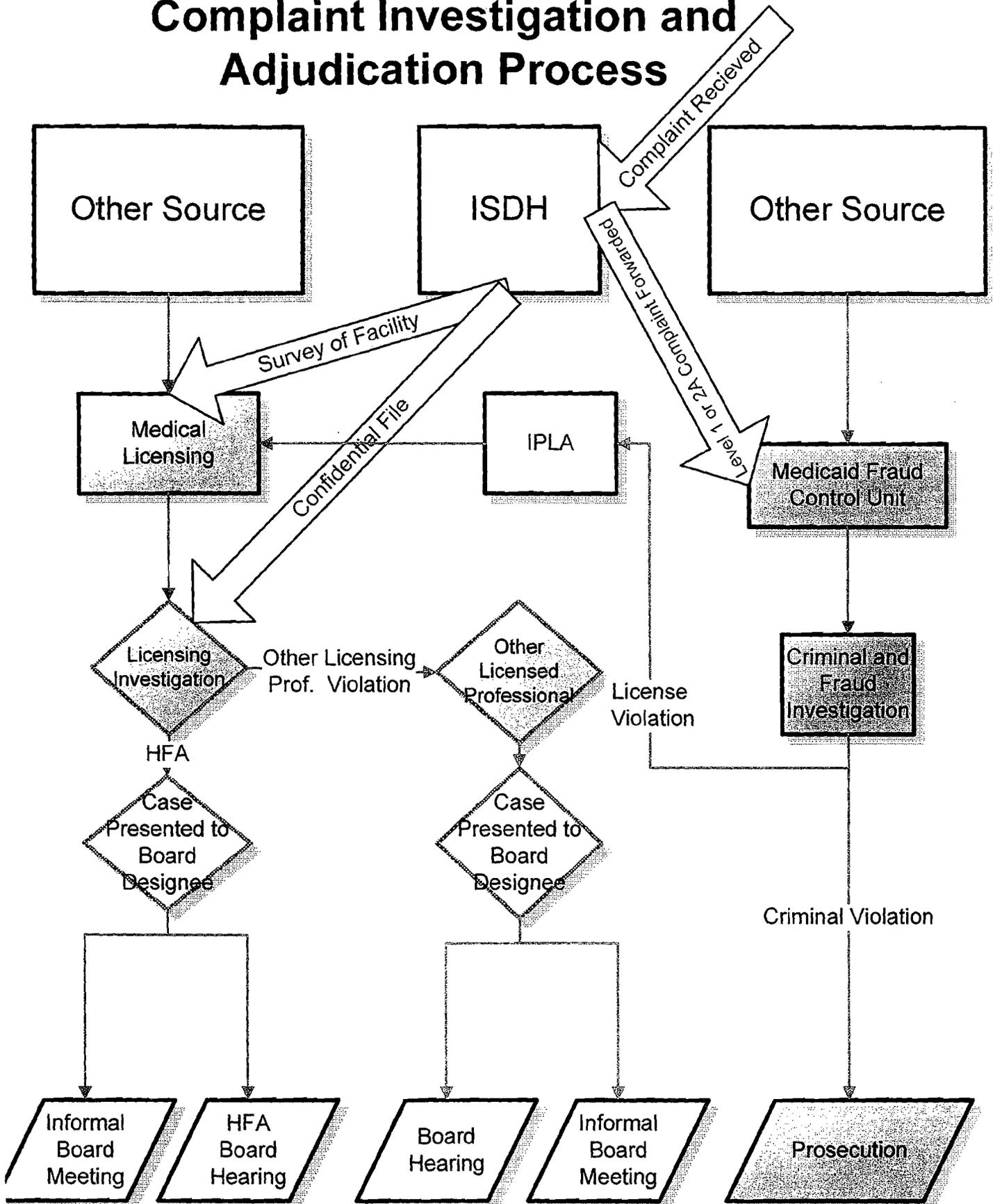
Formal Board Action

Yr	IBM	Open Yr	2005	2006	2007	2008	2009	2010	Total
2005		Case Dismissed			2	2			4
2006	3	Fine	1	1	1	1	1		5
2007	1	No Violation				4			4
2008	31	Reprimand	1		3	5	1		10
2009	9	Revoked			1				1
2010	4	Settled		1					1
Total	48	Suspension	1	1		2	3	1	8
		Pending						1	1
		Grand Total	3	3	7	14	5	2	34

Yr	IBM	Open Yr	2005	2006	2007	2008	2009	2010	Total
2005	3	Case Dismissed							
2006	5	Fine	3	3	3	3	3	2	17
2007	16	No Violation	59	50	52	55	59	44	319
2008	22	Reprimand	3	2	2	2	3	2	14
2009	22	Revocation	8	7	7	8	8	6	45
2010	0	Suspension	2	1	1	1	2	1	8
Total	68	Pending	54	46	48	51	55	41	296
		Total	129	109	115	122	154	158	787

Dispersion estimated with representative sample of disposition of nursing cases for same time period

Indiana Attorney General Health Facility Complaint Investigation and Adjudication Process



Recommendations by Attorney General Zoeller to the Select Joint Commission on Medicaid Oversight

- (1) Enact legislation which would require that a health professional applying for a license or certification to undergo a criminal background check and the results sent to the Indiana Professional Licensing Agency. It also would require the county prosecutors to notify the Indiana Professional Licensing Agency if a licensee, such as a health facility administrator or nurse is convicted of a crime. This proposal has been announced by Senator Miller and will be heard during the upcoming legislative session.
- (2) Quality care in nursing homes is the responsibility of all owners and administrators. To that end the Department of Health and the Attorney General should continue to refine and enhance protocols governing the reporting of discipline issues to the responsible licensing entities.
- (3) Provide whistleblower protection to nursing home administrators and staff who make reports of misconduct. Such protection is provided to other individuals and entities by statute and should be extended to those providing care in nursing homes.
- 1) Require nursing home facilities to report any termination of an individual licensed by the Indiana Professional Licensing Agency to their respective licensing board. In addition, insurance companies should be required to report any settlement or judgment involving negligence in nursing home care.

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Suite 100
Indianapolis, IN 46204

TOLL FREE 800 466.IHCA
PHONE 317 636.6406
FAX 877 298.3749



Exhibit H
Select Joint Commission on
Medicaid Oversight
September 21, 2010

Select Joint Commission on Medicaid Oversight

September 21, 2010

10 A.M.

Senate Chamber

Presentation by:

Scott Tittle

President

Indiana Health Care Association



Select Joint Commission on Medicaid Oversight

September 21, 2010

Indiana Health Care Association

- I. Economic Impact of Long Term Care in Indiana
- II. Quality Assessment Fee
- III. Indiana Medicaid Reimbursement
- IV. Quality Issues
- V. Phase III
- VI. Background Checks Press Release
- VII. Health Care Act of 2010 Sections dealing with Long Term Care

LONG TERM CARE ECONOMIC IMPACT STATISTICS

INDIANA

NURSING FACILITIES, STAFF & PATIENTS

In Indiana

504 Nursing Facilities

48,534 Employees

39,190 Patients Cared for Every Day

16% of patients rely on Medicare; 61% rely on Medicaid; 22% pay for care with private or other funds.

LONG TERM CARE ECONOMIC IMPACT

Direct & Indirect Contribution To Indiana

\$3.4 billion or 1.4% of state economic activity
(direct effect)

\$5.6 billion or 2.3% of state economic activity
(total impact)

TOP 5 INDUSTRIES/SECTORS SUPPORTED BY LONG TERM CARE

	Economic Activity (in millions)	Employment (jobs)
Health and Social Services	\$3,648.8	71,800
Real Estate and Rental	1,539.6	10,900
Manufacturing	173.3	3,100
Finance and Insurance	78.2	100
Retail Trade	38.7	600
All Industries and Sectors	\$ 5,611.6	88,100

"Long Term Care Facilities" include nursing facilities, assisted living and other long term care residential facilities.

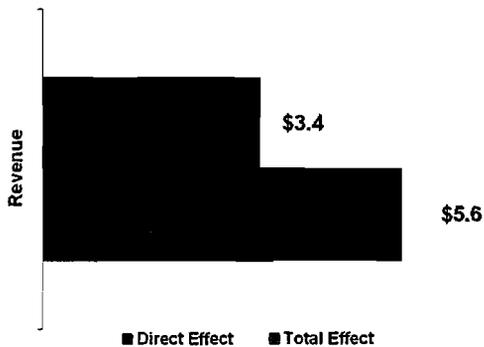
Economic Impact of Long Term Care Facilities

Indiana

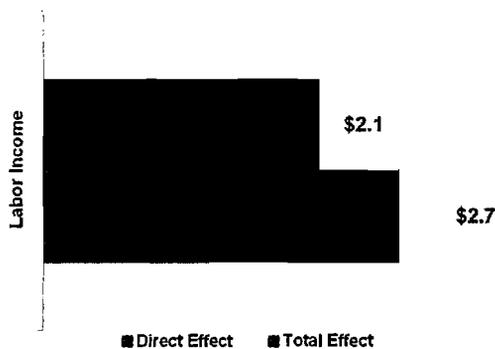
January 2009

Long Term Care (LTC) facilities* support an estimated \$5.6 billion or 2.3% of the state's economic activity

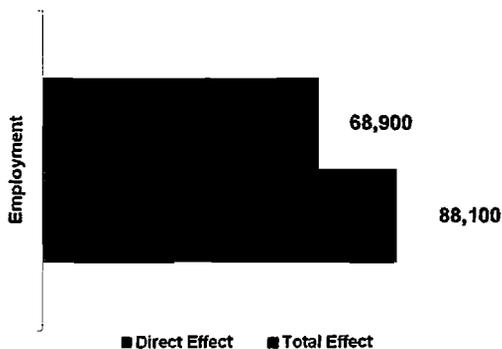
LTC facilities support \$5.6 billion in revenue...



LTC facilities support \$2.7 billion in labor income...



LTC facilities contribute to approximately 88,100 jobs...



*Long Term Care (LTC) facilities include nursing homes, assisted living, and other residential care facilities. These facilities do not include government-owned or hospital-based facilities.

LTC facilities' **direct** economic impact on Indiana represents...

- 1.4% of economic activity
- 1.3% of labor income
- 1.9% of employment

LTC facilities' **total** economic impact on Indiana supports...

- 2.3% of economic activity
- 1.7% of labor income
- 2.4% of employment

LTC facilities generate \$0.8 billion in tax revenue...

- \$0.3 billion in state/local taxes
- \$0.6 billion in federal taxes

Demographics of Indiana

Population (2007)	6.3 million
% Population 65+ years (2007)	12.4%
% Population 85+ years (2007)	1.8%
State economic activity (2007)	\$243.6 billion

Prepared by:

The **LEWIN GROUP**

Economic Impact of Long Term Care Facilities

Indiana

January 2009

Summary: Economic Impact of LTC Facilities

Estimated Impact	Direct	Indirect	Induced	Total	% of Total State Activity
Output (in billions of dollars)	\$3.4	\$0.7	\$1.5	\$5.6	2.3%
Labor Income (in billions of dollars)	\$2.1	\$0.2	\$0.5	\$2.7	1.7%
Employment (jobs)	68,900	5,500	13,700	88,100	2.4%
Estimated Impact	State/Local	Federal	Total		
Tax (in billions of dollars)	\$0.3	\$0.6	\$0.8	-	

LTC facilities support other industries and sectors statewide...

Industry/Sector	Estimated Impact	
	Employment (jobs)	Economic Activity (in millions)
Health and Social Services	71,800	\$3,648.8
Retail Trade and Retail	10,900	\$1,569.6
Manufacturing	3,100	\$173.3
Finance and Insurance	100	\$73.2
Retail Trade	600	\$38.7
Accommodation and Food Services	300	\$36.5
Professional - Scientific and Tech Services	800	\$33.6
Wholesale Trade	200	\$27.3
Utilities	100	\$21.8
All other industries	100	\$13.9
Total	88,100	\$5,611.6

NAICS: North American Industry Classification System

Note:

Numbers may not add due to rounding.

Sources:

Economic impact analysis: The Lewin Group analysis using Impact Analysis for Planning (IMPLAN) software, Minnesota IMPLAN Group, Inc, 2007 data
Population data: U.S. Census Bureau, <http://www.census.gov/>

Economic Impact Definitions

Direct Effect represents the impact (e.g., change in employment or revenues) for the expenditures and/or production values specified as direct final demand changes.

Indirect Effect represents the impact (e.g., change in employment or revenues) caused by the iteration of industries purchasing from industries resulting from direct final demand changes.

Induced Effect represents the impacts on all local industries caused by the expenditures of new household income generated by the direct and indirect effects of direct final demand changes.

Total Impact is the sum of the direct, indirect and induced effects.

Labor Income is the sum of employee compensation and proprietary income.

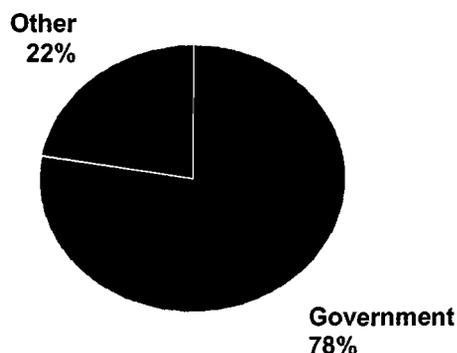
Prepared by:

The **LEWIN GROUP**[®]

Indiana

2010 Long Term Care Health Care Overview

Nursing Facility Resident Population by Payor (2009)



Government - Includes Medicaid and Medicare

Other - Includes Private, Insurance and Medicare Advantage

Facility Characteristics

	Facilities	Beds/ Units	Employees
Nursing Facilities: (2009)	504	57,450	48,534
ICFs/MRDD*: (2009)	546	4,181	5,310
Assisted Living: (2007)	190	14,665	N/A

Government Expenditures (2010)

	Medicaid	Medicare
Estimated Total Nursing Facility Expenditures	\$1,205,189,000	\$823,641,600
Estimated Total ICFs/MRDD* Expenditures	\$328,564,000	N/A

Medicaid Shortfall Nursing Facilities (2009)

Average Per Patient Day	Estimated Total
N/A	N/A

Estimated Medicare Cuts FY 2010 - 2019**

Final Rule	Health Care Reform
\$358.1	\$451.2

*Intermediate Care Facilities for the Mentally Retarded/Developmental Disabilities

**Dollars in millions



Quality Assessment Fee

History of the QAF

The 2003 Indiana General Assembly passed legislation authorizing the Indiana Office of Medicaid Policy and Planning (OMPP) to collect a quality assessment fee (QAF) from nursing facilities and use the revenue to enhance nursing facility reimbursement.

In 2004, 2005 and 2006, the Indiana General Assembly extended the QAF for one year each time, reaffirming their near-unanimous support for this initiative. During the 2009 legislative session, the QAF was extended for two years; it is now authorized through June 30, 2011.

The QAF could not be implemented, however, until it was approved by the Centers for Medicare & Medicaid Services (CMS). Implementation began July 1, 2005.

Federal Approval

OMPP submitted a State Plan Amendment to CMS on September 30, 2003. It was approved by CMS on April 12, 2005. The quality assessment will be applied retroactively to July 1, 2003.

How the QAF works

An assessment is collected from providers based on the number of non-Medicare days in their facility. Providers are assessed the fee, which generates \$98 million in state dollars that is paid to the State.

The State then spends the money within the Medicaid program so it becomes eligible for federal matching funds (based on every dollar the State spends, the federal government provides \$1.62 back to OMPP).

Funds Returning to Facilities*

The \$98 million, when matched with federal financial participation, generates a total of approximately \$270 million (state and federal dollars), 80% of which is returned to long-term care to help pay for the care of Indiana's frail and elderly.

Funds Returning to State

The state Medicaid program receives 20% of the total revenue, which generates an estimated **\$54 million** (state and federal) annually to be used at the State's discretion in the Medicaid program.

Furthering Policy Goals

The QAF will also help further shared policy goals of IHCA and the state such as:

- Quality care incentives
- Improved funding for specialized care for those afflicted with Alzheimer's Disease
- Implement a closure/conversion fund, which will help Indiana address mutual policy goals

Waiver Exemptions

The quality assessment utilizes a federal waiver (42 C.F.R. 433.68) that allows an assessment to be levied and at the same time exclude certain providers from paying the fee while still meeting the federal requirements to qualify for matching funds.

Indiana's approved plan exempts Continuing Care Retirement Communities (CCRCs), hospital-based facilities and the Indiana Veteran's Home.

QAF MAXIMIZATION

Current Assessment (4.0%)

\$98,668,552



Federal Maximum (5.5%)

\$135,539,576



Additional Revenues

\$36,871,024



State Share (80/20 Split)

\$7,374,205



Closure and Conversion Fund

\$29,000,000



It's part of the collection of the QAF but set aside to close and convert facilities. No money has been spent from this account.

Civil Monetary Penalty

\$9,000,000



Money collected from providers for fines paid from surveys and controlled by Indiana State Department of Health (ISDH)

Current States with NF Provider Taxes

State	Waiver	Waiver Status	Annual Tax Per Licensed	Tax Per Occupied Bed	Tax Per Non-Medicare Day	Tax as a Percent of Revenue	At or Close to 5.5%
Alabama			\$2,960				x
Arkansas				\$9.62			x
California	Yes	Approved		\$11.16			x
Colorado	Yes	Approved			\$7.62		
Connecticut	Yes	Approved			\$15.90		x
District of Columbia			\$4,441				x
Florida	Yes	Approved			\$15.89		x
Georgia	Yes	Approved			\$12.21		x
Idaho					\$11.74		
Illinois				\$1.50			
Indiana	Yes	Approved			\$10.00		
Iowa	Yes	Approved			\$5.26		
Kansas	Yes	Pending	\$1,500				
Kentucky	Yes	Approved			\$10.60		
Louisiana				\$8.02			x
Maine						5.50%	x
Maryland	Yes	Approved			\$14.01		
Massachusetts	Yes	Approved			\$18.41		x
Michigan	Yes	Approved			\$21.25		x
Minnesota			\$2,815				x
Mississippi				\$12.09			x
Missouri				\$9.27			x
Montana				\$8.30			
Nevada	Yes	Approved			\$22.84		x
New Hampshire						5.50%	x
New Jersey	Yes	Approved			\$11.92		
New York						6.0% of Non-T-18	x
North Carolina	Yes	Approved			\$12.75		x
Ohio				\$11.95			x
Oklahoma				\$6.70			
Oregon	Yes	Approved			\$15.38		x
Pennsylvania	Yes	Approved			\$23.75		x
Rhode Island						5.50%	x
Tennessee			\$2,225				
Utah					\$10.20		x
Vermont			\$3,963				
West Virginia						5.50%	x
Wisconsin			\$1,800				

Indiana Medicaid Reimbursement

Revised August 2009

System Overview

- Case Mix Reimbursement Methodology (Rule 14.6 of the Indiana Administrative Code)
- Prospective System of Payment
- Medicaid Cost Report is filed annually for the period:
 - FYE 8/31 = 9/1/Yr 1 - 8/31/Yr 2
 - FYE 12/31 = 1/1/Yr 1 - 12/31/Yr 2
- Rates calculated annually based on allowable costs reported on the filed cost reports
- Data from MDS assessments used to determine the facility's Case Mix Index (CMI)
- Rates adjusted quarterly to reflect changes in the CMI for Medicaid Residents
- Rate is derived from five Cost Components
- Each Cost Component (excluding Therapy) is subject to limitations and profit incentives, which are based on Statewide Medians

Rate Components

Direct Care

DEFINED BY THE FOLLOWING COSTS:

Director of Nursing

RN's, LPN's, CNA's

Medical Director

Other Nursing Staff

Nursing Consultant

Pharmacy Consultant

Medical Records Costs

Pooled Personnel

Routine Nursing Supplies

Non-Routine Medical Supplies

NATCEP Costs (Nurse Aide Training Competency Evaluation Program)

Allocated Employee Benefits for the Above Salaries

Rate Components

Therapy

DEFINED BY THE FOLLOWING COSTS:

Physical Therapy

Speech & Audiology Therapy

Occupational Therapy

Respiratory Therapy

Allocated Employee Benefits for the Above Salaries

These costs are adjusted to “carve” out the Medicaid portion of costs based on utilization.

Rate Components

Indirect Care

DEFINED BY THE FOLLOWING COSTS:

Dietary - Wages, Raw Food, Supplies, Dietician

Housekeeping - Wages, Supplies, and Services

Laundry - Wages, Supplies, and Services

Plant Operations - Wages, Utilities

Repairs & Maintenance – Auto, Equipment, Building

Activities - Wages and other Services

Social Services - Wages and other Services

Allocated Employee Benefits for the Above Salaries

Rate Components

Administrative

DEFINED BY THE FOLLOWING COSTS:

Administrator and Assistant Administrator

Allocated Home Office Costs

Office and Clerical Staff

Legal and Accounting Fees

Help Wanted Advertising

Travel

Telephone

Licenses, Dues, and Subscriptions

Office Supplies and Postage

Working Capital Interest

State Gross Receipts Tax

Utilization Review

Liability Insurance

Management Consultant Fees

Other General and Administrative

Allocated Employee Benefits for the Above Salaries

Rate Components

Capital

DEFINED BY THE FOLLOWING COSTS:

Property Insurance

Real Estate Taxes

Personal Property Taxes

and

A Fair Rental Value (FRV)* allowance, which is used in lieu of the following costs in the calculation of the rate:

Interest

Depreciation

Building Lease/Rent

Equipment Lease/Rent

Home Office costs of the above

- **The FRV** allowance is determined in part by the facility's number of licensed beds and the historical cost of allowable patient-related property of the median bed.

Computation of Rate

- Allowable costs reported on the Annual Financial Report (Cost Report) are adjusted for inflation.
- The allowable, inflated costs are then grouped into the five cost component categories and a cost per patient day (PPD) is computed for each component based on the facility's actual patient days for the cost reporting period.
- The cost PPD for the **Direct Care** component are "normalized" or adjusted by dividing the cost PPD by the Total Facility CMI score. The "normalized" PPD are then multiplied by the Medicaid CMI score to reflect only the Medicaid portion of costs.
- Each component's costs PPD (excluding Therapy) are then compared to the limitations (medians) and incentive parameters (profit add-ons) and adjusted if necessary.
- The facility's total Medicaid rate is derived from the sum of the five component's adjusted cost PPD.

Limitations & Incentives

Limitations

- **Direct Care** - 120% of the Median.
- **Therapy** - No limitation.
- **Indirect Care** - 115% of the Median.
- **Administrative** - 105% of the Median.
- **Capital** - 100% of the Median.

Profit Incentives (if below limit)

- **Direct Care** - 30% of the Difference.
- **Therapy** - No Profit Incentive.
- **Indirect Care** - 60% of the Difference.
- **Administrative** - 60% of the Difference
- **Capital** - 60% of the Difference.

General Information

- **Non Allowable Costs:**
 - Personal and Federal Income Taxes
 - Promotional or Public Relations Costs
 - Bad Debts
 - Drugs
 - Non Patient Care Related Costs
 - Air Fluidized Beds/Mattresses (i.e. Clinitron)
 - Pet food & supplies (i.e. aviary, fish)
 - Lobbying expense
 - Cable television (allowable in common areas but not in individual resident rooms)

Bed Changes

- **Any requests to change a facility's *licensed* beds or *certified* beds should be submitted to the State by the Reimbursement Services Department.**
- Changes can be done up to twice per year. The first change must be on January 1 and the second change must be on either April 1, July 1 or October 1.
- Only 1 of the changes per year can be a decrease. 45-day notice must be given for bed change requests (i.e. for bed changes to be effective January 1, notice must be given by November 15).

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← [Technology Grants Announced For New Remote Monitoring Projects AgeSong and Barnes and Noble to Hold Elders Prose and Poetry Contest](#) →

New Survey Shows Nursing Homes Are Getting Better Recommendations All Around

July 28th, 2010 · No Comments

Referrals are the best source of business and nursing homes are no different. The 2009 National Survey of Consumer and Workforce Satisfaction in Nursing Homes, recently released by My InnerView, shows a majority (85%) of consumers (residents and their families) report their willingness to recommend their facility as either “excellent” or “good.” Sixty-eight percent (68%) of employees recommend their facility as a place to work as either “excellent” or “good.” The recommendation of



nursing homes shows incremental improvements every year since My InnerView began conducting research on these trends in 2005. The report shows an increase in employees willing to recommend the facility as a place to work and satisfaction among nurses and nursing assistants remains lower than the satisfaction of employees in other job categories.

“This is by far the largest database ever collected about the willingness to recommend a facility by residents, families and employees in America’s nursing homes,” said Neil Gulsvig, president, My InnerView. “This report is useful to consumers — who want more information when choosing a nursing home — as well as providers and policymakers — who are warranted to demonstrate value to these consumers and taxpayers. The data allow nursing home leaders and public policymakers to more precisely target quality issues and workforce retention efforts.”

[Download the 2009 National Report \(PDF\)](#)

Tags: [Nursing Homes](#)

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**ISDH Long Term Care
Newsletter Issue # 10-12
August 6, 2010**

In Today's Issue:

- GPRA Update
- Seasonal Influenza Alert
- Residential Sprinklers
- Recall
- Coming Events



As part of the Government Performance Responsibility Act (GPRA), the Centers for Medicare and Medicaid Services (CMS) in 2005 established pressure ulcers and restraints as their two GPRA goals. The GPRA data includes all Indiana nursing homes. The Indiana State Department of Health (ISDH) continues to monitor our progress on preventing pressure ulcers and reducing the use of restraints.

GPRA Pressure Ulcer Rates

The following are events related to pressure ulcer prevention:

- October 2005: CMS began its GPRA initiative on pressure ulcers
- October 2007: ISDH conducted a Leadership Conference on the topic of pressure ulcers
- July 2008: ISDH implemented the Indiana Pressure Ulcer Initiative
- October 2008: Learning sessions began for first group of 163 Indiana Initiative participants
- August 2009: First group of 163 facilities and agencies completed the Indiana Initiative
- October 2009: Learning sessions began for second group of 80 Initiative participants
- September 2010: Second group of 80 facilities and agencies to complete the Indiana Initiative

GPRA pressure ulcer data for Indiana nursing homes (includes all nursing homes):

<u>Quarter/Year</u>	<u>IN Rate</u>	<u>IN Rank</u>	<u>National Rate</u>	<u>Region V Rate</u>
Q4 2008	8.3%	35th	8.0%	7.4%
Q1 2009	8.0%	29th	8.2%	7.6%
Q2 2009	7.6%	27th	7.9%	7.2%
Q3 2009	7.3%	26th	7.6%	6.9%
Q4 2009	7.8%	32nd	7.7%	7.1%
Q1 2010	7.6%	29th	7.8%	7.1%

Overview:

- Since the beginning of the GPRA pressure ulcer data report going back to 2003, Indiana has had the highest pressure ulcer rate in CMS Region V.
- The first quarter of 2009 was the first time since the start of data in 2003 that Indiana was below the national average.
- Since 2003, Indiana has ranked last (6th) in CMS Region V. In the third quarter of 2009, Indiana improved to 4th but slid back to 6th in the fourth quarter. Indiana currently ranks last in the six state Region V.

The ISDH is pleased with the progress made by Indiana facilities over the past year. The 1% reduction translates into approximately 250 fewer residents per quarter with pressure ulcers and a cost savings of

over \$10 million. The ISDH encourages facilities to review their pressure ulcer prevention systems and implement improvements. The ISDH Pressure Ulcer Resource Center provides useful resources and best practices and is found at <http://www.in.gov/isdh/24558.htm>.

GPRA Restraint Rates

The following are events related to restraint reduction:

- October 2005: CMS began its GPRA initiative on pressure ulcers
- March 2008: ISDH conducted a Leadership Conference on the topic of behavior management and restraint reduction

GPRA pressure ulcer data for Indiana nursing homes (includes all nursing homes):

<u>Quarter/Year</u>	<u>IN Rate</u>	<u>IN Rank</u>	<u>National Rate</u>	<u>Region V Rate</u>
Q4 2007	4.4%	31st	4.8%	4.0%
Q1 2008	4.0%		4.5%	3.8%
Q2 2008	3.6%		4.2%	3.6%
Q3 2008	3.4%		4.0%	3.6%
Q4 2008	3.1%	27th	3.9%	3.4%
Q3 2009	2.5%	23rd	3.3%	3.0%
Q4 2009	2.3%	21st	3.1%	2.9%
Q1 2010	2.2%	25th	2.9%	2.7%

Overview:

- The Indiana restraint rate continues to decline.
- Beginning in Q4 of 2008, Indiana improved from fourth in the region to third! Indiana remains ranked third in the region.

Congratulations to Indiana nursing homes on the continued efforts to reduce restraints.



Summary

Influenza A (H3N2) virus infections have been recently detected in people in a number of states across the U.S., including two small localized outbreaks. Sporadic cases of influenza and localized summer outbreaks from seasonal influenza viruses are detected each summer. Clinicians are reminded to consider influenza as a possible diagnosis when evaluating patients with acute respiratory illnesses, including pneumonia, even during the summer months. Treatment decisions should not be made on the basis of a negative rapid influenza diagnostic test result since the test has only moderate sensitivity. False positive results also can occur, particularly at times when overall influenza prevalence is low.

For patients for whom laboratory confirmation is desired, or to confirm initial influenza cases in a community in which cases have been tested by rapid influenza diagnostic tests, it is recommended that reverse transcriptase -polymerase chain reaction (RT-PCR), and/or viral culture is utilized. Clinicians should use empirical treatment with influenza antiviral medications for persons hospitalized with suspected influenza, and for suspected influenza infection of any severity in high-risk individuals, regardless of influenza immunization status. Early initiation of treatment provides more optimal clinical responses, although treatment of moderate, severe, or progressive disease begun after 48 hours of symptoms can still provide benefit.

Background

Overview of CMS Nursing Facility Quality Measures

CMS Nursing Facility Average Quality Measure Scores by State, 1st Quarter 2010

CHRONIC CARE													POST ACUTE CARE		
State	Pain	High Risk Pressure Ulcer	Low Risk Pressure Ulcer	Physical Restraint	Depression	Weight Loss	ADL	Bedfast	Locomotion	Indwelling Catheter	Incontinence	UTI	Delirium	Pain	Pressure Ulcer
IL	3.60%	13.10%	1.90%	3.00%	16.30%	8.80%	14.40%	2.00%	11.70%	5.20%	42.80%	8.40%	1.80%	19.30%	13.80%
IN	2.50%	10.30%	1.50%	2.20%	16.90%	8.20%	21.00%	3.20%	12.80%	5.50%	49.50%	8.90%	0.70%	17.60%	9.90%
KY	2.70%	10.80%	1.20%	4.60%	18.50%	9.70%	17.30%	7.70%	12.40%	6.10%	51.70%	10.60%	0.60%	16.70%	12.00%
MI	3.00%	10.20%	1.40%	3.30%	13.80%	7.70%	12.10%	3.30%	9.50%	4.80%	52.40%	8.60%	1.40%	19.20%	11.00%
OH	4.70%	10.30%	1.70%	3.80%	18.20%	7.90%	13.00%	4.20%	10.80%	6.10%	47.30%	10.50%	1.30%	23.00%	12.50%
WI	3.30%	9.00%	2.30%	1.10%	18.30%	7.60%	14.60%	1.90%	11.40%	6.90%	48.60%	8.00%	1.60%	25.80%	9.90%
US	3.15%	11.00%	1.70%	2.90%	14.70%	7.80%	14.70%	4.00%	11.30%	5.10%	50.90%	8.80%	1.30%	18.80%	13.00%

Indiana Ranking Compared to Surrounding States

IN	#1	tied for 3rd	3rd	2nd	3rd	4th	last	3rd	last	2nd	4th	4th	2nd	2nd	tied for 1st
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Indiana's preventable medical errors fall

State's report shows incidence of bed sores dropped by third in '09

By Daniel Lee

Posted: August 31, 2010

Indiana's hospitals and ambulatory surgery centers reported a decrease in preventable medical errors last year -- including a 33 percent drop in the number of bed sores.

Overall, 306 facilities reported 94 preventable medical errors in 2009, according to a report released Monday by the Indiana State Department of Health. That's down from 105 errors reported each year in 2008 and 2007.

The 22 pressure ulcers, also called bed sores, reported for 2009 were the fewest since the state's medical-error reporting system began four years ago. Indiana health facilities reported 33 bed sores in 2008.

The decrease in bed sores likely is linked to the Department of Health's Indiana Pressure Ulcer Initiative, according to the report.

The initiative, which began in June 2008 and runs through September, focuses on improving hospitals' systems for assessing risk factors for patients

developing bed sores. Efforts have included in-person and online prevention training for hospital personnel.

More than 230 health-care facilities and agencies have participated in the initiative, the Department of Health said.

The department's Indiana Medical Error Reporting System is based on 28 serious reportable errors as defined by the National Quality Forum, a Washington, D. C.-based nonprofit group focused on improving the quality of health care. Reportable errors include medication mix-ups, surgery on the wrong body part, and death or serious injury from a fall.

Last year, the most common error, with 29 instances, was the retention of a foreign object such as a sponge in a patient after surgery. In 17 instances, health facilities performed surgery on the wrong body part.

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Clarian Health -- with Methodist Hospital, Riley Hospital for Children and Indiana University Hospital -- had the biggest tally of errors last year with 18. Clarian, with 56,022 inpatient discharges and 168,689 outpatient visits, also was by far the busiest hospital system.

Dr. Gene Beyt, Clarian's senior vice president of Medical Quality and Patient Safety, noted that Clarian's trauma centers, cancer center and transplant programs take care of some of the state's sickest and most complex patients.

But, he added: "Zero (errors) is what we want."

Some large local hospitals reported zero or one preventable error in 2009. Wishard Memorial Hospital reported a single error, a surgery performed on the wrong body part.

St. Francis Hospital in Beech Grove reported one error, a foreign object left in a patient after surgery. St. Francis' Indianapolis hospital, on the Southeastside, did not record any errors last year.

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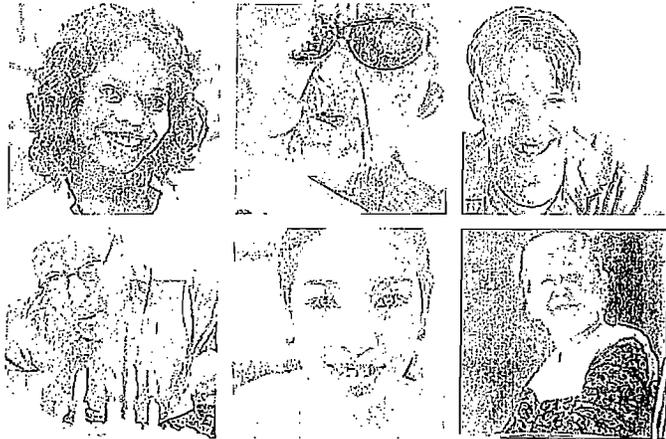
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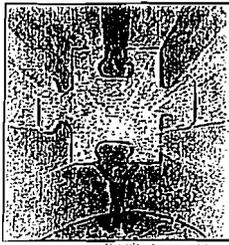
Rewarding Quality Nursing Home Care



STATE QUALITY PROGRAMS
AND PURCHASING MODELS
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November 2009



OVERVIEW

The pace of state development of new Medicaid quality-and-value strategies with respect to nursing home services, including but not limited to value-based purchasing, continues to accelerate. This trend reflects a widening recognition that regulatory and enforcement strategies, while necessary, are not fully effective as the primary mechanism to ensure quality and optimize value for consumers or taxpayers. At the same time, national collaboratives like *Advancing Excellence in America's Nursing Homes* (www.nhqualitycampaign.org) are enabling payers, consumers and providers to forge a consensus on critical interdependent and multidimensional drivers of quality and performance. In turn, information technology is now available to support data collection and analyses of key metrics so they can be practically applied to policy and practice decisions. Because of their unique leverage, state Medicaid programs have ready opportunities to tap into and help drive progress in this socially important arena as the population ages.

Though only one additional state (Colorado) was added to the list of Medicaid programs with active value-based purchasing features during 2009, several other states have set in motion initiatives designed to broaden nursing home performance measurement beyond traditional regulatory strategies and motivate improvement through evidence-based approaches and greater public transparency.

In addition, early state adopters of nursing home performance-based purchasing policies — including Iowa, Kansas, Georgia and Oklahoma — have continued to refine and focus their efforts based on data accumulated and lessons learned from early years of experience with these strategies. These states are providing valuable insights to other states for their own development of this policy area.

Background

State Medicaid programs remain the majority purchasers of nursing home care in the United States, bearing responsibility for two-thirds of the nation's 1.5 million nursing home residents and approximately half of all nursing home expenditures. Though long-term nursing home utilization rates have flattened or declined in the wake of expanded home- and community-based services, and Medicare spending on short-stay nursing home residents has been growing, the Medicaid institutional population continues to be a significant component of overall Medicaid expenditures. Importantly, expansion of nursing home use, in absolute terms, will likely begin to reappear in the near future under demographic forecasts for rapid growth in the number of "old" elderly who are most in need of long-term care. In addition, the nursing-home resident population will consist of those whose functional dependencies and associated healthcare needs are more severe and complex. Thus, even if Medicaid programs purchase relatively fewer days of service than in prior periods, the cost for each day of care will continue to rise. These facts underscore the need to focus more intently on both quality and value, whereas previous purchasing policies responded to quantity and intensity of services.

These realities help to explain why states have begun to experiment with "market-based" reforms, which include offering more actionable information to

consumers to induce greater overall system competitiveness, together with steps to directly align Medicaid payment incentives with measurable quality outcomes and demonstrated improvement. Currently, eight states have some form of pay-for-performance (P4P) arrangement in place for nursing homes, with five other states in process of implementation. When implemented in all 13 states, these programs will impact the care provided by nearly 30 percent of the nation's nursing homes and a quarter of nursing home residents.

When implemented in all 13 states, these programs will impact nearly 30% of the nursing homes and 1/4 of the residents nationwide.

Consumers and providers, as well as legislators, find the idea of matching incentives to performance attractive in principle, and have been provisionally supportive of initiatives designed to bring about such an alignment. As applied to nursing home care in particular, an evidence-based reorientation to quality and value, while not simple, poses fewer complexities and variables as compared with value-based purchasing programs in acute and primary care or in managed care contexts. Early state initiatives of this kind have been launched and sustained with investments that are quite small in relation to the dollar volume of their overall Medicaid nursing home purchases, and are beginning to exhibit positive results. Despite current budget woes, other states (Indiana, Maryland, Massachusetts, Texas, Virginia) have embarked on the development of policy frameworks and information systems necessary for value-based purchasing.

This third in a series of reports from My InnerView summarizes these trends and offers fresh practical guidance drawn from evolving state practices and My InnerView's unique field experience and data resources. Our organization currently provides data management and analytic support for nursing home performance-measurement initiatives across the nation, and collects performance data on nearly half of U.S. licensed nursing facilities. The company works with state governments, quality-improvement organizations (QIOs) and other entities to provide independent research and operational support to promote quality-improvement initiatives.

Earlier papers (*Value-Based Purchasing in Nursing Homes: Insights from Early Adopters*, November 2007, and *Value-Based Purchasing For Senior Care Services: Optimizing Value for Medicaid Systems*, November 2008) provide insights gleaned from the experience of early adopter states and highlight basic principles to guide the future development of effective value-based purchasing strategies in nursing homes.

SUMMARY of current state programs

The following is a summary of activity for states with a current pay-for-performance program:

COLORADO



The Colorado Department of Health Care Policy and Financing (CDHCPF) began a nursing home P4P program on July 1, 2009, authorized in state legislation passed in 2008.

The program is voluntary on the part of nursing homes. In order to apply for consideration, facilities must satisfy two prerequisites:

- (1) completion of a qualifying resident/family satisfaction survey by an external entity; and
- (2) absence of substandard deficiencies on the most recent health department certification

Eligible facilities have an opportunity to apply for program awards via an application supported by detailed documentation that they have put in place Quality of Life and Quality of Care programs. The latter two "domains" are defined in the CDHCPF application document by means of ten separate subcategories containing 35 individual program or performance elements.

Program monetary awards are based on a possible 100 points earned by meeting or exceeding program elements. At least 21 points are required for the minimum award of \$1 per resident day, with a score of 80 or more points needed for the maximum payment of \$4 per resident day. Available points are divided roughly equally between the Quality of Life and Quality of Care domains and their subcategories.

The Colorado program is distinguishable for its broad emphasis within the Quality of Life domain on institutional "culture change" focused on person-directed care and home-like environments, and

consistent staff assignments to residents. Given this emphasis, the program may prove somewhat less attractive to nursing homes that are focused on short-stay patients and have very high admission and discharge rates. As of this writing, approximately a third of Colorado nursing homes had applied for P4P awards through the program.

The Quality of Care domain is comprised of more commonly-employed metrics such as nationally-reported clinical measures, staff retention rates and employee satisfaction.

GEORGIA



The *Georgia Quality Initiative* is a collaborative quality measurement and improvement program for Georgia nursing homes. The Initiative was created in 2003 and has been sustained through the

cooperative efforts of the following agencies and organizations:

Georgia Department of Community Health
Alzheimer's Association, Georgia Chapter
American Association of Retired Persons, Georgia
Office of Long Term Care Ombudsman
Georgia Medical Care Foundation
Georgia Health Care Association

The Initiative has served as a unique example of stakeholder collaboration behind an evidence-based approach to continuous quality improvement in the state's nursing homes. More than 95 percent of the state's nursing homes participate in the program. Analyses covering the 2004–2008 period identified measurable improvement in customer satisfaction, clinical outcomes and staff retention.

At the program's inception, My InnerView began collecting data on resident, family and employee satisfaction; workforce performance; and clinical outcomes. My InnerView has provided participating facilities with feedback reports and quality-improvement training.

In 2007, the Georgia Quality Initiative became the Quality Incentive Program. This value-based purchasing program blends My InnerView satisfaction survey and workforce data with a subset of Centers for Medicare and Medicaid Services (CMS) clinical outcomes results as the basis for additional reimbursement. A point system uses these data to determine reimbursement eligibility. Facilities must receive three total points to be awarded an incentive payment, and one of these points must be awarded from the CMS data. Reimbursement eligibility is determined quarterly to encourage facilities to maintain a focus on improvement and superior outcomes.

IOWA



The *Iowa Accountability Measures Incentive Program* is the longest-running of the current state P4P programs involving nursing home care, but is now in the process of a significant makeover. It will be renamed

the *Iowa Nursing Home Pay for Performance Program* effective July 1, 2010. The program continues to be mandatory for all nursing homes. Since 2002, the program offered monetary incentives based on a schedule of ten measures, consisting of a collection of regulatory results, nursing hours, resident satisfaction, staff retention, special licensure, Medicaid utilization and administrative efficiency. (Specific clinical quality indicators are absent from this program, but are among those slated to be added.)

Incentive payments have been available in increments of \$1, \$2, or \$3 per resident day, tied to a point allocation for measures met or exceeded.

An early independent analysis of the program showed improvements on accountability measures for deficiency-free surveys, nursing hours, resident

satisfaction score and employee retention rate from state fiscal year 2003 to 2004.

The *Accountability Measures Incentive Program* was the target of media and legislative criticism in 2008 tied to the program's payment to incentive awards to certain facilities with negative regulatory survey outcomes. Legislative amendments and agency actions imposed interim restrictions in late 2008, and set the stage for a more thorough revamp of the program next year. Among the suggested changes likely to be adopted are:

- ☐ Redesignate the program as *Nursing Home Pay for Performance*
- ☐ Specify prerequisites facilities must meet to quality for incentive payments
- ☐ Increase both performance thresholds and payment amounts
- ☐ Set fixed performance targets to replace comparative performance levels
- ☐ Restructure metrics around four domains — quality of care, quality of life, efficiency and access
- ☐ Disseminate best practices

KANSAS



The *Kansas Nursing Facility Quality and Efficiency Outcome Incentive Factor* was added to the state's Medicaid nursing facility payment methodology in 2005, and was modified on July 1, 2009. Among state

programs of this kind, Kansas employs the fewest number of performance criteria — staffing, turnover/retention, Medicaid occupancy and completion of a culture-change survey. A work group advising the Kansas Health Policy Authority recently recommended the addition of resident, family and employee satisfaction surveys to the incentive factors.

Currently, facilities have the opportunity to earn a maximum annual payment add-on of \$2.60. Most of the available incentives are tied to case-mix-adjusted staffing levels and staff turnover thresholds.

MINNESOTA



The *Minnesota Quality Add-on* was first introduced in 2003 and continues to be a work in progress as the original recommended design has not been fully implemented. Currently, the add-on payments are calculated with reference to seven measures — staff retention, staff turnover, use rate of temporary staff, a wide spectrum of MDS-based clinical quality indicators, resident quality of life, consumer satisfaction and deficiency-free surveys relative to certain care-related regulatory items.

A quality score grounded in the clinical indicators is the most prominent feature of the program. Allocation of add-on payments is pursuant to a 100-point system, with the heaviest allocation (40 points) made to the clinical quality score. In 2007, additional payments of up to 2.4 percent of the daily operating rate were possible, but median awards were much smaller. However, Minnesota has implemented a separate program that allows facilities to earn medical assistance payments of up to 5 percent of the operating payment rate. Facilities can submit proposals to implement programs that seek to improve quality and efficiency, and contribute to the rebalancing of the state's long-term care system.

OHIO



The Ohio Department of Jobs and Family Services administers that state's *Quality Incentive Payment* program. Implemented pursuant to legislation in state fiscal year 2007, the program provides additional payments to Medicaid-participating nursing facilities that meet specific performance on these factors:

- ❑ Deficiency-free on the most recent standard survey results
- ❑ Resident satisfaction survey results above the statewide average

- ❑ Family satisfaction survey results above the statewide average
- ❑ Number of nursing hours per resident day above the statewide average
- ❑ Employee retention rate above the average for the facility's peer group
- ❑ Occupancy rate above the statewide average
- ❑ Medicaid utilization rate above the statewide average
- ❑ Annual case-mix score above the statewide average

Though designed to offer additional payments for performance, industry sources indicate that the ability of facilities meeting the criteria to access additional payments is dependent on factors lying within the basic payment methodology. This methodology has been in the process for several years of transitioning from a cost-based to a price-based model. The number of facilities qualifying for add-on payments which actually receive those payments is unclear.

OKLAHOMA



Focus on Excellence is the name given to Oklahoma's three-pronged program to drive nursing home improvement. The program employs multiple performance measures to support P4P, a consumer

Web site and star rating system, and continuous feedback of performance data to nursing facilities for their use in tracking and improving quality. It is the only state program designed to support each of these reinforcing components by use of a single, consolidated base of evidence.

Though voluntary, *Focus on Excellence* has attained participation of more than 90 percent of the state's nursing homes. Early provisional data for the program indicate measurable improvement on most included performance factors. Like Georgia's program, *Focus on Excellence* emphasizes a broad and balanced set of metrics, and assesses performance frequently. Incentive payments are calculated and revised on a

quarterly basis, as are nursing home ratings on the consumer Web site.

The state is in the process of making a number of refinements to Focus on Excellence based on lessons learned in the first two years. An independent analysis of the program by the Pacific Health Policy Group was recently completed and is viewable at <http://www.ohca.state.ok.us/about.aspx?id=10323&parts=7447> along with other reports by the program data-management vendor, My InnerView.

UTAH



For the past five years, Utah has maintained a quality-improvement program through Medicaid under which facilities could receive payments for voluntary improvement efforts that meet a set of prerequisites. The program is not always listed by analysts as a true pay-for-performance undertaking, inasmuch as it has not yet included specific performance requirements. However, the state agency anticipates adding a feature which would require facilities to demonstrate above-average performance on selected measures through their quality-improvement programs in order to qualify for financial awards in future years.

Programs in development

Beyond the programs described, at least five additional states are known to be in active processes to establish new quality-measurement or P4P programs for nursing homes.

- Maryland and Texas are proceeding based on legislation enacted or revised during their 2009 legislative sessions.
- Indiana has recently proposed new rules as the first action in a multi-step development leading to a well-rounded P4P regime by 2011.
- The Virginia Department of Medical Assistance Services issued comprehensive recommendations in 2007 for creation of a public nursing home Web site, followed by implementation of a performance-based Medicaid payment feature. Action on the plan has been delayed due to budget considerations.
- Massachusetts has initiated a pay-for-reporting process as a means of acquiring information on several measures antecedent to a possible P4P arrangement in future years.

CRITICAL CONSIDERATIONS

As leaders evaluate the approach of paying for performance in Medicaid nursing home programs, there are a number of critical considerations that must be carefully assessed prior to and during implementation:

CHOOSING THE RIGHT PERFORMANCE MEASURES

Superior performance is the result of getting the predicates of superior performance right. States recognize that nursing home performance is multi-dimensional. Consequently, they are assembling a core of measures which encompass clinical and non-clinical outcomes, and similarities are emerging across states on specific measures used (see Table 1, page 9). This trend results from both stakeholder consensus and the improvement of empirical knowledge of what elements of performance are meaningful and possess explanatory and predictive value in the nursing home context.

Gain experience — The most logical and first step is to acquire the necessary low-cost data infrastructure and devote an initial period to data collection of provisional metrics in order to gain experience with the system. This step will lay a solid foundation on which to erect a value-based purchasing policy, as well as more effective public reporting to consumers.

Inputs versus outputs — Certain input and process measures (e.g., workforce stability and engagement) are very strongly correlated to outcomes and merit inclusion in programs designed to be quality-sensitive. Workforce characteristics — due to their strong correlation to performance on quality indicators and consumer satisfaction — are virtually synonymous with those outcomes and merit inclusion with significant weight within P4P and public reporting programs. Others (e.g., raw measures of staffing levels) are popular with some stakeholders but are ambiguous as predictors of consistent good outcomes.

Regulatory and certification surveys — Though a number of states have incorporated elements of a facility's regulatory history as measures for incentive payments, the recent trend is to use those results as prerequisites for initial and continued participation by nursing homes in P4P programs.

Sensitivity to change — Metrics must be sensitive to change so that they capture subtle, but real, improvements or declines in performance occurring over the short term. The more sensitive to change, the more likely providers are to adopt "best practices" to improve performance.

PRIORITIZING THE MEASURES

Because not all of the performance measures are equally important, they should be appropriately weighted for use by the Medicaid program, the public and the providers. Either at the outset of P4P, or after a year or two of experience, states will typically incorporate some type of differential weighting of the program performance measures.

Differential weighting — An approach that assigns different numerical weights to each metric or domain of metrics to balance the value of each can be useful and justified if: (a) the weighting scheme accurately represents the balance of values within the metrics, (b) if the application of the weights does not distort the distribution of results unnecessarily, and (c) if the weights do not unfairly or systematically create winners and losers among groups being evaluated.

Stakeholder consensus — Adequate input should be gained from key stakeholders to ensure that metrics are meaningful.

Statistical correlation — There should be evidence of predictive strength of each metric in relationship to overall performance.

ENCOURAGING DATA-DRIVEN BEHAVIOR

The data used in this endeavor — both the data gathered from the providers as well as the derivative reimbursement information — are powerful motivators of facility behavior. In order to maximize this potential, the data should be gathered frequently and in a timely fashion, be reported in a way that is easily related and understood by all stakeholders, and be completely transparent.

Frequency and timeliness of reporting — The more tightly coupled incentive payments are to real-time performance, the more success providers can achieve in changing operational processes to improve performance. Performance improvement efforts are far more likely to succeed when performance data are available in real-time than when these data are reported retrospectively after many months have elapsed, and that currently demonstrated improvement will result in higher reimbursement within a few months and vice versa.

Data transparency — The data should be supplied back to the nursing homes utilizing a reporting vehicle that is easily understood and readily available. The results should also be made available in summary form to consumers to allow them to find facilities in their geographic area that are high quality and performing in areas that are important to the consumer. Such public visibility would also hold facilities accountable in a very open fashion — another powerful driver of behavior.

SETTING STANDARDS FOR PERFORMANCE AND IMPROVEMENT

Programs should incorporate fixed standards and designs to reward significant improvement as well as comparative performance as early as practical in the life of the program. Both are priorities that will benefit all parties under P4P programs and represent important second-step refinements to be undertaken with early performance data as the primary reference point. Those data will enable states to set static standards; periodically review and adjust them going forward; and define degrees of improvement suitable for year-to-year financial rewards.

Comparative performance — Comparative targets based purely on relative performance such as median or percentile rankings might be a good way to start a program until there is enough data available to be evaluated.

Fixed performance targets — The accumulation of new data makes it easier to develop fixed performance targets. Since fixed targets are known in advance, providers can further focus their quality-improvement efforts on what matters most. Fixed targets are also easier for consumers to interpret and understand. Program managers can also review fixed targets annually to determine from actual data how key performance thresholds should be adjusted over time. This strategy creates greater flexibility for program managers to better direct future program priorities.

ENSURING DATA INTEGRITY

To address data integrity and validity in self-reported programs, stakeholders should consider:

Medicaid provider agreement — The nursing facility Medicaid provider agreement is amended if necessary to bring any self-reported data that will implicate provider payments under the purview of federal and state Medicaid penalties for willful false reporting.

Audit programs — Provider record retention requirements and audit programs are extended to documentation pertinent to P4P participation.

Data quality — Processes must be in place to ensure, to the highest degree possible, that data used for determining incentive payments are accurate, valid, complete and timely. This may involve steps such as outlier analysis and anomaly detection, or working with original source data providers to improve the quality of their data-creation processes.

STATE MEDICAID NURSING FACILITY P4P CRITERIA BY INCIDENCE OF USE

Year of Inception	ESTABLISHED							PROPOSED		
	GA (2007)	KS (2006)	IA (2002)	MN (2006)	OH (2006)	OK (2007)	CO (2008)	VA	MD	TX
Staff stability/retention (10)	o	o	o	o	o	o	o	o	o	o
Customer satisfaction (9)	o		o	o	o	o	o	o	o	o
Regulatory compliance (8)		o	o	o	o	o	o	o		o
Quality of clinical care (7)	o			o		o	o	o	o	o
Employee satisfaction (6)	o		o			o	o	o		o
Quality of life (6)			o	o		o	o	o		o
High Medicaid occupancy (5)		o	o		o	o	o			
Culture change/ person-directed care (5)		o	o			o	o			o
Nursing staffing levels (4)		o	o		o	o				
Staff training/development (3)			o				o		o	
Total occupancy (2)			o		o					
Low operating costs (1)			o							
Pool staff use (1)				o						
Complaint resolution rates (1)			o							
Medicare volume (1)						o				
Special licensure (1)			o							
Case mix score (1)					o					
Avoided re-hospitalization (1)										o
Staff vaccinations (1)									o	
Infection control (1)									o	

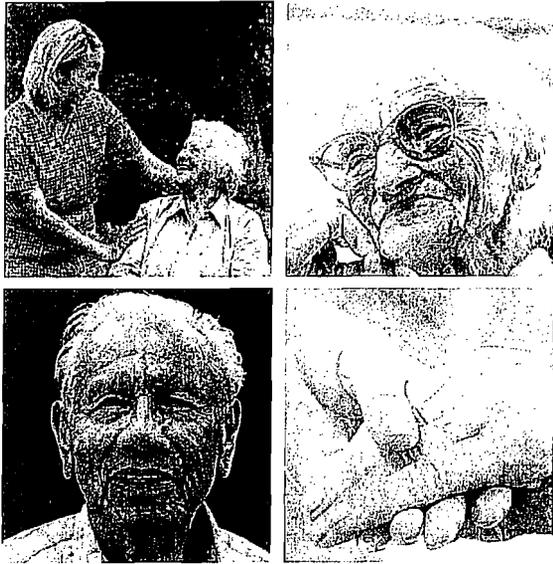
TABLE 1

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Contact us at www.myinnerview.com to receive an electronic version of this or previous reports. Other related information (including the 2008 National Survey of Consumer and Workforce Satisfaction in Nursing Homes) can be found in the Resource Center of our Web site.



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2009 National Survey of Consumer and Workforce Satisfaction in Nursing Homes

OVERVIEW
BACKGROUND AND FINDINGS
RESPONDENT COMMENTS
METHODOLOGY


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In this report:

Overview

- Satisfaction as a predictor for recommendation
- Why satisfaction matters
- Beyond quantitative data
- Key findings
- Conclusion

Part one: Background and findings

- Survey respondents 2005 to 2009
- Consumer and workforce demographics
- Consumer and workforce recommendation
- Factors that drive consumer recommendation
- Consumers identify strengths and opportunities
- Factors that drive workforce recommendation
- Workforce identify strengths and opportunities
- Interdependence of consumer and workforce satisfaction

Part two: Respondent comments

- Words that matter to residents
- Words that matter to families
- Words that matter to workforce

Part three: Methodology

- Workforce satisfaction
- Consumer satisfaction
- Predictive validity
- Weighting procedures

OVERVIEW

An applied research company, My InnerView has been measuring and reporting the level of consumer and workforce satisfaction in nursing homes since 2005. This multi-year series of national reports helps foster greater accountability in the use of public and private resources for long-term care services. It also offers greater transparency to help consumers make informed decisions when seeking nursing home care.

This is the fifth and most in-depth annual report published by My InnerView. It is the most comprehensive voluntary survey ever taken of nursing home consumers (residents and families) and staff in the United States. Encompassing one in three nursing homes, the 2009 report represents the largest national database of nursing homes and the opinions of 82,473 residents, 150,829 family members and 283,404 employees.

My InnerView's database provides robust longitudinal estimates and describes trends in consumer and workforce satisfaction in nursing homes across America. Our estimates are based on a methodology that My InnerView researchers developed to assign weights that adjust for facility characteristics on a state and national level.

LARGEST NATIONAL DATABASE

1 IN 3
NURSING HOMES
NATIONWIDE

CONSUMER:	Family members	150,829
	Residents	82,473
WORKFORCE:	Employees	283,404
	Total voices	516,706

Satisfaction as a predictor for recommendation

This year's report underscores the important fact that consumer and workforce satisfaction are positively correlated — meaning that facilities that do well on consumer satisfaction tend to do well on workforce satisfaction.

The report analyzes key consumer- and workplace-related factors that influence overall satisfaction, such as:

- 1. Consumer and workforce demographics
SEE FIGURES 2–3, PAGES 8–9
- 2. Resident and family concerns
SEE FIGURE 7, PAGE 12
- 3. Staff issues
SEE FIGURE 9, PAGE 14
- 4. Pay-for-performance systems
SEE FIGURE 6, PAGE 11

The data reveal a strong interdependence of resident and family satisfaction, and family and employee satisfaction. SEE FIGURES 11–12, PAGE 16

Why satisfaction matters

Demonstrating value to key stakeholders, such as consumers and payers, is paramount in discussions about how to set priorities in the allocation and expenditure of state and federal resources. Policy-makers, payers, regulators, consumers and providers need to reach a consensus as to how quality can be redefined to better align their interests as important stakeholders. This report suggests that input from nursing home residents, family members and employees is important in any comprehensive system of quality measurement and improvement.

Satisfaction measures are critical dimensions of quality where the interests of consumers, payers and providers are aligned. For the field of practice, this year's report contains very positive results. The level of satisfaction in the country's nursing homes shows incremental improvements every year since these data were first collected by My InnerView in 2005.

Consumers and payers are demanding more. Renewed efforts by the long-term care profession are warranted to demonstrate value to consumers and taxpayers, especially when it comes to the expenditure of state and federal taxpayer dollars.

Beyond quantitative data

For the first time, we have gone beyond reporting quantitative data, and have identified and rated key words in the comments (or answers) respondents provided to open-ended questions. These comments were analyzed based on a word count and content analysis. The qualitative data are especially useful because these data were coded to reflect a "positive versus a negative versus a mixed (both positive and negative)" meaning from the perspective of the respondent. Using content analysis, we were able to identify those factors that matter most to consumers and workers, and at the same time determine how

Measuring satisfaction is a critical dimension of quality where the interests of consumers, payers and providers are aligned.

positive or negative these factors are perceived to be. SEE FIGURES 13–15, PAGES 19–21

Key findings

The 2009 National Report is part of an expanding series of My InnerView reports that are helping to guide the development of more systematic approaches to quality improvement in America's nursing homes.

- Consumer and staff recommendation is above the national average in states with pay-for-performance programs.
- The care and services provided by the employee — and the employee/resident relationship — are the most consistent predictors of consumer recommendations.
- Competent and caring staff is a consistent predictor of resident and family recommendation.

Although resident and family perspectives are not identical, both families and residents are important stakeholders who are able to provide valid feedback about nursing home care. Input from both groups can help improve nursing home care overall.

We have seen an increase in satisfaction of consumers and employees from 2005–2008. This high level of satisfaction remains stable since 2008. The increases are consistent across sectors (such as nonprofit and privately owned facilities) and across many geographic areas (states, urban, suburban and rural).

Conclusion

To better align financial incentives, reimbursement systems (especially new value-based reimbursement systems) should take into account consumer and workforce satisfaction. A more balanced set of metrics should be incorporated into value-based reimbursement systems and consumer report

cards to place greater emphasis on consumer and workforce satisfaction to complement basic metrics related to state surveys and clinical outcomes.

In recent years, Medicaid agencies in more states have added workforce and/or consumer satisfaction metrics into their value-based payment systems to provide financial incentives to facilities that demonstrate progress in implementing practices that improve consumer and workforce satisfaction.

National collaborative partnerships such as the *Quality First* initiative, *CMS' Nursing Home Quality Initiative* and the *Advancing Excellence in America's Nursing Homes* campaign¹ promote a broader, more systematic definition of long-term care quality that views consumer and workforce satisfaction as critical indicators of organizational excellence. This report underscores the fact that providers of senior care services in the United States are responding to those initiatives, and are paying attention to the voices of consumers and the workforce. My InnerView data lend support to the view that incremental progress is being made, in part because greater attention is now being paid to these matters.

There is growing recognition that the definition of nursing home quality must continue to evolve to make it more congruent with the needs and preferences of many older Americans and their families who are seeking long-term care. This My InnerView series of national reports contributes to an expanding body of research demonstrating the value of benchmarking consumer and workforce satisfaction as a basic parameter of nursing home quality. Gradual progress is being made, but much work remains to be done to support the improvement of consumer and workforce satisfaction in America's nursing homes.

¹ *Quality First* is a commitment to performance excellence in quality of care and quality of life by the long-term care community. The *CMS Nursing Home Quality Initiative*, launched in 2002, provides information to consumers about the quality of care provided and offers important resources available to improve the quality of care in facilities. The *Advancing Excellence in America's Nursing Homes* campaign is a broadly-based initiative that includes government and other stakeholders. Provider participants select up to eight performance outcomes, including consumer satisfaction, as part of their quality-improvement program.

Part One
BACKGROUND
AND FINDINGS

Survey respondents 2005 to 2009
Consumer and workforce demographics
Consumer and workforce recommendation
Factors that drive consumer recommendation
Consumers identify strengths and opportunities
Factors that drive workforce recommendation
Workforce identify strengths and opportunities
Interdependence of consumer and workforce satisfaction

Background and findings

More nursing homes participated in My InnerView's consumer and workforce satisfaction survey in 2009 than in any previous year. SEE FIGURE 1, PAGE 7 The continued growth of our database suggests that the long-term care profession is gradually redefining organizational excellence using a balanced set of measures that supports the interdependent interest of diverse stakeholder groups such as residents, family members, workers and payers.

Consumer and workforce demographics

Consumer and workforce demographics play a key role when measuring recommendations. Only by understanding each group individually can facility owners begin to fully define where to invest their improvement efforts.

Consumer demographics

Consumer respondents total 233,302: 65% are families of residents and 35% are residents. Results are broken down by resident's age, length of stay, how often the resident is visited, and who the visitors are: grandchild, friend, sibling and other. SEE FIGURE 2, PAGE 8

Workforce demographics

Employee respondents total 283,404. Results are broken down by employees' age, job category, hours worked and length of employment. SEE FIGURE 3, PAGE 9

Key findings

High levels of satisfaction among nursing home consumers and employees is indicative of their

likelihood to recommend a facility to others. The probability of recommendation among these two key groups is measured by the combined percentage of "excellent" and "good" responses, and continues to be stable since 2005. SEE FIGURES 4–5, PAGES 10–11

- Recommendation among nurses, nursing assistants and overall workforce has steadily risen every year since 2007.

- Consumer recommendation was at 85% in 2008 and essentially unchanged in 2009.

- States with pay-for-performance systems have higher degrees of consumer and workforce satisfaction when compared to the national average. SEE FIGURE 6, PAGE 11

- Care and competency of staff are the two top factors that drive consumer recommendation. SEE FIGURE 7, PAGE 12

- Primary opportunities for improvement differ between residents and families. SEE FIGURE 8, PAGE 13

- The top four factors that drive workforce recommendation are the same for all workforce groups. SEE FIGURE 9, PAGE 14

- The care/concern of supervisors is seen as a primary strength by employees; job stress and management issues are the main areas for improvement. SEE FIGURE 10, PAGE 15

- There is a strong interdependence of resident and family satisfaction as well as family and employee satisfaction. SEE FIGURES 11–12, PAGE 16

Survey respondents 2005 to 2009

Surveys returned and percent of total

	2005	2006	2007	2008	2009
CONSUMER RESPONDENTS					
Family members	63,160 89%	77,491 84%	118,985 81%	146,949 73%	150,829 65%
Residents	7,806 11%	14,942 16%	27,397 19%	54,711 27%	82,473 35%
Total respondents	70,966	92,433	146,382	201,660	233,302
WORKFORCE RESPONDENTS					
Nurses		20,150 19%	30,309 19%	42,042 19%	54,094 19%
Nursing assistants		41,465 39%	63,157 39%	87,315 39%	114,490 40%
All other staff		45,243 42%	68,442 42%	94,092 42%	114,820 41%
Total respondents		106,858	161,908	223,449	283,404
Facilities	2,224	3,030	4,116	5,075	5,091

Figure 1 * "Facility count" is unduplicated total of facilities completing consumer and/or workforce satisfaction surveys

As more providers recognize the value of national benchmarks for consumer and workforce satisfaction, participation in My InnerView's voluntary satisfaction surveys continues to increase.

The total number of respondents has grown tremendously from 70,966 in 2005 to 516,706 in 2009.

2,867 more facilities participated in 2009 than in 2005.

There were 228% more consumer respondents in 2009 (233,302) than in 2005 (70,966).

There were 165% more workforce respondents in 2009 (283,404) than in 2006 (106,858).

More than one-third (35%) of consumers surveyed in 2009 are nursing home residents (as opposed to their family members).

From 2006 to 2009, My InnerView surveyed a total of 775,619 nursing home employees from all 50 states and the District of Columbia. These respondents include 306,427 nursing assistants, 146,595 nurses (RNs, LVNs and LPNs in non-administrative positions) and 322,597 other staff. During these years, the overall distribution of workers in various job classifications remained constant. Nurses account for 19%, nursing assistants for 39–40%, and other staff for 41–42% of the workers surveyed each year.

Consumer demographics

233,302 respondents: 65% families of residents; 35% residents

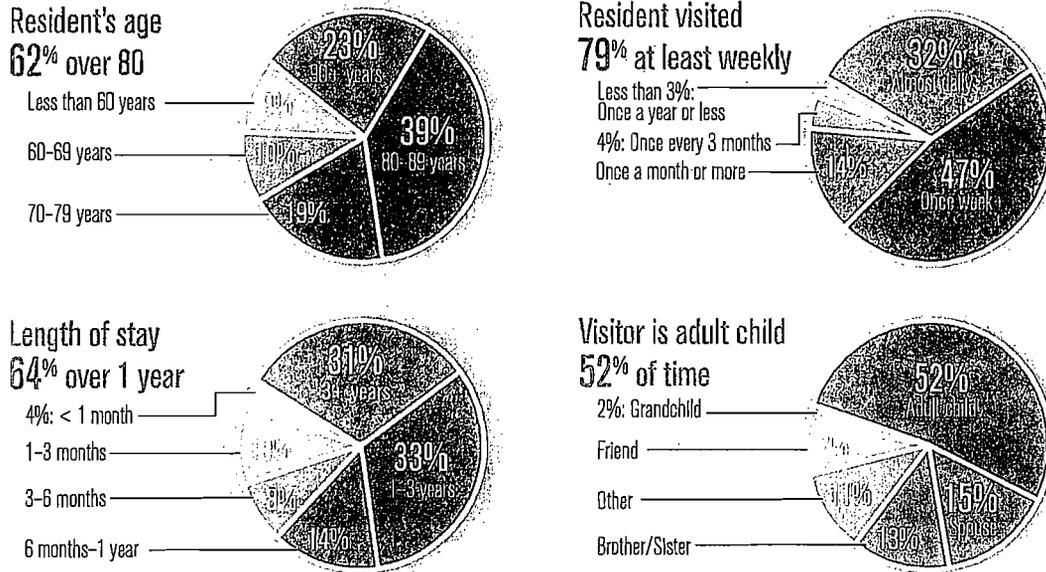


Figure 2 May not total 100% due to rounding

Resident and family demographics are stable across survey years. These characteristics remain essentially the same since 2005. Response rates are improving and the representation of residents has increased every year. Despite that, the other demographic characteristics of respondent groups are comparable across years, suggesting that the underlying demographic characteristics of respondents participating in these voluntary surveys over time is stable.

In 2009, My InnerView collected surveys from 5,091 nursing homes, 82,473 nursing home residents and 150,829 family members.

The number of resident respondents continues to rise. Residents represented 19% of consumer respondents in 2007, but 35% in 2009.

Nearly two-thirds (64%) of residents had been in the facility for more than one year at the time of the survey.

62% of residents responding are over 80 years of age.

The number of residents less than age 60 and 60-69 are nearly equal, 9% and 10% respectively.

The overwhelmingly majority of residents (79%) are visited in the nursing facility at least weekly. Family members represent 82% of visitors.

The most frequent visitor (52%) is the resident's adult child.

Workforce demographics

283,404 respondents: 40% nursing assistants; 19% nurses; 41% other

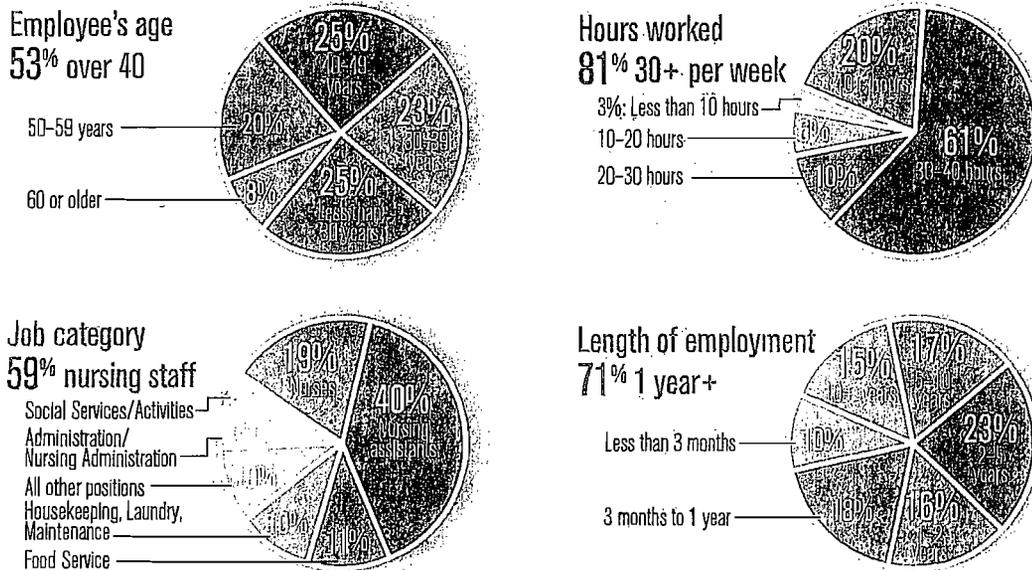


Figure 3 May not total 100% due to rounding

My InnerView collected 283,404 surveys from nursing home employees in 2009. Of those respondents, 54,094 are nurses and 114,490 are nursing assistants.

- The data continue to point out the importance of an aging workforce, with 53% of employees being over the age of 40.
- 23% of employees are age 30–39; 25% are less than 30 years.
- The data continue to indicate a fairly stable workforce: 71% of all employees report working in the

same facility for one year or more. However, recent data from My InnerView and other sources indicate that overall staff turnover has declined during the present economic downturn.

- There are twice as many nursing assistants (40%) than nurses (19%). The next largest groups are food service (11%), and housekeeping, laundry and maintenance (10%).
- 81% of employees work more than 30 hours a week.

Consumer: Recommendation to others

Combined percentage "excellent" and "good" recommendations of the nursing home to others



Figure 4

Consumer and workforce recommendation are becoming broadly recognized as important dimensions of nursing home quality. Although there is more work to be done, monitoring the state of consumer and workforce satisfaction in the nation's nursing homes is an important step towards improving nursing home care in general.

Overall, the number of consumers who would recommend a long-term care facility remains high at 85%, four percentage points higher than 2005. The number of residents who would recommend a nursing home increased by one percentage point over 2008. The likelihood of families to recommend a facility remains essentially unchanged, just one percentage point lower than in 2008. SEE FIGURE 4

Resident satisfaction was relatively stable between 2007 and 2009, but the overall trend has been an increase in satisfaction since 2005, indicating that more providers are implementing practices recommended by national quality-improvement initiatives and accepting satisfaction metrics as important dimensions of quality.

Impact of value-based purchasing on recommendation

Consumers and payers are demanding more comprehensive information about nursing home quality than ever before. As a consequence, states are exploring how to add more meaningful information to consumer Web sites, and payments systems for nursing homes are adopting components of value-based purchasing (also referred to as "pay for performance").

Reimbursement systems for nursing homes are likely to continue evolving toward value-based purchasing due to pressures for greater fiscal accountability and transparency in programs such as Medicare and Medicaid.

States with value-based purchasing programs have higher degrees of consumer and workforce satisfaction compared to the national average. SEE FIGURE 6, PAGE 11

Workforce: Recommendation to others

Combined percentage "excellent" and "good" recommendations of the nursing home as a place to work

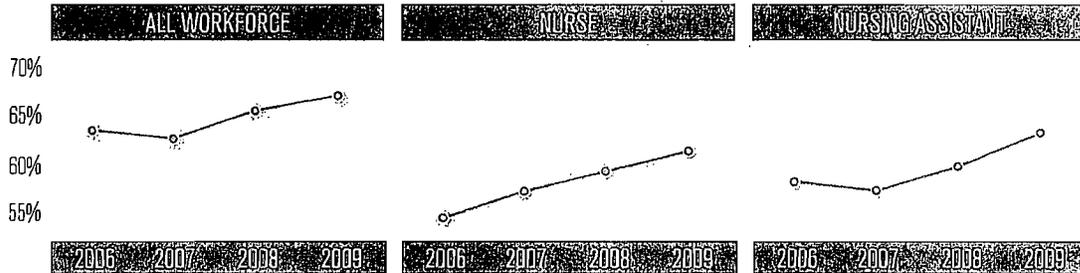


Figure 5

Workforce satisfaction increased in every job category between 2007 and 2009. Satisfaction among nurses and nursing assistants remains lower than the satisfaction of employees in other job categories; however, both types of workers have become more satisfied with their facilities since 2006, showing a sustained upward trend. SEE FIGURE 5

Workforce and consumer satisfaction are correlated positively. Facilities with higher workforce satisfaction also have higher family satisfaction. SEE FIGURE 12, PAGE 16 An effective strategy for quality improvement must include an intense and sustained focus on the skills, commitment and satisfaction of the workforce, particularly those staff who directly care for residents and communicate with family members.

In pay-for-performance states:

The seven states listed below—Colorado, Georgia, Iowa, Kansas, Minnesota, Ohio and Oklahoma—have had pay-for-performance programs for at least the past two years. Although these data don't tell us why these differences in consumer and workforce satisfaction exist between states with and without pay-for-performance systems, they lend support to the proposition that aligning financial incentives with better performance is an effective strategy for quality improvement in nursing homes.

	CONSUMER			WORKFORCE		
	2007	2008	2009	2007	2008	2009
CO, GA, IA, KS, MN, OH, OK	85%	86%	86%	62%	65%	68%
All other states (total)	82%	84%	84%	61%	63%	64%

Figure 6

Factors that drive consumer recommendation

Items ranked by correlation with recommendation to others

RESIDENT	FAMILY
Care (concern) of staff	Care (concern) of staff
Competency of staff	Competency of staff
Choices/preferences	Nursing care
Nursing care	Nursing assistant care
Management responsiveness	Respectfulness of staff
Respectfulness of staff	Choices/preferences
Safety of facility	Safety of facility
Nursing assistant care	Management responsiveness
Resident/family updates	Staffing adequacy
Resident-to-staff friendships	Grooming
Quality of dining experience	Cleanliness of premises
Grooming	Resident-to-staff friendships
Cleanliness of premises	Resident/family updates
Security of personal belongings	Respect for privacy
Quality of meals	Security of personal belongings
Staffing adequacy	Quality of dining experience
Respect for privacy	Meaningfulness of activities
Meaningfulness of activities	Resident-to-resident friendships

Figure 7

Five of the top ten family and resident survey items most correlated to recommending the facility are related to staffing issues. How residents perceive the concern and competency of staff are the two highest predictors of both resident and staff recommendation. SEE FIGURE 7

The third highest predictor among residents is the availability of choices or preferences to the resident within the facility. Of the top five drivers of resident recommendation, three are in the quality of care domain: care (concern) of staff, competency of staff and nursing (RN/LVN/LPN) care.

Family members also perceive care or concern of the staff as the top predictor of how they would recommend the facility to others. Three of the top five predictors of whether a family member would recommend the facility relate to quality care.

Most of the top ten predictors of resident and family recommendations of the facility are the same for both groups.

The most powerful drivers of whether a resident or family member would recommend a nursing facility are workforce issues: care or concern shown by staff, competency of staff, attention to the resident's choices or preferences, and nurse and nursing assistant care.

Differences exist in terms of how residents and family members experience care, as well as in the factors that are most strongly correlated with the recommendation of a facility to others. In planning quality-improvement initiatives, providers need to look carefully at their results to better understand how the responses of families and residents are interrelated. SEE FIGURE 8, PAGE 13

Consumers identify strengths and opportunities

Items ranked by both correlation and performance

RESIDENT	FAMILY
STRENGTHS	STRENGTHS
Competency of staff	Nursing assistant care
Care (concern) of staff	Competency of staff
Resident/family updates	Care (concern) of staff
Resident-to-staff friendships	Nursing care
Nursing care	Safety of facility
Respectfulness of staff	Respectfulness of staff
Safety of facility	
OPPORTUNITIES	OPPORTUNITIES
Choices/preferences	Staffing adequacy
Management responsiveness	Grooming
Quality of dining experience	Management responsiveness
Nursing assistant care	Choices/preferences
	Cleanliness of premises

Figure 8

Survey items that are important drivers of recommendation, yet have a low score, are potential areas that providers should prioritize for improvement. We call these “primary opportunities.” SEE FIGURE 8 For residents and families, two factors that represent primary opportunities for improvement are: meeting resident choices and preferences, and responsiveness of management. For residents, nursing assistant care and dining — the most personal issues they face — are primary opportunities for improvement. Families see staffing levels, cleanliness of premises and grooming as primary opportunities, gravitating their attention to those things visible to them during their visits.

Survey items that are important drivers of satisfaction but are also high scoring are called “primary

strengths.” For families, nursing assistant care is seen as a primary strength. Although we find similarities in the overall rank order of items that predict global satisfaction among residents and families, there are differences in how residents and families rate certain items. Nursing assistant care is rated as a strength by families, but as an opportunity by residents.

Three of the top four predictors of whether a family member would recommend the facility to others relate to care: nursing assistant care, care (concern) of staff and nursing care. Both residents and family name respectfulness of staff as a facility’s strength.

Factors that drive workforce recommendation

Items ranked by correlation with recommendation as a place to work

NURSE	NURSING ASSISTANT	ALL OTHERS
Management cares	Management cares	Management cares
Management listens	Management listens	Management listens
Help with job stress and burnout	Help with job stress and burnout	Help with job stress and burnout
Workplace safety	Workplace safety	Workplace safety
Supervisor cares	Adequate equipment/supplies	Adequate equipment/supplies
Supervisor appreciates	Training to deal with difficult residents	Supervisor cares
Training to deal with difficult residents		Respectfulness of staff
Supervisor informs	Supervisor cares	Supervisor appreciates
Supervisor informs	Supervisor informs	Supervisor informs
Training to deal with difficult family members	Supervisor appreciates	Staff communication between shifts
Adequate equipment/supplies	Training to deal with difficult family members	

Figure 9

Nurses and nursing assistants comprise the majority of the workforce in nursing homes. Nursing staff are responsible for providing most of the hands-on care to residents. They interact daily with residents and family members. Nurse and nursing assistant recommendations of a facility as a place to work are critical indicators of the quality of the work environment.

Each item on the workforce satisfaction survey was ranked in order of the strength of its correlation with the respondent's recommendation of the facility as a place to work. SEE FIGURE 9

Nurses and nursing assistants are very consistent in their ratings of management attention, stress management and safety as items that are predictive of recommending the facility as a place to work.

Items with stronger correlations are given higher ranks because they are more predictive of global job satisfaction. Higher ranked items have stronger effects on worker recommendations, while lower ranked items have weaker effects. The top ten predictors of nurse and nursing assistant recommendations are quite similar.

Four of the top ten drivers of recommendation for all three sectors of the workforce represent items related to effective supervision and management. Care (concern) of management and management who listens are the top two predictors of favorable recommendations of the facility as a place to work for both nurses and nursing assistants. Help dealing with job stress is the third strongest predictor of recommendations for nursing staff. These top three items have ranked consistently as the strongest predictors of positive recommendations of the facility since 2006.

Workforce identify strengths and opportunities

Items ranked by both correlation and performance

NURSE	NURSING ASSISTANT	ALL OTHERS
STRENGTHS	STRENGTHS	STRENGTHS
Supervisor cares	Supervisor cares	Supervisor appreciates
Workplace safety	Supervisor informs	Workplace safety
Supervisor informs	Workplace safety	Respectfulness of staff
		Supervisor cares
		Supervisor informs
OPPORTUNITIES	OPPORTUNITIES	OPPORTUNITIES
Help with job stress and burnout	Help with job stress and burnout	Help with job stress and burnout
Management listens	Management listens	Management listens
Management cares	Management cares	Management cares
Training to deal with difficult residents	Adequacy of equipment/supplies	Adequacy of equipment/supplies
Training to deal with difficult residents	Training to deal with difficult residents	
Supervisor appreciates	Supervisor appreciates	

Figure 10

This year's survey expands on workforce ratings to encompass the opinions of all employees, including nurses, nursing assistants, administration/nursing administration, food service, social services/activities and other support staff. This provides additional data owners can use to ascertain the quality of their facility.

Survey items that are important drivers of global satisfaction based on the respondent's recommendation of the facility as a place to work, but are low scoring, represent potential areas that providers should target for improvement, referred to as "opportunities."

Help with job stress is the top priority item for all sectors of the workforce, followed by management listens, and management cares. SEE FIGURE 10

Survey items that are important drivers of satisfaction but are also high scoring are called "strengths." For employees, the care/concern of the supervisor, workplace safety, and supervisor informs are seen as strengths. Both strengths and opportunities are quite consistent between nurses and nursing assistants.

Interdependence of resident and family satisfaction

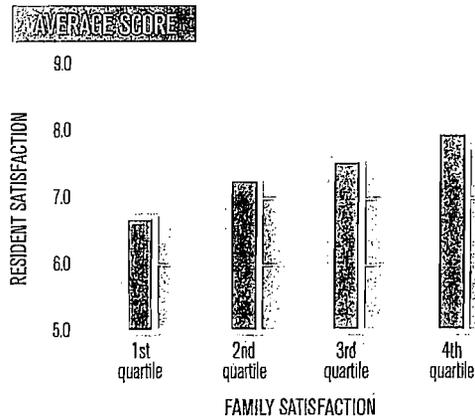


Figure 11

On average, facilities that score higher on family satisfaction also score higher on resident satisfaction. This phenomenon is shown graphically by dividing facilities into quartiles based on their family satisfaction scores. Both family and resident satisfaction scores are highest in the fourth quartile and lowest in the first quartile. SEE FIGURE 11

Facilities that score higher on employee satisfaction also score higher on family satisfaction. The interdependence of workforce and consumer satisfaction is shown graphically by dividing facilities into quartiles based on their employee satisfaction scores. Both employee and consumer satisfaction scores are highest in the fourth quartile and lowest in the first quartile. SEE FIGURE 12

Interdependence of family and employee satisfaction



Figure 12

The quartiles clearly demonstrate that as families are more satisfied, residents are more satisfied. Conversely, as employees are more satisfied, families are more satisfied. It is not often that satisfied employees result in dissatisfied families or vice versa.

When selecting a nursing home, families place tremendous value on assessing quality based on the recommendation of other consumers.²

The same factors that predict a resident's recommendation to others also predict a family's recommendation to others.

² Shiverick, Bradley N.; Moon, Rajean P.; and Mabry, Samantha (2009). "What Consumers Want to Know When Selecting a Nursing Home; 2008 Study on Consumer Choice." My InnerView.

Part Two
RESPONDENT
COMMENTS

Words that matter to residents
Words that matter to families
Words that matter to workforce

Respondent comments

It is important to understand the meaning of words when used by residents, families and employees. Because they are subjective, the same word can have entirely different meanings for each group or an individual depending on the context. For the first time in a national survey of nursing homes, My InnerView developed a way to measure the significance of respondents' replies as it applies to their likelihood to recommend a nursing home.

To capture the data, respondents were asked three key questions about the facility:

- 1. What do we do best?
- 2. What can we do to improve?
- 3. Any other comments or suggestions?

Responses were analyzed based on a word count and a content analysis. The qualitative data presented below are especially useful because they were coded to reflect a "positive versus a negative versus a mixed (both positive and negative)" reply from the perspective of the respondent. Because these open-ended questions elicited such a broad array of responses, key words or themes were identified based on a word count. Major themes were also identified based on their predictive value by evaluating how they related to each other. Words that occurred with a high frequency in the word count and those that had at least a moderate predictive value were retained. Each occurrence of these words was coded and rated to signify a positive, negative or mixed reply based on the meaning of the word within a given context.

Resident comments

Themes identified among residents are generally positive or mixed. Positive themes (or words) that are most predictive of resident recommendations of the facility to others include aspects of staff treatment, clinical care and caring. Themes with a mixed reply include staff showing concern for the resident and staff listening to the resident. Factors that predict resident satisfaction such as nursing care, care and

concern among staff or listening to the resident also were factors.

Family comments

Positive themes that are the most predictive of family recommendations of the facility to others include staff treatment of the resident, staff caring for the family member, and staff showing respect for the resident.

Mixed themes include cleanliness, nursing issues related to clinical staff (RNs, LVNs or LPNs), and employee concerns for family members.

Negative themes among family members include lack of communication with administrator or other staff, and odor perceived by the family member. Predictive factors include care and concern of staff (especially for family members), quality of clinical care, good communication (keeping the family informed about the resident) and cleanliness of the facility.

Workforce comments

Positive themes that predict worker recommendation of the facility to others include patient care, clinical care provided to the resident, and caring or friendly staff.

Mixed themes among workers include administrator issues, and staff showing appropriate consideration or concern for residents and for fellow staff.

Negative themes among workers include not listening or paying attention to staff issues, poor resident treatment or negative staff behaviors, and lack of respect or negative attitudes among staff. It is interesting that several factors identified as being important, such as workplace safety and helping staff cope with job stress/burnout, did not consistently emerge in all data. On the other hand, factors such as listening to employee concerns and caring among managerial or supervisory staff were predictive of the recommendation of the facility to others as seen in all data.

Words that matter to residents

Recurring themes predict recommendation

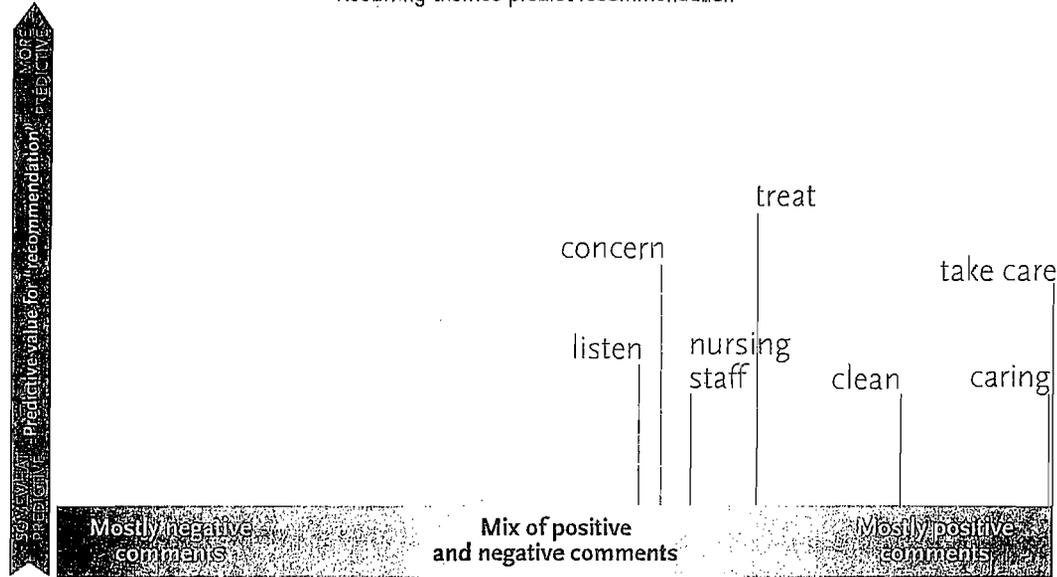


Figure 13

To determine which words matter to residents, family and staff, we looked at the strength of the overall correlation between the meaning of the word and overall recommendation of the facility to others. Note that all of these words have predictive value in the sense that they are at least moderately correlated with the recommendation of the facility.

For residents: SEE FIGURE 13

- ☐ The word “treat” is very predictive of the willingness to recommend, and is usually associated within positive comments.
- ☐ The words “listen” and “concern” are somewhat predictive, but are generally associated with positive comments.
- ☐ The meaning behind these words are mostly associated with positive comments.

Residents are the only group in which all predictive words are mostly positive. While there were some negative comments, none were of sufficient sample size to report.

Words and predominant meaning

Caring:	Demonstrated concern by staff for the resident
Clean:	State of facility or resident's garments or hygiene
Concern:	Awareness and consideration (usually for resident)
Listen:	Pay attention and remember conversations and issues from staff
Nursing staff:	Clinical staff, usually RNs, LVNs or LPNs and CNAs or NAs
Take care:	Render personal clinical care to resident
Treat:	How staff cares for resident

Words that matter to families

Recurring themes predict recommendation

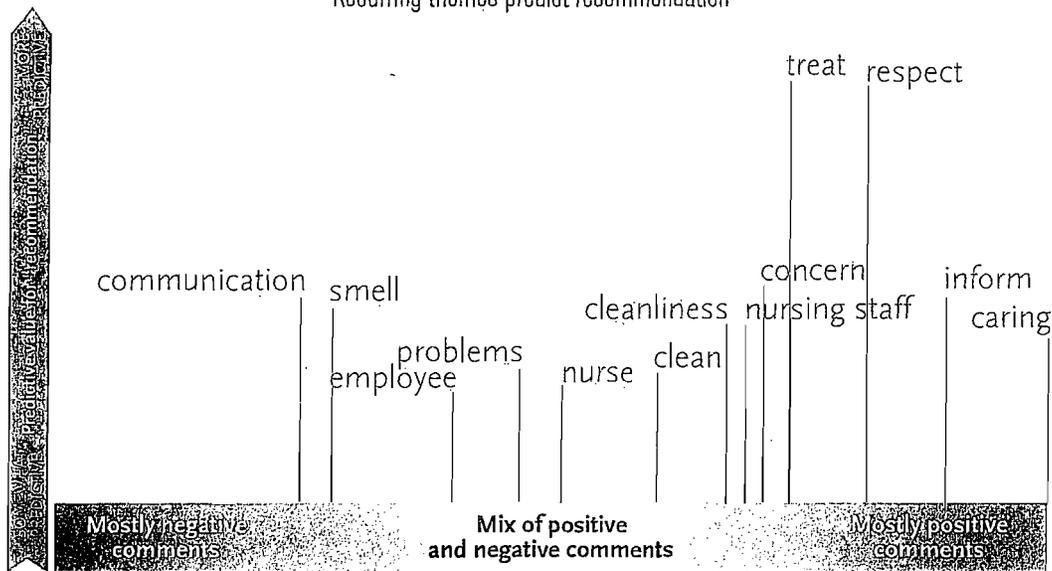


Figure 14

The occurrence of certain words in family comments are also predictive of the family's recommendation of a facility. SEE FIGURE 14

Words on the left side of the chart represent primarily negative comments; words on the right primarily positive comments. Words in the middle are associated with both negative and positive comments. The higher the correlation or predictive value, the higher the placement on the vertical axis.

For families:

☐ The words "treat" and "respect" are very predictive of the willingness to recommend, and are usually used within a positive context.

☐ The words "communication" and "smell" are somewhat predictive but usually associated with negative comments.

Word and predominant meaning

Caring:	Demonstrated concern by staff for family member
Clean:	State of facility or resident's garments or hygiene
Cleanliness:	(Same as "clean")
Communication:	Information passed to family from administrator or staff
Concern:	Awareness and consideration (usually for family member)
Inform:	Tell family something, typically about resident
Nurse:	Clinical staff, usually RNs, LVNs or LPNs
Nursing staff:	Clinical staff, usually RNs, LVNs or LPNs and CNAs or NAs
Problems:	Any negative situation relating to care of the resident or the facility
Respect:	Due consideration for resident
Smell:	Odor(s) noticed by family
Treat:	How staff cares for resident

Words that matter to workforce

Recurring themes predict recommendation

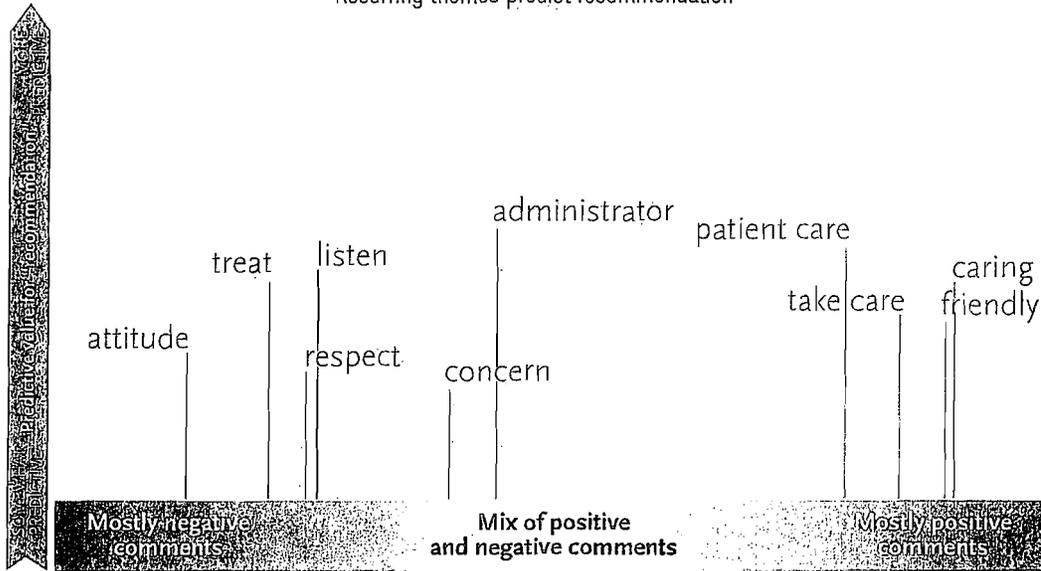


Figure 15

The occurrence of certain words in employee comments predicts the employee's willingness to recommend the facility. SEE FIGURE 15

For workforce:

- ❑ The word "administrator" is used in both positive and negative contexts, and is the most predictive word for employees.
- ❑ The word "attitude" is also somewhat predictive, but is usually associated with negative experiences among workers.
- ❑ Words associated with positive comments include "friendly," "patient care" and "caring."
- ❑ The words "listen," "treat" and "respect" tend to carry a negative meaning for workers.

Word and predominant meaning

Administrator:	Senior manager in nursing home
Attitude:	Predominant manner and disposition exhibited, usually by staff
Caring:	Demonstrated concern and action for staff and residents
Concern:	Awareness and consideration for resident or staff
Friendly:	Outgoing and cheerful to staff and residents
Listen:	Pay attention and remember conversations and issues from staff
Patient care:	Personal clinical service rendered to a resident
Respect:	Due consideration for resident or staff
Take care:	Render personal clinical care to a resident or act in the best interests
Treat:	Take care of a resident, or how one behaves toward residents or staff

Part Three
METHODOLOGY

- ✓ Workforce satisfaction
- Consumer satisfaction
 - Predictive validity
- Weighting procedures

Methodology

This section provides an overview of research methods used to gather information about consumer and workforce satisfaction. Data sources, survey instruments and survey distribution, as well as weighting, imputation and analytic procedures, are described.

My InnerView solicited feedback between 2005 and 2009 from over 3.5 million residents, family members and employees in nursing homes across the United States. Of those solicited, over one million returned the questionnaire, for a total response rate of more than 44%. In all, over 6,540 nursing facilities have participated in the data collection. In 2009 alone, the surveys were completed with 283,404 employees, 82,473 residents and 150,829 family members in 5,091 nursing facilities to produce this report. This represents fully one in three nursing facilities in the United States.

Members of My InnerView's research team — Leslie A. Grant, Ph.D. and Vivian Tellis-Nayak, Ph.D. — designed the survey instruments. Initial survey design was based on reviews of the literature and existing surveys; in-depth interviews with residents, family members and staff; and focus groups and corresponding content analyses. These instruments have undergone extensive field testing and have outstanding psychometric properties. SEE FIGURES 16–17, PAGE 25

Workforce satisfaction

These data come from confidential surveys completed by nursing home employees and returned directly to My InnerView during 2006, 2007, 2008 and 2009. The workforce satisfaction survey consists of 18 content questions and three global satisfaction questions (overall satisfaction, recommendation for care and recommendation as a place to work) along with eight categorical “demographic” questions. Facilities have the option to include additional questions on the survey.

In most cases, workforce satisfaction surveys were sent to the participating nursing facilities, where individual survey packets were distributed to all non-agency staff. To protect respondent privacy and ensure confidentiality, survey questions do not ask for personal identifying information. The surveys were completed by individual employee respondents and mailed directly to My InnerView using a self-addressed, postage-paid envelope included in the survey packet.

A four-point scale (“excellent,” “good,” “fair” or “poor”) is used to rate job satisfaction in five areas: (1) training, (2) work environment, (3) supervision, (4) management and (5) global satisfaction. The workforce survey includes 21 questions corresponding to five sub-scales. Figure 16 (page 25) shows the internal consistency of these measures. Cronbach's coefficient alpha is a special application of construct validity. In general, a Cronbach's alpha of 0.80 or greater is considered excellent. All coefficients for these measures exceed the 0.80 threshold.

Observations with missing or skipped items are excluded from the reliability analysis. Sample sizes are reduced because Cronbach's alpha coefficients are calculated by excluding imputed values to avoid spurious correlations.

Consumer satisfaction

These data were gathered through mail surveys completed by residents and family members in participating facilities. This report includes data from satisfaction surveys that were completed and returned to My InnerView during 2005, 2006, 2007, 2008 and 2009. The survey consists of 22 items and two global satisfaction questions (overall satisfaction and recommendation of the facility to others).

Respondents were asked to rate nursing facilities using a four-point scale (“excellent,” “good,” “fair” or “poor”). An additional eight questions gather demographic and background information, but no personally identifiable data are collected.

The consumer survey includes 24 questions encompassing four sub-scales: (1) quality of life, (2) quality of care, (3) quality of service and (4) global satisfaction. Figure 17 shows the internal consistency of these measures.

Observations with missing or skipped items are excluded from the reliability analysis. Sample sizes are reduced because Cronbach's alpha coefficients are calculated by excluding imputed values to avoid spurious correlations.

Predictive validity

Grant³ found strong positive correlations between consumer and workforce satisfaction assessed using My InnerView's satisfaction survey instruments. Data from other sources, including clinical outcomes (e.g., CMS' quality indicators or QIs), workforce performance (e.g., tracked by My InnerView's Quality Profile™), and state survey data (e.g., collected in the federal OSCAR system) are predictive of these consumer and workforce satisfaction metrics. Because these data elements are taken from independent sources, there is strong empirical evidence for the predictive validity of My InnerView's survey instruments.

Weighting procedures

This report represents a convenience sample of U.S. nursing homes. The sample of facilities is not randomly selected nor is it stratified by state or other facility characteristics. In order to make our national estimates more robust, we use a standard weighting methodology to adjust for facility characteristics such

Cronbach's alpha coefficients for workforce satisfaction scale and sub-scales

	NUMBER OF ITEMS	CRONBACH'S ALPHA	N
Training	4	.87	259,558
Work environment	9	.88	239,691
Supervision	3	.90	273,064
Management	2	.92	273,101
Global satisfaction	3	.91	272,744
Workforce satisfaction scale	21	.96	223,163

Figure 16

Cronbach's alpha coefficients for consumer satisfaction scale and sub-scales

	NUMBER OF ITEMS	CRONBACH'S ALPHA	N
Quality of life	10	.92	180,275
Quality of care	8	.92	169,669
Quality of service	4	.79	179,083
Global satisfaction	2	.93	222,646
Consumer satisfaction scale	24	.97	124,096

Figure 17

as ownership type, location (MSA/non MSA), bed-size and census within each state and nationally. To address missing data for individual survey items, missing values are imputed based on selected demographic and facility characteristics for each respondent using the standard hotdeck procedure available in Stata[®] software.⁴

³ Grant, L.A. (2004).

⁴ Ford, B.L., (1983).

My InnerView is an applied research company that currently works with over 9,000 senior care providers throughout the United States to promote quality improvement through evidence-based management.

Contributions to this report were made by the following members of My InnerView's research team: Leslie A. Grant, Ph.D.; Eric Lewerenz, M.S.; and John Mabry, M.P.H.

An electronic version of this report and other related information (including the 2005, 2006, 2007 and 2008 consumer and 2006, 2007 and 2008 workforce reports) can be found at www.myinnerview.com.

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Value Based Purchasing/Phase III

1. The Patient Protection and Affordable Care Act (PPACA) requires the Centers for Medicare & Medicaid Services (CMS) to submit a plan to Congress by 2012 to implement value-based purchasing (VBP) for skilled nursing facilities (Facilities), among others.
2. Indiana's Family and Social Services Administration (FSSA) has convened a Clinical Expert Panel for the purpose of identifying specific quality measures that would be used to create a VBP program for the Indiana Medicaid Program. The Indiana Health Care Association (IHCA) is represented on the Panel.
3. The IHCA believes that any VBP program instituted by CMS or FSSA should incorporate the following principles:
 - a. All Facilities shall receive a stable and sustainable base rate for services rendered.
 - b. Any Facility that meets or exceeds certain predetermined quality measures adopted by the VBP program during a particular one-year cycle shall receive an "add on" incentive VBP payment.
 - c. The VBP payments shall be funded by "new money" that is available to FSSA through QAF maximization or civil money penalties.
 - d. The VBP program shall use only the most proven quality measures that show strong correlation with quality and for which there is great confidence and consensus within the long term care industry. At the present time, the quality measures should include, at a minimum, the following:
 - i. Direct Care (Nursing and Therapies) Staffing Hours Per Resident Day
 - ii. Direct Care Staffing Retention Rates
 - iii. Administrator and Director of Nursing Tenure
 - iv. Results of Resident and Family Satisfaction Surveys (Conducted by My Inner View)
 - v. Results of Direct Care Satisfaction Surveys (Conducted by My Inner View)
 - e. Quality indicators derived from MDS should not be used at this time.

Table 1
Summary of Quality Measures Used in States’
Nursing Home Medicaid Pay-for-Performance (P4P) Programs

State	Clinical Quality Measures	Staffing ^a	Regulatory Deficiencies ^b	Consumer Satisfaction	Occupancy	Efficiency	Medicaid Use ^c	Culture Change
Existing Medicaid P4P in nursing homes								
Colorado	X	X	X	X			X	X
Georgia	X	X	X	X				
Iowa		X	X	X	X	X	X	
Kansas		X			X	X	X	
Minnesota	X	X	X	X				
Ohio		X	X	X	X	X	X	
Oklahoma	X	X	X	X			X	X
Utah			X	X				X
Vermont		X	X	X		X		
Planned Medicaid P4P in nursing homes ^d								
Maryland	X	X		X				X

a. Staffing includes staffing levels, staff retention, and/or staff satisfaction.

b. Regulatory deficiencies are based on state inspections (i.e., from Online Survey, Certification and Reporting or OSCAR).

c. Medicaid use is the number of Medicaid resident-days as a proportion of all resident-days; facilities with higher Medicaid use receive higher bonuses.

d. The structure of planned programs is subject to change.

Table 2
Summary of Clinical Areas Covered by Clinical Quality Measures
in States With Nursing Home Pay-for-Performance (P4P)

Clinical Area of Quality Measures	Colorado	Georgia	Minnesota	Oklahoma	Mayland ^a
Resident behavior			X		
Depression or anxiety			X		
Physical restraints	X	X	X	X	X
Bowel or bladder incontinence			X		
In-dwelling bladder catheters			X	X	X
Infections			X		X
New falls			X	X	
Burns, skin tears, or cuts			X		
Unexplained weight loss			X	X	
Moderate to severe pain	X	X	X		
New pressure sores	X	X	X	X	X
Inappropriate antipsychotics use			X		
Change in functional status			X		
Change in walking or mobility			X		
Vaccination rates					X

a. The structure of planned P4P programs is subject to change.

Table 3
Summary of the Size of Financial Incentives
Used in State Nursing Home Pay-for-Performance (P4P) Programs

	Maximum Per Diem Add-On	Average Per Diem Rate ^a	Total Paid in P4P Bonuses (in millions)	P4P Bonuses as Percentage of Nursing Home Budget
Colorado	\$4.00	\$143.75	— ^b	— ^b
Georgia	1.0% ^c	\$119.51	\$5.0	0.4
Iowa	\$3.68	\$102.56	\$6.7	1.4
Kansas	\$3.00	\$101.81	\$2.4	0.7
Minnesota	2.4% ^c	\$137.01	\$12.0	1.4
Ohio ^d	\$6.16	\$157.00	\$18.4	0.6
Oklahoma	\$5.45	\$96.20	\$12.7	1.8
Utah	\$0.60	\$105.55	\$1.0	0.7
Vermont	— ^e	\$147.24	\$0.1	0.1

a. Based on 2004 estimates in Grabowski, Zhanlian, and Mor (2008).

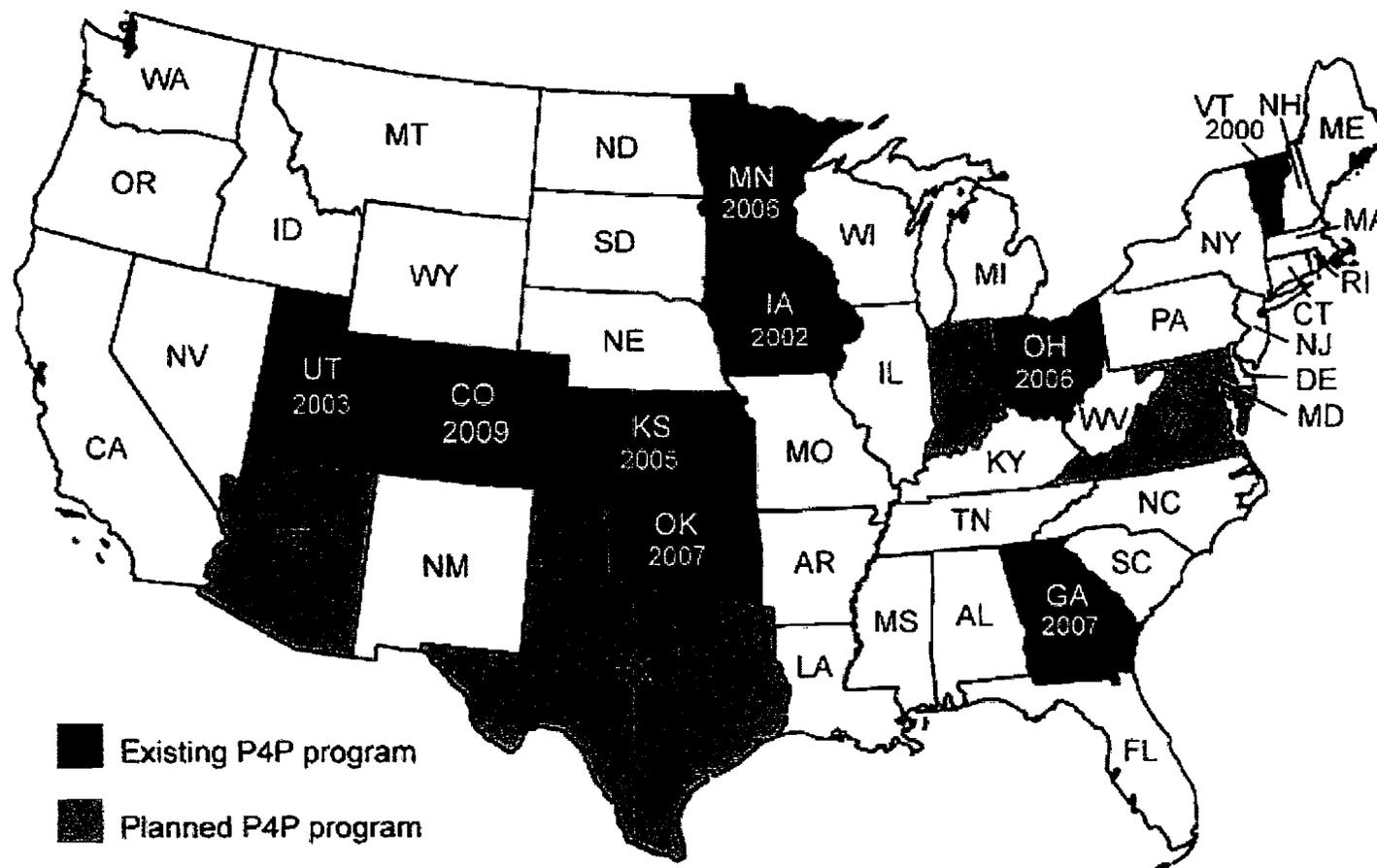
b. In Colorado, where the P4P program was initiated in 2009, bonuses have not yet been paid out.

c. Bonuses are a percentage of the facility's per diem rather than an absolute amount.

d. Receipt of bonus payment is contingent on having costs that are below established price points.

e. Bonuses are not based on per diem add-ons. Each nursing home that qualifies for a bonus payment receives \$25,000.

Figure 1
States With Existing or Planned Nursing Home Pay-for-Performance (P4P) Programs in 2009. In States With Existing P4P Programs, the Year of Implementation Is Also Displayed



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FOR IMMEDIATE RELEASE

**INDIANA HEALTH CARE ASSOCIATION EXPRESSES SUPPORT
OF SENATOR'S PROPOSAL ON BACKGROUND CHECKS**

INDIANAPOLIS – The Indiana Health Care Association (IHCA) went on record today (Sept. 20) in support of a legislative proposal that would require criminal background checks on nurses and other health care professionals.

State Senator Pat Miller (R-Indianapolis) indicated last week she would introduce a bill in the upcoming General Assembly session requiring background checks by law enforcement on health care workers who have regular contact with patients. “It is essential,” she said, “that Indiana’s public policies protect patients and do so at little or no cost to the state.”

The IHCA, Indiana’s largest trade association for the long term care profession, thanked Senator Miller for her concern and commitment and indicated it would work with her to achieve her legislative objective.

IHCA President Scott B. Tittle said: “Our members are committed to ensuring the safety of nursing home residents....Consistency in obtaining criminal background information on all health care professionals is an important public policy objective. We look forward to working with Senator Miller in seeking efficient and effective legislation.”

**Summary of Issues Affecting Long Term Care in
the Health Care and Education Affordability Act of 2010 (H.R. 4872)
March 19, 2010**

Regarding next steps on health care reform, AHCA/NCAL understands that House Democratic Leadership plans to hold two votes over the weekend. The first vote will be on legislation governing the rules of debate for the reconciliation bill, which if it passes, will also “deem” the Senate health care reform bill, *the Patient Protection and Affordable Care Act* (H.R. 3590), as having passed the House. The second vote will be on the reconciliation bill itself, *the Health Care and Education Affordability Act of 2010* (H.R. 4872).

On March 18, the House Rules Committee released the text of a substitute amendment, which will replace the entire contents of the reconciliation bill passed earlier in the week by the House Budget Committee, whose action was required to start the reconciliation process by current law.

This document summarizes the changes made to the Senate bill by the reconciliation bill, as contained in the substitute amendment, expected specifically to affect skilled nursing facilities (SNFs) and assisted living residences (AL).

Medicare

Medicare Prepayment Medical Review Limitations (Section 1302)

In order to streamline procedures for conducting Medicare prepayment reviews to facilitate additional fraud and abuse reviews, Section 1847A of the Social Security Act is repealed. That section permits the Secretary of Health and Human Services (HHS) to enter into contracts with any eligible entity to serve as a Medicare Administrative Contractor (MAC) and process Medicare Part A and B Fee for Service (FSS) claims.

CMS-IRS Data Match to Identify Fraudulent Providers (Section 1303)

Allows the Secretary of Treasury to share Internal Revenue Service (IRS) data with the Secretary of Health and Human Services (HHS) and HHS employees on taxpayers who have applied to enroll, or reenroll, as a provider of services or supplier under the Medicare program. The information includes the taxpayer identity information; the amount of the seriously delinquent tax debt owed by that taxpayer; and the taxable year to which the seriously delinquent tax debt pertains. The HHS Secretary may use this data to help screen and identify fraudulent providers or providers with tax debts, and can use this information either to deny applications to enroll or reenroll in Medicare or to apply enhanced oversight to providers of services with serious delinquent tax debt.

Funding to Fight Fraud, Waste and Abuse (Section 1304)

Increases funding for the Health Care Fraud and Abuse Control Fund by \$250 million through FY 2016. Indexes funds to fight Medicaid fraud based on the increase in the Consumer Price Index.

pilot. The post-acute care quality measures must be site neutral. The Secretary would develop policies to ensure the traditional fee-for-service program provides payment for post-acute care (PAC) services in the appropriate setting for those patients who require continued PAC services after the 30th day following the discharge. The pilot must be conducted for five years, and if it improves patient outcomes, reduces costs and improves efficiency, then the Secretary would be required to submit a plan to Congress to make the program permanent. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending.

Value-Based Purchasing (Section 3006)

By October 1, 2011, the HHS Secretary is required to submit to Congress a Medicare value-based purchasing implementation plan for Skilled Nursing Facilities. The plan must consider the following: (1) the development, selection, and modification process of measures to the extent feasible and practical of all dimensions of quality and efficiency; (2) the reporting, collection, and validation of quality data; (3) the structure of proposed value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments; (4) methods for publicly disclosing performance information on performance; and (5) any other issues as determined by the Secretary. In developing each plan, the Secretary would be required to consult with relevant stakeholders and take into consideration experiences with demonstrations that are relevant to value-based purchasing in SNFs.

MedPAC Must Consider Medicaid Into Account in Certain Circumstances (Section 1681(b)(3))

The bill includes language offered as an amendment by Senator Ron Wyden (D-OR) that requires MedPAC to report Medicaid data as to trends in spending, utilization, and financial performance for those providers having a significant portion of either revenue or services from Medicaid. The section also expands MACPAC's mission to include assessment of adult services in Medicaid including those for dual eligibles in conjunction with MedPAC.

Assisted Living Part D Copay Partial Elimination (Section 3309)

This provision of the bill would eliminate Medicare Part D cost-sharing for institutionally eligible dual eligible beneficiaries receiving services under Sec. 1115 or 1915 waivers or under a 1915(i) state plan amendment, as well as for duals receiving services in a Medicaid managed care organization.

Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-term Care Settings (Section 3310)

For plan years beginning on or after January 1, 2012, the bill would require Medicare Part D prescription drug and Medicare Advantage prescription drug plans to employ utilization management techniques, such as weekly, daily or automated dose dispensing, when providing medications to beneficiaries residing in long-term care facilities in order to reduce waste associated with 30-day fills.

Independent Medicare Advisory Board (Section 3403)

An independent Medicare Advisory Board would be established, comprised of 15 members appointed by the President and confirmed by the Senate, to develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries. Qualifications for members of the Board would be similar to the qualifications required for members of the Medicare Payment Advisory Commission (MedPAC). Members would serve six-year, staggered terms and would continue to serve until replaced. The Board is tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts.

Congress would take up the recommendations under an expedited procedure. Congress would have the option of modifying the recommendations of the Board but would have to achieve the same level of savings. If Congress fails to act on the recommendations of the Board, the recommendations would go into effect by an established deadline.

MedPAC would continue to exist in its current form as an advisory body to Congress.

Payment Adjustment for Conditions Acquired in Hospitals (Section 3008)

Starting in FY 2015, hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare. This provision also requires the Secretary to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a health care acquired condition policy related to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics.

Maximum Period for Submission of Medicare Claims (Section 6408)

Beginning January 2010, the maximum period for submission of Medicare claims would be reduced to not more than 12 months.

Recovery Audit Contractors (Section 6411)

Medicare Parts C and D, as well as Medicaid, would be included in the Recovery Audit Contractors (RACs) Program, which collects and identifies underpayments and overpayments currently for Medicare Parts A and B.

Ability of Physician Assistants to Certify Need for Post Acute Care (Section 3108)

Provides the authority for physician assistants to certify the need for post-hospital extended care services.

Establishment of Center for Medicare and Medicaid Innovation within CMS (Section 3021)

Establishes within the Centers for Medicare and Medicaid Services (CMS) a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for

testing of models that require benefits not currently covered by Medicare. Successful models can be expanded nationally.

Medicare Shared Savings Program (Section 3022)

Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program.

Hospital Readmissions Reduction Program (Section 3025)

Beginning in FY 2012, this provision would adjust payments for hospitals paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum. Also, provides the Secretary authority to expand the policy to additional conditions in future years and directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions.

Community-based Care Transitions Program (Section 3026)

Provides funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission.

Extension of Gainsharing Demonstration (Section 3027)

The *Deficit Reduction Act of 2005* authorized a demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries. This provision would extend the demonstration through September 30, 2011 and extend the date for the final report to Congress on the demonstration to September 30, 2012. Additional funding would be provided for this purpose.

Immediate Reduction in Coverage Gap for 2010 (Section 3315)

The bill contains language that, beginning on January 1, 2010, the initial coverage limit for Medicare Part D plans would be increased by \$500.00. Procedures would be established for retroactive reimbursement of beneficiaries for the costs incurred before implementation.

MedPAC Study of Payment Adequacy for Rural Providers (Section 3127)

The Medicare Payment Advisory Commission (MedPAC) must examine the adequacy of payments for items and services provided under Medicare in rural areas and report to Congress by January 1, 2011 on any recommendations for administrative or legislative action. The study must analyze the following: any payment adjustments; access to items and services; the adequacy of payments to providers and suppliers serving rural areas; and the quality of care furnished.

Independence at Home Demonstration Program (Section 3024)

Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes.

Face-to-Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare (Section 6407)

Requires physicians to have a face-to-face encounter with the individual prior to issuing a certification for home health services or DME. The Secretary would be authorized to apply the face-to-face encounter requirement to other items and services based upon a finding that doing so would reduce the risk of fraud, waste, and abuse.

Adjustments to the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Acquisition Program (Section 6410)

Requires the Secretary to expand the number of areas to be included in round two of the competitive bidding program from 79 of the largest metropolitan statistical areas (MSAs) to 100 of the largest MSAs, and to use competitively bid prices in all areas by 2016.

Medicaid

Medicaid Presumptive Eligibility Determinations by Hospitals (Section 2202)

Starting on January 1, 2014, this provision would allow any hospital the option, based off preliminary information, to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries (Section 2602)

Requires the Secretary to establish a Federal Coordinated Health Care Office (CHCO) within CMS by March 1, 2010. The purpose of the CHCO would be to bring together officials of the Medicare and Medicaid programs to (1) more effectively integrate benefits under those programs, and (2) improve the coordination between the Federal and State governments for individuals eligible for benefits under both Medicare and Medicaid (dual eligibles) to ensure that dual eligibles have full access to the items and services, including long term care, to which they are entitled.

Medicaid Bundled Payments Demonstration Project (Section 2704)

A Medicaid bundled payment demonstration project would be established in eight states to begin on January 1, 2012 through December 31, 2014. Services included would encompass acute care hospital, concurrent physician, and post acute care services. Hospitals would receive a single bundled payment from Medicaid for such services.

**Changes to the Medicaid and CHIP Payment and Access Commission (MACPAC)
(Section 2801)**

In FY 2010, MACPAC is to receive \$11 million in funding, \$9 million from Medicaid funds and \$2 million from CHIP. The proposal expands MACPAC's mission to include assessment of adult services in Medicaid, including dual eligibles. Issues to be examined by MACPAC include payments, access to services, quality of care, and interactions with Medicare and Medicaid. The bill also requires MACPAC to consult regularly with MedPAC and other stakeholders such as states.

Medicaid Reimbursement for Health Care Acquired Conditions (Section 2702)

As of July 1, 2011, Medicaid would no longer provide payments to states for services related to health care acquired conditions (HCACs). The HCAC definition under Medicaid would be consistent with the Medicare definition, but will be expanded to include conditions acquired in facilities other than hospitals. Differences between the Medicare and Medicaid programs, and their beneficiaries, would also be considered in the HCACs definition, as would current state practices. No denial of care must result from enforcement of this section.

Provider Participation Termination Under Medicaid if Terminated Under Medicare or Other State Plan (Section 6501)

This provision would require States to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another State's Medicaid program.

Medicaid Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliations (Section 6502)

Individuals or entities are temporarily excluded from participating in Medicaid if the entity has unpaid overpayments. This exclusion extends to affiliated entities under management, control, or ownership of entities that are excluded from participation.

Billing Agents and Other Alternate Payees Required to Register Under Medicaid (Section 6503)

Requires any agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers to register with the State and the Secretary in a form and manner specified by the Secretary.

Medicaid Overpayments (Section 6506)

Extends the period for States to repay Medicaid overpayments to one year when a final determination of the amount of the overpayment has not been determined due to an ongoing judicial or administrative process. When overpayments due to fraud are pending, State repayments of the Federal portion would not be due until 30 days after the date of the final judgment.

Mandatory State Use of National Correct Coding Initiative (Section 6508)

Medicaid claims filed on or after October 1, 2010 will be subject to compatible methodologies of the National Correct Coding Initiative (NCCI) currently administered by CMS. The current program is designed to promote correct coding methodologies and to control improper coding leading to inappropriate payment in Medicare Part B claims. This new initiative would apply these same principles to Medicaid claims.

Elimination of Exclusion of Coverage of Certain Drugs (Section 2502)

As of January 1, 2014, the following pharmaceuticals will be removed from Medicaid's excludable drug list: barbiturates, benzodiazepines, and smoking cessation drugs.

Medicaid Global Payment System Demonstration (Section 2705)

A Medicaid Global Payments demonstration project would be established in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment system from a fee-for-service structure to a global capitated payment structure. The CMS Innovation Center would conduct an evaluation of each demonstration project examining any changes in health care quality outcomes and spending. The Innovation Center would be exempted from budget-neutrality requirements for an initial testing period. The Innovation Center also would be given the authority to terminate or modify the demonstration project during the testing period. The Secretary would be required to conduct an analysis of the demonstration project and report her findings to Congress.

Nursing Home Transparency

Required Disclosure of Ownership and Additional Disclosable Parties (Section 6101)

The bill requires SNF/NFs to disclose information on their organizational structures as well as information on officers, directors, trustees, or managing employees, including names, titles, and start date of service. The term "managing employee" means an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

The bill requires disclosure of owners of a whole or part interest in any mortgage, deed or other obligation exceeding 5 percent of a facility's total property/assets. Additional disclosable parties include entities that provide policies or procedures for any of the operations of the facility, provide financial or cash management services, or provide management or administrative services, management or clinical consulting services, or accounting or financial services to the facility. However, the provision was amended in this bill, and in earlier iterations of the Senate Finance bill, to exclude a requirement for facilities to disclose parties that lend funds or provide financial guarantees of any amount to facilities. The bill also requires disclosure of limited liability company information and any limited partners of the limited partnership who have an ownership interest in the limited partnership, which is equal to or exceeds 10 percent.

The bill requires a facility to make all disclosable parties' information available to the public upon request and update the information as necessary to reflect changes. Facilities are required to certify to the Secretary, the Inspector General that the information submitted upon request is, to

the best of the facility's knowledge, "accurate and current", and the Secretary must develop a standardized format for the information within two years of date of enactment.

Compliance Program (Section 6102)

The bill requires nursing facilities/skilled nursing facilities have a compliance and ethics program in operation 36 months after enactment of the concept paper. The compliance/ethics program must be effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care. Three years after the date of the promulgation of regulations under this section, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subsection and will submit a report to Congress on this evaluation.

Nursing Home Compare Medicare Website (Section 6103)

The legislation requires Secretary to ensure that information provided for comparison of nursing homes be posted on the Nursing Home Compare website in a manner that is prominent, easily accessible, updated on a timely basis, readily understandable to consumers of long-term care services, and searchable. The website must also include summary information on the number, type, severity, and outcome of adjudicated instances of criminal violations by a facility or the employees of a facility that were committed inside the facility and the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

The bill would also require that additional information on the Special Focus Facility Program be posted on the Nursing Home Compare website. States must also maintain a consumer-oriented website providing info on SNFs/NFs in the state including State inspection reports, facilities plan of correction, and any other information that the state or the Secretary considers useful to the public.

In reviewing and modifying the website, the Secretary must now consult with State long-term care ombudsman programs, consumer advocacy groups, and provider stakeholder groups.

Reporting of Expenditures (Section 6104)

The bill would require SNFs/NFs to report expenditures separately for direct care services, indirect care services, capital assets, and administrative costs on cost reports for cost reporting periods beginning on or after two years after date of enactment. The Secretary, in consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports, shall redesign such reports.

Standardized Complaint Form (Section 6105)

The bill requires the Secretary to develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program.

Ensuring Staffing Accountability (Section 6106)

The bill requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, including information on agency or contract staff. Effective two years after date of enactment.

GAO Study and Report on Five-Star Quality Rating System (Section 6107)

The bill directs the Comptroller General to conduct a study of the CMS 5-Star system. The study will evaluate how the system is being implemented, and problems associated with the system, and how the system may be improved. The Comptroller must issue a report of the study's findings to Congress two years after enactment of this bill.

Civil Money Penalties (CMPs) (Section 6111)

The bill states that Secretary may reduce civil money penalties (CMPs) up to 50 percent in the case where a facility self-reports and promptly corrects a deficiency within 10 days. Reductions would not be made for self-reported deficiencies citing an immediate jeopardy or actual harm violation. With respect to repeat deficiencies, the Secretary can not reduce these penalties if the Secretary had reduced a penalty imposed on the facility in the preceding year.

Thirty days after imposition of civil penalty, the bill gives the facility an opportunity to participate in independent formal dispute resolution, but this opportunity does not affect the responsibility of the State survey agency for making final recommendations for penalties.

The Secretary would have the authority to place CMPs imposed, for deficiencies citing an immediate jeopardy or actual harm violation, in an escrow account following completion of the informal dispute resolution process, or the date that is 90 days after the date of the imposition of the CMP.

The Secretary would be authorized to use a portion of collected CMPs to fund activities that benefit residents. Such funds would also be used for facility improvement initiatives approved by the Secretary, including joint training of facility staff and surveyors and technical assistance for facilities implementing quality assurance programs.

National Independent Monitor Demonstration Project (Section 6112)

The bill requires HHS Secretary along with the Office of the Inspector General to establish a demonstration project to develop, test, and implement use of independent monitoring program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities. Chains would be responsible for a portion of the costs associated with appointment of independent monitors. HHS OIG would evaluate the demonstration project after two years.

Notification of Facility Closure (Section 6113)

The bill imposes sanctions for a facility's failure to comply with the Facility Closure Notification requirements, including CMPs of \$100,000 as well as possible exclusion from participating in any federal health care program.

National Demonstration Project on Cultural Change and Use of Information Technology (Section 6114)

The bill requires the Secretary to conduct two demonstration projects, one for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement and one for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care. The demonstration projects will be implemented no less than 1 year after the enactment of the bill.

The Secretary will award one or more grants to facility-based settings for the development of best practices

Dementia and Abuse Prevention Training (Section 6121)

Requires facilities to include dementia management and abuse prevention training as part of pre-employment initial training for permanent and contract or agency staff, and if the Secretary determines appropriate, as part of ongoing in-service training.

Nationwide Program for Background Checks (Section 6201)

The bill also includes the entire text of the *Patient Safety and Abuse Prevention Act* (S. 631). The Secretary must establish a nationwide program for national and State background checks on direct patient access employees of certain long-term care (LTC) facilities or providers and provide Federal matching funds to States to conduct these activities. States that enter into an agreement with the Secretary would be responsible for monitoring compliance with the requirements of the nationwide program and have specified compliance procedures in place. The HHS Inspector General would be required to conduct an evaluation of the nationwide program and submit a report to Congress no later than 180 days after completion of the national program in FY 2012.

LTC providers (including assisted living/residential care providers) that participate in either the Medicare or Medicaid programs would be required to obtain state and national criminal history and other background checks on their prospective employees through such means as the Secretary determines appropriate. To conduct these checks, states would utilize a search of state-based abuse and neglect registries and specified state and federal databases and records, including a fingerprint check. There is a 60-day grace period during which newly hired staff may be given provisional employment, pending the completion of the criminal background check.

Quality

National Strategy to Improve Health Care Quality (Section 3011)

The HHS Secretary is directed to create a national quality improvement strategy addressing the following priorities: delivery of health care services, patient health outcomes, and population health. This strategy must be submitted to Congress for review by January 1, 2011. The Secretary is tasked with identifying national priorities and must consider: high-cost chronic diseases; patient safety improvements and medical errors, preventable hospital admissions and readmissions, health care-associated infections; reduce health disparities across health disparity populations and geographic areas; and other areas as determined appropriate by the Secretary. Once the priorities are established, a strategic plan must be created taking into account the following: coordination among agencies to minimize duplication and utilization of common quality measures; agency-specific strategic plans; a regular status reporting process; establishment of annual benchmarks for each participating agency; strategies to align incentives among public and private payors for quality and patient safety efforts; incorporating quality improvement and measures for HIT. A website must be created so that the public may access the details of the strategy.

Interagency Working Group on Health Care Quality (Section 3012)

A "Working Group" with the following goals would have to be convened. Goals include:

- 1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models and timetables consistent with the national priorities under the Public Health Service Act.
- 2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.
- 3) Assess alignment of quality efforts in the public sector with private sector initiatives.

The Working Group would be composed of senior level representatives from HHS, CMS, HRSA, AHRQ, etc. Not later than December 31, 2010, and annually thereafter, the Working Group must submit to the relevant Committees of Congress, and post on a public website, a report describing the progress and recommendations of the Working Group in meeting its goals.

Quality Measure Development (Section 3013)

As part of the National Strategy to Improve Health Care Quality, the term quality measure is defined as "a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services." At least every three years, the Secretary must do an analysis to identify where there are no existing quality measures or where existing ones need improvement, updating, or expansion. The results of the analysis must be posted on a publicly available website. Grants will be awarded to: improve, update, or expand quality measures with priority given to those assessing health outcomes, functional status, coordination across episodes of care and transitions; meaningful use of HIT; safety, effectiveness, patient centeredness, appropriateness and timeliness of care; efficiency of care; health disparities; patient satisfaction; and other areas as determined by the Secretary.

Quality Measure Endorsement (Section 3014)

Grants will be awarded to a consensus-based entity to make annual recommendations to the Secretary on the aforementioned national priorities and identify gaps. In the process of making these recommendations in a transparent way, the entity must convene voluntary "multi-stakeholder groups", which must involve representatives from a broad range of interested parties including; post acute providers, health care professionals, hospitals, quality alliances, health plans, labor, employers and public purchasers, licensing and credentialing organizations; government agencies and consumer representatives. These multi-stakeholder groups will provide guidance on the selection of quality measures and must provide information to the Secretary by February 1 of each year beginning in 2012, such as whether the group has endorsed a particular quality measure. A pre-rulemaking process also will be established for these activities. The Secretary takes the endorsement of such measures under advisement, and may only use a non-endorsed measure in certain circumstances and by following a specific procedure, which includes publication of the rationale in the *Federal Register*. The Secretary must also disseminate these quality measures so that they may be used in workforce programs, training curricula, and payment programs among others.

Quality Data Collection and Public Reporting (Section 3015)

The Secretary is required to collect and compile consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information. Grants may be awarded to conduct this activity. The collection, aggregation, and analysis systems must encompass a wide variety of patient populations, providers, and geographic areas. The Secretary must make this data publicly available in addition to performance information, tailored for the needs of individual types of providers. The data must include clinical conditions and be provider-specific, although disaggregated.

Medicaid Adult Health Quality Measures (Section 2701) Directs the Secretary of HHS to develop a core set of quality measures for Medicaid eligible adults similar to that in place for the Children's Health Insurance Program. The Secretary and the States will report on the development of and improvements to the quality measurement program on a regular basis.

Quality Reporting for Long Term Care Hospitals, Inpatient Rehabilitation Hospitals and Hospice Programs (Section 3004) The bill contains language that, for each of these providers for the rate year 2014 and each subsequent rate year, if the provider does not submit quality data to the Secretary, any annual update to a standard Federal rate for discharges shall be reduced by 2 percentage points. Not later than October 1, 2012, the Secretary shall publish the quality measures to be used. Quality measures would be reported on the CMS web site.

Health Care Delivery System Research: Quality Improvement Technical Assistance (Section 3501)

The Center for Quality Improvement and Patient Safety of the AHRQ (referred to as the "Center") would conduct or support activities related to best practices for quality improvement in delivering health care services; assess research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery; and build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs. The Center may establish a Quality Improvement Network Research Program that would develop practice recommendations applicable to a variety of settings. Recommendations would include practical methods to address health care associated infections, reducing preventable hospital admissions and readmissions, etc.

Fraud, Waste and Abuse – Medicare, Medicaid Program Integrity Provisions

Provider Screening (Section 6401)

The bill would require that the Secretary, in consultation with the OIG, to screen all providers and suppliers before granting Medicare, Medicaid, and CHIP billing privileges and at time of revalidation. At a minimum all providers and suppliers would be subject to licensure checks. Certain groups of providers and suppliers would be subject to additional screening measures according to risk, as defined by the Secretary. The additional types of screening measures could include: submission of fingerprints, criminal background checks, multistate data base inquiries, and random or unannounced site visits. The screening requirement would begin one year from the date of enactment.

An application fee of \$200 for individual practitioners, adjusted for inflation beginning in 2011, and \$500 for institutional providers and suppliers adjusted for inflation beginning in 2011, would be imposed to cover the costs of screening each time they re-verify their enrollment (every five years).

States failing to create effective screening programs would be subjected to a financial penalty through a reduction in their Federal Medical Assistance Percentage (FMAP). A hardship exception to the fee would be permitted, as would waiver of the fee for Medicaid providers for whom the state can demonstrate the fee would impede beneficiary access to care.

Disclosure Requirements (Section 6401)

The bill would also impose new disclosure requirements on providers and suppliers enrolling or re-enrolling in Medicare or Medicaid. Applicants would be required to disclose current or previous affiliations with any provider or supplier that has uncollected Medicare or Medicaid debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked. The Secretary would be authorized to deny enrollment in Medicare if these affiliations pose an undue risk to the program.

Compliance Programs (Section 6401)

By a date determined by the Secretary, certain providers and suppliers would be required to establish a compliance program. The requirements for the compliance program would be developed by the Secretary and the HHS OIG.

Enhanced Medicare and Medicaid Program Integrity Provisions (Section 6402)

- **Integrated Data Repository** Requires CMS to include in the integrated data repository (IDR) claims and payment data from the following programs: Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS).
- **Access to Data** The Secretary would be required to enter into data-sharing agreements with the Commissioner of Social Security, the Secretaries of the VA and DOD, and the Director of the IHS to help identify fraud, waste, and abuse. The Committee Bill would grant the HHS OIG and the Department of Justice (DOJ) access to the IDR for the purposes of conducting law and oversight activities consistent with applicable privacy, security, and disclosure laws.
- **Overpayments** In the bill, the Secretary would have increased authority allowing for suspensions of payment during creditable investigations of fraud; and new procedures for disclosure and repayment of overpayments. Further, the 60 days providers and suppliers have to repay Medicare overpayments would be modified to either 60 days after the date on which the overpayment was made or the date the corresponding cost report is due. Providers and suppliers would be required to repay any Medicare or Medicaid overpayment identified through an internal compliance audit. The bill requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later.

- **National Provider Identifier** Requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications.
- **Medicaid Management Information System** Authorizes the Secretary to withhold the Federal matching payment to States for medical assistance expenditures when the State does not report enrollee encounter data in a timely manner to the State's Medicaid Management Information System (MMIS).
- **Permissive Exclusions** Subjects providers and suppliers to exclusion for providing false information on any application to enroll or participate in a Federal health care program.
- **Civil Monetary Penalties** Expands the use of Civil Monetary Penalties (CMPs) to excluded individuals who order or prescribe an item or service, make false statements on applications or contracts to participate in a Federal health care program, or who know of an overpayment and do not return the overpayment. Each violation would be subject to CMPs of up to \$50,000.
- **Testimonial Subpoena Authority** The Secretary would be able to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question by the Secretary.
- **Surety Bonds** Requires that the Secretary take into account the volume of billing for a DME supplier or home health agency when determining the size of the surety bond. The Secretary would have the authority to impose this requirement on other providers and suppliers considered to be at risk by the Secretary.
- **Payment Suspensions** Authorizes the Secretary to suspend payments to a provider or supplier pending a fraud investigation.
- **Health Care Fraud and Abuse Control Account** Increases Health Care Fraud and Abuse Control (HCFAC) funding would by \$10 million each year for fiscal years 2011 through 2020. The provision would also permanently apply the CPI-U adjustment to HCFAC and Medicare Integrity Program (MIP) funding.
- **Medicare and Medicaid Integrity Programs** Requires Medicare and Medicaid Integrity Program contractors to provide the Secretary and the HHS OIG with performance statistics, including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment for such activities.

Elimination of Duplication Between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank (Section 6403)

Requires the Secretary to maintain a national health care fraud and abuse data collection program for reporting certain adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB). The Secretary would also be required to establish a process to terminate the

Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in the HIPDB is transferred to the NPDB.

Enhanced Penalties (Section 6408)

Subjects persons who fail to grant HHS OIG timely access to documents, for the purpose of audits, investigations, evaluations, or other statutory functions, to CMPs of \$15,000 for each day of failure. Also, persons who knowingly make, use, or cause to be made or used any false statement to a Federal health care program would be subject to a CMP of \$50,000 for each violation. The violations that could be subject to the imposition of sanctions and CMPs by the Secretary would include Medicare Advantage (MA) or Part D plans that: (1) enroll individuals in a MA or Part D plan without their consent, (2) transfer an individual from one plan to another for the purpose of earning a commission, (3) fail to comply with marketing requirements and CMS guidance, or (4) employ or contract with an individual or entity that commits a violation. Penalties for MA and Part D plans that misrepresent or falsify information

Medicare Provider Self-Disclosure Protocol (SRDP) (Section 6409)

The Secretary would be required to establish, within 180 days, a mechanism for providers to disclose voluntarily specific information regarding actual and potential violations of the physician self-referral law. The mechanism would be similar to the Provider Self-Disclosure Protocol (SRDP) operated by the HHS OIG.

The Secretary shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to a SRDP.

The mechanism would be available to all health care providers and would not be limited to a particular industry, specialty, or service. The mechanism would also offer an incentive to encourage providers to participate, such as a damage calculation near the lower-end of the statutory spectrum.

The Secretary would not be required to resolve all matters disclosed in this manner. However, the Secretary would be required to work closely with providers that come forward in good faith seeking a resolution. Neither the HHS OIG nor the DOJ would be precluded from opening an investigation into a provider while the disclosure protocol is being implemented. Any resolution entered into by the Secretary and the provider would not be binding on the DOJ or other Federal or state agency.

Tort Reform

Sense of the Senate Provision (Section 6801)

The bill would express the Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. In addition, it states that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system.

Workforce

National Health Care Workforce Commission (Section 5101)

Establishes a national commission tasked with reviewing health care workforce and projected workforce needs, with the goal of providing comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources.

State Health Care Workforce Development Grants (Section 5102)

Competitive grants are created to enable State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels. Grants will support innovative approaches to increase the number of skilled health care workers such as health care career pathways for young people and adults.

Health Care Workforce Assessment (Section 5103)

Codifies the existing national center and establishes several regional centers for health workforce analysis to collect, analyze, and report data related to Title VII (of the Public Health Service Act) primary care workforce programs. The centers will coordinate with State and local agencies in collecting labor and workforce statistical information and provide analyses and reports on Title VII to the Commission.

Workforce Demonstration Project (Section 5507)

A new HHS demonstration project would be established for low-income individuals who would like to obtain education and training for those health care occupations that are in high demand or are experiencing shortages. Grants would be made to states, local workforce investment boards, or community based organizations. The demonstration will determine the efficacy of developing core training competencies in the following areas: the role of the personal or home care aide; consumer rights, ethics, and confidentiality; communication, cultural, and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills; personal care skills; health care support; nutritional support; infection control; safety and emergency training; training specific to an individual consumer's needs; and self-care. The project will also evaluate the methods used to implement these competencies including: length of training; appropriate student to trainer ratio; time spent in the classroom compared to on-site; trainer qualifications; content for hands-on training and written certification exam; and continuing education requirements. A personal care aide is defined as one "who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer's disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual."

Graduate Nurse Education Demonstration Program (Section 5509)

The bill would establish a graduate nurse education demonstration program under Medicare in order to increase the supply of highly skilled advanced practice nurses. Participating hospitals would receive reasonable costs reimbursement from Medicare for the educational costs

(including faculty salaries, any student stipends, clinical instruction costs, and other direct and indirect costs) of a hospital and affiliated schools attributable to the training of advanced practice nurses. The demonstration aims to provide these nurses with skills necessary to provide primary and preventive care, transitional care, chronic care management, and other appropriate nursing services through affiliation with one or more accredited nursing schools and in partnership with two or more non-hospital community-based patient care settings where at least half of all clinical training occurs. The Secretary would be able to waive the requirement for affiliation with accredited nursing schools for clinical training of advanced practice registered nurses in rural and medically underserved areas. The term "advanced practice nurse" under this section would include a clinical nurse specialist, nurse practitioner, certified registered nurse anesthetist, and certified nurse midwife.

Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education (Section 5305)

Authorizes funding to geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools and family caregivers; develop curricula and best practices in geriatrics; expand the geriatric career awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; and establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing.

Training Opportunities for Direct Care Workers (Section 5302)

The bill would establish grants to institutions of higher education to provide training opportunities to direct care workers employed in long term care settings, e.g. ALFs, SNFs, ICFs/MR, HCB settings, etc. Once an individual has completed the training, he/she must work in the field of geriatrics, disability services, long term services and supports, or chronic care management for at least 2 years.

Protection for Employees (Section 1558)

Amends the Fair Labor Standards Act to ensure that no employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee has received a premium tax credit or for other reasons.

Other Issues of Specific Interest to Long Term Care, Post Acute Care, and Assisted Living

Elder Justice Act Amendment (Sections 1911 – 1913)

The legislation includes the entire text of the *Elder Justice Act* (S. 795), which amends the Social Security Act to establish an Elder Justice program under Title XX Block Grants to States for Social Services. It also establishes within the Office of the Secretary of Health and Human Services (HHS) an Elder Justice Coordinating Council (EJCC) as well as an Advisory Board on Elder Abuse, Neglect, and Exploitation. The HHS Secretary is directed to make grants to eligible entities to establish stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation. In addition, the Secretary must provide incentives for individuals to train for, seek, and maintain employment

providing direct care in a long term care (LTC) facility. Grants will be made to LTC facilities to: (1) offer continuing training and varying levels of certification to employees who provide direct care to LTC facility residents; and (2) provide bonuses or other benefits to employees who achieve certification. Other grants also will be made to assist LTC facilities in offsetting the costs for standardized clinical health care informatics systems designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors. HHS must not only provide funding to state and local adult protective services offices that investigate reports of elder abuse, neglect, and exploitation; but also collect and disseminate related data in coordination with the Department of Justice. A program of annual adult protective services grants to states must also be created. Moreover, the Secretary must make grants to eligible entities to improve the capacity of state LTC ombudsman programs to respond to and resolve abuse and neglect complaints; and conduct pilot programs with state or local LTC ombudsman offices. Programs must be established to both provide and improve ombudsman training for national organizations and state LTC ombudsman programs. Additionally, each individual owner, operator, employee, manager, agent, or contractor of an LTC facility receiving certain federal support must report to the Secretary and local law enforcement entities any reasonable suspicion of crimes occurring in such facility. Additionally the owner or operator of such an LTC facility must notify the Secretary and the appropriate state regulatory agency of a facility's impending closure, as well as establish a plan for the transfer and adequate relocation of facility residents. The Secretary must also study and report to the EJCC and appropriate congressional committees on establishing a national nurse aide registry.

Establishment of a National Voluntary Insurance Program for Purchasing Community Living Assistance Services and Support (CLASS Program) (Section 8002)

Like the House reform bill, the Senate bill establishes a new, voluntary, public long-term care insurance program called the CLASS Independence Benefit Plan, so that individuals with functional limitations can purchase community living assistance services and supports. The Secretary must make sure that the Plan is actuarially sound and that it ensures solvency for 75 years; allows for a five year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of \$50 per day. For institutionalized eligible beneficiaries enrolled in Medicaid, the beneficiary shall retain 5% of the cash benefit (in addition to the Medicaid personal needs allowance) and the rest shall be applied toward the facility's cost of providing care. Medicaid shall be secondary payor. For beneficiaries receiving home- and community-based (HCB) services, they retain 50% of the cash benefit and the remainder shall be applied to the cost of the state of providing Medicaid assistance. Medicaid provides secondary coverage subject to various conditions. The definition of HCB services includes HCB services under Medicaid waivers and 1915(i) HCB State Plan Option.

Unlike the House bill, in the Senate bill there is a requirement to establish a Personal Care Attendants Advisory Panel no later than 90 days after the Act is enacted. The Panel will examine and advise the Secretary and Congress on workforce issues related to personal care attendant workers, including the adequacy of the number of such workers, and access by individuals to the services provided by such workers.

HIPAA Administrative Simplification (Section 1104)

Accelerates HHS adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans governed under the Health Insurance Portability and Accountability Act (HIPAA). Establishes a process to update regularly

the standards and operating rules for electronic transactions. The goal of this section is to make the health system more efficient by reducing the clerical burden on providers, patients and health plans.

Long Term Care Services and Supports

A series of amendments discussing long term care services and supports were included in the bill language.

- **Community First Choice Option (Section 2401)** —The bill would establish the Community First Choice Option, which would create a state plan option under section 1915 of the Social Security Act to provide community based attendant supports and services to individuals with disabilities who are Medicaid eligible and who require an institutional level of care. These services and supports include assistance to individuals with disabilities in accomplishing activities of daily living, instrumental activities of daily living, health related tasks and additional supports such as voluntary training on how to select manage, and dismiss attendants. Services and supports may be provided by family members, agencies and others. States would be required to provide these services under a “person-centered” plan and services would be “consumer controlled,” meaning that the individual or his/her representative would have maximum control of HCB attendant services, “regardless of who may act as the employer of record.” States would have to establish Development and Implementation Councils. Under the Community First Choice Option, services must be provided without regard to age, type or severity of disability or form of HCB services required to lead an independent life. States who choose the Community First Choice Option would be eligible for enhanced federal match rate of an additional six percentage points for reimbursable expenses in the program. The Community First Choice Option also would require data collection.
- **Spousal Impoverishment (Section 2404)** – The bill would protect against spousal impoverishment in all Medicaid home and community based services programs by requiring states to apply the same spousal impoverishment rules currently provided to the spouses of nursing home residents in Medicaid. The provision would sunset after five years.
- **Removal of Barriers to Providing Home and Community-Based Services (Section 2402)** This would remove barriers to providing HCBS by giving states the option to provide more types of HCBS through a state plan amendment to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment.
- **Money Follows the Person Rebalancing Demonstration (Section 2403)** This provision would extend the current Money Follows the Person Demonstration grant program for an additional 5 years until 2016. It would change the requirement that a qualifying individual has been in an institution from not less than 6 months to not less than 90 consecutive days and it also excludes rehab stays.

Clarification of Definition of Medical Assistance (Section 2304)

The bill would clarify the original intent of Congress that the term "medical assistance" as used in various sections of the *Social Security Act* encompasses both payment for services provided and the services themselves.

Sense of the Senate Amendment on Long Term Services and Supports (Section 2406)

The bill expresses the Sense of the Senate that this Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need and that long term services and supports should be made available in the community in addition to in institutions.

State Option to Provide Health Homes for Enrollees with Chronic Conditions (Section 2703)

The bill states that, beginning January 1, 2011, under a State plan amendment a state may provide medical assistance to eligible individuals with chronic conditions who select a designated provider, a team of health care professionals operating with such a provider, or a health team as the individual's "health home" to provide individual with health home services. Services may include comprehensive care management; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; referral to community and social support services, etc. Providers may include physicians, physician practices, community health centers, home health agencies, or other entities deemed by both the HHS Secretary and the State that have the infrastructure in place to provide home health services. Payments made to the provider shall be treated as medical assistance except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the FMAP applicable to such payments shall be equal to 90 percent. The total amount of payments made to States shall not exceed \$25,000,000.00.

Hospital Wage Index Amendments (Section 3137)

By December 31, 2011, the Secretary is to submit a report to Congress that includes a plan to reform the hospital wage index system. Changes to the hospital wage index that are not hospital specific, are generally adopted in the SNF and other PAC settings the following year. The bill includes additional hospital-specific language that may indirectly have an impact on nursing homes. Since these changes are implemented in a budget neutral manner, there will not be an overall gain or loss for the industry, but various geographic areas may be somewhat affected positively and others negatively.

Hospice Reform (Section 3132)

The bill states that beginning no later than January 1, 2011, the Secretary shall collect additional data and information [than as is currently collected] as appropriate to revise payments for hospice care. Data may include information on charges and payments; the number of hospice visits; the type of practitioner providing the visit; etc. Hospice programs and the Medicare Payment Advisory Commission (MedPAC) will be consulted regarding the data and information to be collected. Not earlier than October 1, 2013, the Secretary would, through regulation, implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care. Revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing care and services during

the entire episode of care. MedPAC's hospice program eligibility recertification recommendations would be adopted.

Removing Barriers and Improving Access to Wellness for Individuals with Disabilities (Section 4203)

The bill would require that no later than 24 months after enactment of the Act that the Architectural and Transportation Barriers Compliance Board consult with the Commissioner of the FDA to create minimum technical criteria for medical diagnostic equipment. The equipment would have to be accessible to, and usable by, individuals with accessibility needs and allow them independent entry to, use of, and exit from the equipment.

Program to Facilitate Shared Decision Making (Section 3506)

Establishes a program at HHS for the development, testing, and disseminating of educational tools to help patients, caregivers, and authorized representatives understand their treatment options.

Nondiscrimination (Section 1557)

Protects individuals against discrimination under the Civil Rights Act, the Education Amendments Act, the Age Discrimination Act, and the Rehabilitation Act, through exclusion from participation in or denial of benefits under any health program or activity.

Oversight (Section 1559)

The Inspector General of the Department of HHS shall have oversight authority with respect to the administration and implementation of this title as it relates to such Department.

Rules of Construction (Section 1560)

Nothing in this title shall be construed to modify, impair, or supersede the operation of any antitrust laws.

**Summary of Issues Affecting Long Term Care in
the Patient Protection and Affordable Care Act
December 16, 2009**

On November 18, 2009, Senate Majority Leader Harry Reid (D-NV) released a bill that merged the provisions of the two bills reported by the Senate Finance Committee and the Senate Health, Education, Labor and Pensions Committee. For technical reasons of parliamentary procedure, the bill was released as an amendment to H.R. 3590, which is unrelated to health care. Note that this document highlights only those issues expected specifically to impact skilled nursing facilities (SNFs) and assisted living residences (AL).

Medicare

Skilled Nursing Facility (SNF) Market Basket Productivity Adjustment (Section 3401)

Beginning in Fiscal Year (FY) 2012, the Skilled Nursing Facility (SNF) market basket will be reduced by a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private non-farm business multifactor productivity as projected by the Secretary.

Note that although the Congressional Budget Office did not provide a specific figure for SNF cuts for this bill, in previous versions of the bill, it estimated the cuts to be \$14.6 billion over 10 years.

Therapy Caps (Section 3103)

The current exceptions process for Medicare Part B outpatient therapy services is extended through December 31, 2010.

National Pilot Program on Payment Bundling (Section 3023)

By January 1, 2013, the Secretary will implement a national, voluntary pilot program to coordinate care for Medicare beneficiaries not covered under Part C during an entire episode of care for eight conditions to be specified by the Secretary. Services to be included in the bundle are: acute care inpatient hospital services; physician services delivered inside and outside of the acute care hospital setting; outpatient hospital services, including emergency department visits; services associated with acute care hospital readmissions; post acute care services including home health, skilled nursing, inpatient rehabilitation, long term care hospital; and other services that the Secretary determines appropriate. The Secretary must take the following into account: whether the specified conditions include both chronic and acute; whether there is a mix of surgical and medical conditions; whether a condition allows providers and suppliers to improve the quality of care while reducing total expenditures; whether there is significant variation in the number of readmissions, the amount of expenditures for post-acute care; whether a condition "has high volume and high post acute care expenditures; and which conditions the Secretary decides are most "amenable to bundling across the spectrum of care given practice patterns". The episode of care established in the pilot program would start three days prior to a qualifying admission to the hospital and span the length of the hospital stay and 30 days following the patient discharge, unless the Secretary determines another timeframe is more appropriate for purposes of the pilot. The Secretary must decide which patient assessment tool as well as which quality measures, for both episodes of care and post acute care, are to be used in the

Medicaid

FMAP (Section 1201)

Eliminates the provision of the Senate bill providing for a 100% federal matching rate just for Nebraska to cover the costs of newly eligible individuals to the Medicaid program. Substitutes in its place, federal Medicaid matching payments to all states, except expansion ones, for the costs of services to newly eligible individuals at the following rates: 100% in 2014, 2015, and 2016; 95% in 2017; 94% in 2018; 93% in 2019; and 90% thereafter. For expansion states, the state share of the costs of covering nonpregnant childless adults is reduced by 50% in 2014, 60% in 2015, 70% in 2016, 80% in 2017, 90% in 2018. Beginning in 2019 and thereafter, expansion states would revert to the same state share for newly eligible individuals as

non-expansion states.

Other Issues

Employer Mandate (Section 1003)

Changes the fee that an employer with more than 50 employees must pay per employee if health insurance is not offered to all for full time equivalents (FTEs) from \$750 to \$2000. However, for employers with 50 or more FTEs that do not choose to offer insurance, they are allowed to subtract the first 30 full time employees from the payment calculation (e.g., a firm with 51 workers that does not offer coverage will pay an amount equal to 51 minus 30, or 21 times the applicable per employee payment amount). The assessment for workers in a waiting

period is eliminated, although the 90-day limit on the length of any waiting period is retained

beginning in 2014.



**INDIANA ASSOCIATION OF HOMES
& SERVICES FOR THE AGING, INC.**

Assisting members in providing the highest quality of life for those they serve.

James M. Leich
President

**Exhibit I
Select Joint Commission on
Medicaid Oversight
September 21, 2010**

**Indiana Association of Homes and Services for the Aging
Testimony for the Select Joint Commission on Medicaid
Oversight
September 21, 2010**

**Information on the Quality Assessment, Nursing Home
Reimbursement, and Nursing Home Quality Assurance and
Improvement Initiatives**

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INDIANA ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

Medicaid Nursing Home Cuts Preceding the Implementation of the Quality Assessment

Indiana's Nursing Home Cuts – 2001

- Utilize the RUG-III version 5.12, 34-grouper resident classification system with new case mix indices based on recalculated supply components.
- The therapy change noted above (adds \$6.85 million);
- Move repairs and maintenance costs to the indirect care component. This was a public policy initiative that all parties agreed would be an improvement to the system. This will increase the indirect care median. (adds \$3.76 million)
- No longer pay for Medicare Parts A and B co-payments and deductibles. It is estimated that most of these costs would be recoverable on a facility's Medicare cost report as bad debt. However, subsequent Medicare changes mean that facilities will not be able to recoup all of these funds. (\$17.19 million savings)
- Reduce the “profit” incentive for facilities with costs below the median in the direct and indirect care components from 60% to 52%, while keeping the incentives at 60% for the administrative and capital components. (cuts \$5.32 million)
- Eliminate bed hold payments for therapeutic leave days for facilities with occupancy rates below 90%. (\$4.97 million savings)
- Reduce the inflation rate for setting medians to the HCFA (now CMS) SNF index minus 3.3%. The medians will still reflect the inflation represented in actual cost reports but the inflation forward into the next rate period will be reduced by this amount. (\$29.61 million savings) (scheduled as temporary for two years)
- A \$1 million adjustment to three ventilator units' rates since they are projected to lose \$2 million because Medicaid is concerned about accessibility of these services. The losses are directly attributable to the therapy changes and indicate that the RUG system does not effectively account for these services.

Indiana's Nursing Home Cuts – 2002

- Eliminate Medicare therapy costs included in the indirect care and administrative components
- Eliminate the profit add-on payment for direct care (scheduled a temporary for two years)
- Establish a minimum occupancy requirement of 65% for the direct care, indirect care, and administrative components
- Recalculate nursing facility rates every two years instead of every year

Indiana Nursing Home Cuts - 2002

- Make permanent the elimination of the profit add-on for direct care
- Make permanent the cut of 3.3% in the inflation rate used in calculating rates
- Return to rebasing annually

Indiana Nursing Home Cuts – 2003

- Move to an 85% occupancy standard but give facilities an opportunity to de-license beds
- Apply occupancy standard to only fixed costs (25% of direct care, 37% of indirect care, and 84% of administrative)

INDIANA ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

QA Nursing Home Reimbursement Changes

The Quality Assessment was authorized by statute in 2003. However, the state needed CMS approval of their state plan amendment for implementation of the QA. The state plan amendment was submitted in 2003 which established the starting point for the collection of the Assessment and the resulting reimbursement changes. It was not until April 2005 that CMS approved the plan amendment and the QA could be implemented retroactively to 2003.

The QA raises about \$100 million from facilities which is matched by the federal government bringing about \$170 million in federal dollars. Of this amount, 80% is to be used for nursing home reimbursement. The remaining 20% was made available to the state for other Medicaid purposes. The plan exempts hospital based skilled units, continuing care retirement communities registered with the Secretary of State's office, and the Indiana Veteran's Home from payment of the QA.

Use of the Enhanced Nursing Home Funding: During the first three years of the decade, nursing homes had received a series of cuts in reimbursement caused by state budget issues related to the recession. These cuts were to a system which was already seriously underfunded. By the time the QA was approved, many nursing homes were facing serious financial problems.

The QA was a means to obtain additional dollars to enhance reimbursement. However, Medicaid clearly intended that these funds would not come as simply an add-on to facility rates but would be distributed based on solid public policy objectives. The following describes the changes in the reimbursement system to utilize these additional funds:

- Increase the upper limit on direct care to allow more facilities to get their costs covered for this quality of care component which pays for nursing staff and medical supplies;
- Increase the upper limit on indirect care to allow more facilities to get their costs covered for this quality of life component which pays for social services, activities, food, housekeeping, and maintenance costs;
- Establish an add-on for facilities with special care units for persons with dementia. When the case mix system was first established, it became clear to IAHSA that the indices did not fully cover the time it took to appropriately care for persons with dementia in specialized settings. Medicaid agreed to conduct a time study where caregivers were given handheld devices to track the time it took to care for residents. The study clearly showed that the case mix system underfunded these services. However, until the QA there was no additional new

funding to address this issue. The QA provided an add-on per day for facilities with special care units.

- Establish the first pay for performance component of the rate system through the quality add-on. This add-on was based on the facilities survey report card score which is a weighted average of the last three annual surveys focusing on the 46 deficiencies most closely related to quality of care.
- Restore the inflation factor to the HCFA (CMS) SNF Index. Rates are based on cost reports from the previous years where costs are inflated forward to the next rate year to incorporate cost inflation. During the 2000 – 2003 rate cutting period, the inflation factor had been reduced by 3.3%, significantly limiting the percentage of a facility's costs covered by the Medicaid rate.
- Remove the administrator's salary from the owners and directors compensation limitation. This salary would now become part of the administration component and not capped. This should raise the administrative median and allow more of these costs to be covered.
- Increase the profit add-on efficiency incentive which had been cut significantly during the 2000-2003 period. This allows a facility to keep a portion of the difference between their costs and the median as an incentive for efficiency. The profit add-on is much less for direct care than for the other components.
- Increase the upper limit on administration and capital components. Capital had been historically underfunded that the increased proved helpful.

Retroactive Payments: As noted above, the state plan amendment was submitted in the third quarter of 2003 but CMS approval didn't come until the second quarter of 2005. State Plan Amendments are effective on the first day of the quarter in which they are submitted, even if CMS approval occurs much later. Once the state plan amendment was approved in 2005, retroactive payments were made to facilities back to 2003. These payments were based on cost reports from this period and reflected the changes noted above. The accountability for these funds was based on the cost reports and the policies on how the funding was to be distributed. Much of these funds were to reimburse expenditures already made – inflation, increases in upper limits, and the special care unit add-on.

IAHSA nonprofit members used these one-time funds to replenish reserves depleted by years of underfunding and cuts, to address deferred maintenance on their buildings, and get caught up on vendor payables.

INDIANA ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

Phase 2 Nursing Home Reimbursement Changes

CMS approved the state plan amendment for the Phase 2 reimbursement changes in May of 2010 and these changes were retroactive to January 1, 2010. The following is a summary of these changes:

- **Ventilator Add-on:** Increases the per diem add-on for Facilities with Ventilator units to \$11.50 from \$8.79. This change was designed to provide a greater incentive for facilities to develop ventilator units to serve this underserved population.
- **Special Care Unit Add-on:** Increases the per diem add-on for Facilities with Dementia Care units to \$12.00 from \$10.80 and annually determine the facilities that qualify. This change brought the add-on up to date regarding which facilities had such units and how many residents they served and to provide a greater incentive to serve persons with dementia in special care units.
- **Report Card Score Add-on:** Increases the per diem add-on for ISDH Report card Scores to \$5.75 for scores less than 83. Eliminates the per diem add-on for scores greater than 265. Scores from 83 to 265 receive an add-on equal to \$5.75 less \$.03125 for every point the score is greater than 83. The purpose of this change was to update the add-on to current report card scores, eliminate any add-on for the poorest performing facilities, and to increase the rate incentive for the best performing facilities.
- **Minimum Occupancy:** Increase the minimum occupancy standard from 85% to 90% for the Direct, Indirect and Administrative components of the rate. Facilities with 50 or fewer beds are exempted from this increase. This change was designed to improve efficiency and occupancy rates for Indiana facilities.
- **Administrative Component:** Reimburse administrative costs at 100% of the weighted median. This change increased the incentives for efficiency in this rate category which did not directly impact patient care.
- **Profit Add-on:** Year 1 - Facilities with a report card score less than 83 retain 100% of the add-on. The add-on will be eliminated for facilities with a score greater than 357. Facilities with scores from 83 to 357 receive a proportional add-on equal to 100% less .36232% for every point above 83. This change was designed to penalize facilities which sacrificed quality in order to increase profit by squeezing costs, particularly staffing costs.
- **Direct Care Maximum Annual Increase:** Beginning on the effective date of the rule, the Direct Care Component will no longer be subjected to a Maximum Annual Increase (MAI). This change was meant to address an unintended consequence of the rate cap established in FY 2008 which unfairly penalized facilities which were serving a sicker, more acute resident population.

- **Low Needs Residents:** Reduce the case mix indices for the lower 4 RUG categories to 65% of current indices for residents admitted to a facility after January 1, 2010. The indices are reduced to 55% in the second year and to 45% in the third year. This change was designed to provide incentives to move residents with limited needs to more appropriate community settings.

IAHSA and HOPE met extensively with the Division of Aging as the Phase 2 program was being developed. These discussions focused on the policy objectives of Phase 2 and the most effective means of achieving these objectives while limiting unintended consequences for nursing facilities.

Based on these changes, a number of changes were made. These are summarized in the following table.

	Original Proposal	Final Rule
Ventilator Add-On	\$382,787	\$382,787
Special Care Unit Add-On	\$3,613,273	\$3,613,273
Report Care Score Add-On	\$3,737,249	\$3,737,249
Minimum Occupancy	(\$18,364,163)	(\$10,124,243)
Administrative Component	(\$12,180,293)	(\$1,857,817)
Profit Add-On	(\$9,271,922)	(\$16,087,341)
Direct Care MAI	0	\$11,290,842
Low Needs Residents	(\$12,751,292)	0
Total	(\$44,834,421)	(\$9,045,301)

The following describes the changes made due to these discussions and their rationale:

- Minimum occupancy – the state’s original proposal was to increase the occupancy standard from 85% to 95%. The occupancy standard is used to adjust the cost per resident in the various cost categories for facilities with occupancy below the standard. For these facilities, their cost per resident day would be adjusted to assume the occupancy minimum, significantly lowering their cost per day and subsequent reimbursement. IAHSA and HOPE argued that 95% was too high a standard. The average occupancy rate in the state is around 85% and the change would have a significant impact on rates. In addition, it is difficult for facilities to maintain 95%+ occupancy given the rapid turnover in residents from the increasingly important Medicare residents. It would be particularly difficult for small facilities (50 beds or less) to maintain this rate since the change of only one resident significantly impacts occupancy. The final agreement was to raise the standard to 90% except for facilities of 50 beds or less which remained at 85%.
- The reduction of the occupancy level reduced the impact of moving to a price for the administrative component.
- Profit add-on – the purpose of this Phase 2 change was to penalize facilities which squeezed expenses (particularly staffing expenses) at the expense of quality. Facilities have been able to keep a portion of the difference between the median and their costs per day for the various cost components as an efficiency incentive.

This change said that you would progressively lose your ability to obtain this “profit” if being efficient meant quality suffered based on the facility’s survey report card score. Through our discussions with the state, we suggested making this penalty more significant.

- Direct care maximum annual increase – Several years ago, the nursing home profession agreed to a limit on individual facility rate increases proposed by FSSA Secretary Mitch Roob. The state was concerned about expenditure growth and the state budget. This cap had an unintended impact of limited rate growth based on increases in the facility’s case mix index. In other words, facilities would not receive credit for serving sicker residents which was a state policy goal. This change allowed these facilities to obtain this needed increase while continuing to limit growth in other rate components.
- Low needs residents – the state’s original proposal was to decrease the case mix index on residents in the four Resource Utilization Groups representing the lowest needs residents. This change did not impact residents with dementia or incontinence. The policy goal was to provide incentives for facilities to find home and community based placements for these residents. However, we were concerned that it would apply to residents who had been in the facilities for many years and would be very difficult to place in the community. They were admitted because no community placements or funding was available and now had not home or community support system to make this transition possible. Based on our discussions, the state agreed to apply this change only to residents admitted after the date of implementation (January 1, 2010).

Please contact Jim Leich, IAHSA President/CEO at 317-733-2380 or jimleich@iahsa.com if you have any questions.

INDIANA ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

Quality Initiatives in Indiana

The following reflect quality initiatives that have been undertaken in Indiana in recent years. Indiana is unusual in that the various stakeholders in nursing home quality have worked closely together in implementing various effective quality improvement initiatives. This strong working relationship between the Indiana State Department of Health, the three associations representing nursing homes, the federally funded Quality Improvement Organization HealthCare Excel, and consumer advocates has also lead to opportunities for additional federal funding for these initiatives.

In 2007, the nursing home associations noted that the scope and severity of survey findings had increased significantly between 2005 and 2007. We noted:

- Indiana had significantly higher percentages of G and above citations (actual harm), substandard quality of care, and immediate jeopardies (IJs) than surrounding states and the national averages.
- The number of Gs and above and IJs have skyrocketed over the last six to nine months.
- Significant disparities exist between survey districts on these statistics.
- Many of the immediate jeopardy citations appeared to be complaint surveys triggered by self-reported incidents.

A review of the actual IJ survey findings by the associations and found that many reflected significant care breakdowns and serious harm to residents. The associations initiated a meeting with Dr. Judith Monroe, State Health Commissioner, where we discussed the fact that there was little trend and data analysis currently being performed by ISDH on the survey process and that the data indicates that Indiana is an outlier. We felt it was important to determine the scope of the problem and to jointly work to address the issues.

This led to four related activities.

Monthly meetings between the three associations and ISDH: The three nursing home associations and ISDH initiate monthly meetings where we discussed survey issues, evaluated trends, and planned quality improvement activities. These meetings have been ongoing since early 2007 and have resulted in a strong working relationship and led to joint quality improvement efforts. ISDH also initiated quarterly meetings with consumer advocates and the state ombudsman.

ISDH initiated internal efforts to improve survey consistency across survey districts and between states.

ISDH Long Term Care Leadership Conferences: ISDH initiated a series of leadership conferences and activities around care issues identified by the survey process. These efforts brought in national speakers for large conferences and ongoing quality improvement activities. Subjects included pressure ulcers, falls, emergency preparedness, health care associated infections, incontinence, staffing, restraints, behavior problems, and Alzheimer's and dementia. These efforts are ongoing and have demonstrated significant impact in improving outcomes.

IAHSA and HOPE Quarterly Compliance Training: IAHSA and HOPE initiated a series of education and training events occurring quarterly since January of 2007. Each session looked at specific IJ citations and looked at what went wrong at these facilities and provided training on systems and quality improvement activities that could be utilized to prevent these types of events. Attendance at these events has typically been 150+.

Results: We have seen significant survey improvements based on these activities. In 2007, the percentage of facilities with IJs was 160% higher than the nation as a whole. By the second quarter of 2009 (most recent data), Indiana's percentage was below the national average. IJs declined from 107 in 2007 to only 31 in 2009. The percentage of facility surveys with IJ findings decreased from 4.3% in 2007 to 1.3% in 2009.

The pressure ulcer initiative involved facilities in long term quality improvement activities. Twenty percent of Indiana's nursing homes participated and participating facilities saw an almost 30% decline in pressure ulcers. The second phase of this effort is underway.

In addition, the percentage of facilities with surveys with no deficiencies in 2009 was 56% higher than the national average.

Other Initiatives:

Advancing Excellence in America's Nursing Homes: Advancing Excellence is a national voluntary effort initiated by CMS but sustained by voluntary efforts of coalitions of nursing homes, consumers, and nursing home staff at the state level. The goal is to promote and implement quality improvement efforts at the facility level. There are eight goal areas and facilities are encouraged to select several goal areas, set facility goals, implement quality improvement programs, and measure results. Tools, best practices, and evidence-based resources are available. In Indiana, IAHSA is the convener of the Local Area Network of Excellence (LANE) for Indiana.

35% of Indiana nursing homes are registered for Advancing Excellence but others utilized the materials. A total of 120 consumers are participating.

Indiana Culture Change Coalition: Culture change is about changing the culture of nursing homes to de-institutionalize the environment and operations of nursing homes. It

involves the transformation of nursing homes from the traditional model to a more resident-centered model.

Some characteristics of a culture change nursing home:

- Care is truly resident-centered: tailored to each resident to meet his/her needs as an individual, based on the individual's needs and preferences;
- Care is delivered by caregivers who have a meaningful and valued role in the residence;
- The environment is truly home-like, with residents having privacy of their own room and bathroom and the functioning of the nursing home - such as nurse stations, resident lounges and dining rooms - being small in scale and close in proximity to the residents' room;

Indiana has a very active group of nursing homes, consumer advocates, and ombudsman working on culture change. Our efforts have been recognized nationally and Indiana recently hosted the national Pioneer Network conference, the national culture change organization, attracting over a thousand attendees from across the country, including more than 100 from Indiana.

Critical Access Nursing Home Project: Due to the strong working relationship between stakeholders in Indiana, we have been asked to participate in a national effort in only three other states to address health care disparities in urban nursing homes. The focus will be on urban facilities in Lake County which will receive special assistance to improve.

HealthCare Excel: HealthCare Excel is the Quality Improvement Organization for Indiana. The QIOs are funded by CMS to implement quality improvement programs with a variety of health care organizations. Their focus in recent years is assisting nursing homes with reducing pressure ulcers and restraints, promoting culture change, and improving care transitions between various levels of care.

Indiana Nursing Homes, EMS, and Emergency Department Transfers of Care Task Force: The three nursing home associations have been working with a physician with IU and Regenstrief on an effort to improve the coordination in transfers of residents to and from the hospital and to reduce the unnecessary use of the emergency room by nursing home residents.

**Exhibit J
Select Joint Commission on
Medicaid Oversight
September 21, 2010**

Long-Term Care Challenges and Opportunities under the Patient Protection and Affordable Care Act of 2010

**Indiana General Assembly, Select Joint Commission on
Medicaid Oversight-September 21, 2010**



**Roger Auerbach
Auerbach Consulting, Inc.**



Selected LTC Provisions of the Patient Protection and Affordable Care Act of 2010

- ❖ CLASS
- ❖ Provisions Affecting Home and Community-Based Services (HCBS)
- ❖ Provisions Affecting Nursing Facility Residents and Consumers

Community Living Assistance Services and Supports (CLASS)

- ❖ New national, voluntary insurance program to help individuals plan and pay for LTC
- ❖ Financing options that allows people to choose the setting of their choice and delay or avoid impoverishment to qualify for Medicaid
- ❖ Private sector opportunity to address financing for LTC that helps government and individuals



CLASS: Who Can Participate?

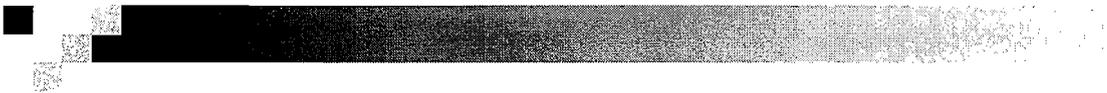
- ❖ Individuals 18 and older who are working enough to qualify for a quarter of Social Security (about \$1100 a year in 2010)
- ❖ Employers, including states, can participate by providing payroll deduction of premiums
- ❖ Premiums have yet to be determined, but younger enrollees would pay less

CLASS: What are the benefits?

- ❖ Cash benefit average likely between \$50-75 a day, indexed to CPI; must have paid premiums for 5 years
- ❖ Must have functional limitation; higher benefits for higher disability levels
- ❖ No lifetime benefit limit
- ❖ Plan required by October 2012

CLASS: What are some of the impacts on States?

- ❖ CLASS enrollees who qualify for Medicaid may retain a portion of CLASS benefits; states must establish links between CLASS and Medicaid systems to ensure primary payor rules
- ❖ Benefits do not affect eligibility for federal, state or local assistance programs
- ❖ States should assess intersection between LTC Partnership program, CLASS and Medicaid; must assure counseling and fiscal agent adequacy



Balancing Incentives Payment Program

- ❖ Incentives for states to offer home and community-based services (HCBS) as a LTC alternative to nursing homes
- ❖ Indiana could qualify for a 2% increase in federal Medicaid match for HCBS over a four year grant period (\$60 million) for new and expanded service offerings beginning 10/2011

Balancing Incentives (2)

- ❖ Indiana would commit to a target of 50% spending on Medicaid HCBS by 2015
- Agree to make structural changes:
 - ❖ No wrong door-Single entry point
 - ❖ Conflict-free case management services
 - ❖ Core standardized assessment instruments

Balancing Incentives (3)

Indiana could use the additional money to make structural changes to improve its system:

- ❖ Options counseling in hospitals and nursing facilities
- ❖ Expanded opportunities for consumer-directed care
- ❖ Optional presumptive eligibility for HCBS



Community First Choice Medicaid State Plan Option

- ❖ New option to provide choice of consumer-controlled personal attendant care services instead of institutional care
- ❖ Not a waiver service; must offer statewide to all Medicaid enrollees who need this service
- ❖ 6% increase in federal match beginning October 2011

Revised Medicaid HCBS State Plan Option

- ❖ States may offer the same HCBS to people as it does in a waiver
- ❖ It can target specific groups with distinct services, but must serve all medically eligible
- ❖ Income eligibility is up to 150% of Federal Poverty Level (\$1354/mo for a single person), but states can offer these services to those eligible for a waiver to 300% SSI (\$2022/mo)

Money Follows the Person Rebalancing Demonstration

- ❖ Program extended to October 2016 with an additional \$2.2 billion allocation
- ❖ Population served still must be Medicaid-enrolled, but only have to have facility stay of 90 days rather than 6 months
- ❖ New states can apply for the demonstration in January 2011; existing states like Indiana are eligible for more money

Spousal Impoverishment Protections

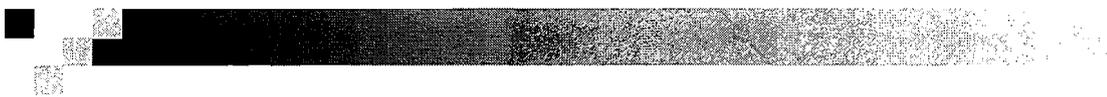
- ❖ Current law allows the spouse of a nursing facility resident with Medicaid to keep a certain level of income and assets to protect against impoverishment and allow him/her to live at home
- ❖ New law requires states to extend the same protections to spouses of individuals receiving Medicaid HCBS beginning January 2014

Community-Based Care Transitions Program

- ❖ Grants for hospitals with high readmission rates, in partnership with community organizations to deliver post-discharge interventions to “high risk” Medicare beneficiaries to prevent hospital readmission
- ❖ 5 year program, \$500 million starting 2011 with priority for Administration on Aging care transition grantees, medically underserved populations, small communities and rural areas

Nursing Homes: Information and Disclosure

- ❖ Nursing homes must disclose ownership and organizational structure, staffing data
- ❖ CMS Nursing Home Compare web site will include expanded staffing data, with explanations on how to interpret the data
- ❖ CMS web site to link with State web sites that have inspection reports, plans of correction, standardized complaint forms, information about complaint resolution, criminal violations



Nursing Home Quality Assurance/Improvement

- ❖ By 12/11 there will be a new quality assurance and performance improvement program; within a year later, facilities must submit plans to meet standards and implement best practices
- ❖ States must create a new process for facilities to challenge deficiencies (Independent Informal Dispute Resolution)
- ❖ New requirements for closure/relocation



Questions?

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December 2009

Striking a Balance:
*Recommendations to Improve
Indiana's Long-Term Care System*

Prepared for AARP Indiana

Executive Summary



Roger Auerbach
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Maximizing independence, quality and resources in long-term services.

EXECUTIVE SUMMARY

Striking a Balance: *Recommendations to Improve Indiana's Long-Term Care System*

AARP Indiana commissioned a study examining the status of Indiana's long-term care (LTC) system for older adults and adults with physical disabilities, analyzing "best practices" from other states' LTC systems and recommending actions to improve Indiana's system.

Over the past few years, AARP has conducted opinion research of its members and others in a variety of states and the findings are very similar regardless of the state: older adults want to be able to have a choice of what type of LTC services they receive and where those services are delivered. A huge majority wants to receive services in their own homes or in a residential setting such as an assisted living residence; very few want to receive services in a nursing facility. A recent AARP survey of Indiana AARP members and the general population confirmed that having choices of LTC services and settings should be Indiana's top or high priority. Eighty-four percent (84%) said that if they or a family member needed LTC services, they would prefer to receive those services at home or in a home-like setting such as an assisted living facility; only 2% said they would prefer care in a nursing facility.

Indiana's Current System and Opportunities for Change

The State of Indiana offers a variety of long-term services and supports aimed at keeping older adults healthy and independent. In addition to vital supports supplied by family, friends and community organizations, Indiana government has a wide range of programs that can support older adults needing long-term care services. However, Indiana spends a disproportionate percentage of its public LTC funds on nursing facility care (95% of its Medicaid LTC spending in Federal Fiscal Year 2007) with Tennessee being the only state that spent a smaller percentage on its Medicaid home and community-based services (HCBS) for older adults and adults with physical disabilities. Although Indiana has made good progress since 2003 with the passage and implementation of Senate Enrolled Act (SEA) 493, it still has a long way to go to achieve a system that provides the timely, affordable and quality LTC services that its residents prefer.

Access to Long-Term Services and Supports

Information and Assistance

Individuals and families need to have understandable, comprehensive, unbiased information about the wide range of long-term care services generally available in most areas across the United States. They need to know where to get this information and very often need the information on an urgent basis. For a state to meet the long-term care needs of its residents, it needs not only to supply this information in a helpful and supportive manner, but also ensure that people know that it is available and how to access it.

The Indiana Division of Aging (IDOA) and each area agency on aging (AAA) provide such information through web sites and toll-free telephone numbers. Indiana has developed a state-wide network of Aging and Disability Resource Centers (ADRCs) in its sixteen (16) AAAs that allows all people to get unbiased information about services choices and help with accessing those services. Since the AAAs assess the need for services for a variety of both state and federally-funded long-term care programs, the ADRCs, with adequate resources, should be able to assist people with both counseling about available options and streamlined access to services. However, determining program eligibility and starting needed services does not always begin quickly.

Counseling

Giving people comprehensive and helpful information at crucial times should be a goal for all state long-term care (LTC) systems. Most often, the need for information and counseling happens immediately preceding a hospital discharge or after discharge when an individual's condition is more stable. This is the point when people need to know where to go for unbiased information and have someone knowledgeable and available to help them explore available options. LTC options counseling is crucial and should be available in people's homes, hospitals and nursing facilities. It should include an assessment of people's capacities, where they may need help and how they can access that help. Where needed, it can also assist in making sure that successful contact is made with appropriate service providers.

Indiana's ADRCs are designed to provide an options counseling function for all who need it. However, this crucial function is available only to those who know about it. There is no organized statewide attempt to reach people at the time of hospital discharge or soon after a nursing home admission, two crucial times when options counseling is needed. While the required nursing home pre-admission screening process provides a mechanism for options counseling, funding is inadequate to devote proper time and attention to such counseling. Targeted options counseling for individuals and families in nursing homes and hospitals should be implemented statewide to give people the vital information they need at a crucial time.

Program Eligibility

Individuals and families requiring long-term services and supports need to know, on a timely basis, about programs and services available to them and whether they will be eligible. Unless people have that information, they cannot make an informed choice about what services and settings are the most appropriate to meet their needs. People often move to nursing facilities because they are unaware of the alternatives, cannot afford those alternatives without public financing or cannot piece together disjointed community services into a coherent plan that could help them remain at home.

Local AAAs can determine eligibility for and authorize both federally-funded Older Americans Act (OAA) and Social Services Block Grant services, as well as state-funded CHOICE services. They also perform assessments for *medical* eligibility for the Medicaid Aged and Disabled Waiver. However, *financial* eligibility for the Waiver is determined by the Division of Family Resources and people must wait a significant time before they are informed of their eligibility for Medicaid Waiver services. In a recent letter, the Division of Aging said it took just under 55 days on average for the AAAs to assess need and develop a care plan and for the state to approve that

plan. This is far better than the over 200 days average it took in June 2008, but still leaves people not knowing whether they will have access to these vital services. Of course, there are other factors that may also create delays in determining *financial* eligibility, also lengthening the total eligibility process. While these timeframes could still likely be shortened with additional efficiencies and resources, Indiana should consider allowing the AAAs to make “presumptive” eligibility decisions, as some other states have done, that would allow services to begin very quickly.

Opportunities to Improve Access

There are many positive actions Indiana has taken to improve access to its long-term services and supports system and specifically to its home and community-based services (HCBS) over the last number of years. However, despite this progress, Indiana still lags behind most states in the resources it dedicates to HCBS. A number of key actions need to be taken to dramatically improve this part of Indiana’s system.

1. Provide more base funding for the ADRCs

While it is very positive that the State has made a commitment to establish ADRCs state-wide, ADRCs need adequate and dedicated funding to properly serve an ever-increasing work load of people needing assistance with long-term care services. The additional funding will especially be necessary with continuing outreach efforts to give people vital information and counseling at crucial times. The Division of Aging should also be clear about the outcomes it wants the ADRCs to achieve. The Division has done a good job reporting data on timeliness of Medicaid assessments and costs of care plans. It should also collect and publicly report data in other areas of focus that relate to consumer satisfaction and provider quality.

2. Publicize and promote the ADRCs through a statewide media campaign and regional outreach

Hoosiers need to know about this valuable resource and also need regular reminders about the need to plan for their long-term care needs and those of their families. The Division of Aging should develop and implement a statewide publicity campaign to publicize and promote the ADRCs, the statewide toll-free telephone number and the statewide web site, which needs to be operational as soon as possible. The Division should also require the ADRCs to submit annual regional outreach plans and the Division should fund specific budgets to implement those plans.

3. Develop and implement a Targeted Options Counseling Program for people recently admitted to nursing facilities

While it is very positive that the ADRCs have developed and implemented options counseling programs, targeted counseling needs to be accomplished for those recently admitted to nursing facilities. This is the time when individuals and families need to know and understand all the options that are available and start planning for future needs. Many people understand they are only in the facility for short-term rehabilitation and then they will return home. Others however may not know that their need for services could be met in their homes and these individuals must be made aware of those options. This is why there must be a specific effort to counsel people at this crucial time.

4. Develop and Implement a Targeted Options Counseling Program for people being discharged from a hospital to a nursing facility

The Indianapolis area AAA, with Administration on Aging funding and in partnership with the Division of Aging and Wished Health Services, is developing and implementing a pilot program to work with hospital discharge planners and others to use interventions to avoid unnecessary long-term care placements and hospital readmissions. This project should be supported and carefully evaluated for replication. During this project, there should be a priority focus on appropriate timing for an initial counseling session about long-term care options.

5. Implement presumptive eligibility determination procedures for the Medicaid Waiver

The Division of Aging has placed great focus on making the Medicaid Waiver eligibility process more efficient. Both the Division and the AAAs have reduced the time needed to make such a determination. However, it still takes a long time for individuals and families to know whether they will be eligible for these services. The AAAs should be given the responsibility for making presumptive eligibility decisions, with appropriate safeguards, and immediately authorizing the start of Waiver services to people who are “at risk of institutionalization.” The Division could choose to narrowly define the circumstances where this presumptive eligibility could be allowed or could pilot presumptive eligibility in a few AAAs before statewide implementation. The Division could also require, as some states have, a statement by the individual and family that attests to their income and assets and notifies them that they could be liable for those service costs if found ineligible for Medicaid. As in other states, Indiana would proceed with a formal eligibility determination for the individual and would not be able to receive federal matching funds for people ultimately not found eligible. As detailed below, states using presumptive eligibility have found their error rates to be extremely small while cost-savings are significant by avoiding unnecessary nursing facility care.

– See page 25 for Successful State Models for Improving Access –

Financing Long-Term Services and Supports

State Budgeting

Many individuals and families have no real choice about where they receive needed long-term services and supports unless timely decisions are made about the availability of public financing. If people decide that they want to receive services in their own home, arranging for those services should proceed efficiently without professionals wondering if there are enough dollars in the home-delivered services budget to support that choice. A number of states have adopted “unified” or “global” budgets where both institutional and home and community-based services (HCBS) are combined in one budget and managed by one entity so that the question is whether there is money in the entire long-term care budget rather than whether there is enough money in any one specific line item.

Indiana has different budget lines for nursing facility services, waiver services, Medicaid State Plan services, and non-Medicaid services. However, these budgets are all tracked and managed by the Indiana Division of Aging (IDOA) and the IDOA produces financial reviews on a regular basis, keeping all stakeholders aware of budget issues.

Separate program budgeting is a challenge, however, at the local level where AAAs are trying to provide needed services across a variety of federal, state, and federal-state programs. Although it is very positive that the AAAs perform nursing facility pre-admission screening and make the initial level-of-care determination for Medicaid long-term care eligibility, the Division of Aging has been very clear that it wants Medicaid dollars utilized before state-only funding. While not surprising that the state would want to maximize federal funding, people needing care quite often need services prior to finding out whether they qualify for Medicaid. The AAAs, working directly with individuals and families, are in the best position to know which programs offer the best and most efficient services. The state should allow the AAAs to have maximum flexibility in arranging HCBS across various programs and funding streams. Indiana must also establish a clear policy that allows use of the state CHOICE program to fund services while Medicaid eligibility is being determined, and allow for a presumptive Medicaid eligibility determination.

Managed Care

Some states have chosen to adopt a managed care approach to long-term care service delivery. Most have chosen to contract with organizations to manage all or part of the Medicaid long-term care (LTC) benefit and some have worked to have the same entity manage both the primary and acute care Medicaid and Medicare benefit. The reasons for implementing these programs have been both for improved care delivery and cost savings. Although most of the managed LTC programs are still relatively small, there are a number of them that have grown enough to represent a large percentage of that state's population receiving Medicaid LTC benefits.

Indiana has not initiated any managed LTC programs. However, with the AAAs having such broad responsibility for developing care plans and contracting for and managing services, the state does have the basis to effectively expand both the authority and accountability of the AAAs for LTC management. For example, the Division of Aging could give each AAA a yearly budget for all long-term care enrollees in their region and set both financial and program outcomes in utilizing that funding. It could give incentives for exceeding financial and program goals such as keeping people healthy for as long as possible and avoiding unnecessary hospitalizations and nursing facility admissions. While this approach would not necessarily follow most of the other state managed LTC programs, Wisconsin did use its established local networks as a basis to implement its managed LTC program, FamilyCare.

Individualized Budgets

Many states have adopted systems of individualized budgets where Medicaid LTC enrollees have control over a specified amount of money allocated for their needs. Adequate safeguards have been adopted to ensure financial integrity and the health and well-being of the individuals in the programs. For many years, the Centers for Medicare and Medicaid Services (CMS) has facilitated the adoption of individualized budgeting and consumer self-direction of services in Medicaid waivers. Although it clearly still requires a good deal of work by a state to design and implement an individualized program, it is not difficult to obtain CMS approval.

Indiana offers a self-directed attendant care option for both its Aging and Disabled Waiver and its CHOICE program. In each of these programs, individuals receiving services can choose an attendant and direct their own care. A fiscal intermediary is hired to pay the personal attendants, file tax and labor reports and provide program participants with reports on how authorized units of

service have been spent and the amount of taxes paid. However, program participants do not have actual budgets of their own and the flexibility to decide whether to spend resources on other items they may need. This type of arrangement, prevalent in many states, allows individuals more independence to control their services within a fixed budget. In addition, Indiana's program is relatively small given the number of people receiving Medicaid waiver and CHOICE services. There is almost no information about the details of this program available on the Department of Aging web site.

Opportunities to Improve Indiana's Financing of the LTC System

Indiana has consolidated the management of its long-term care programs for older adults and adults with physical disabilities within its Division of Aging. The Division and its stakeholders are able to analyze trends and measure the impact of changes to the system. However, at the local level where the AAAs are working to meet individual care needs, there is a lack of flexibility to manage funding across programs that could delay getting the right services to people at the right time. In addition, there are a number of actions Indiana could pursue to make self-directed care more attractive to a larger group of individuals and families. Finally, public funds are not limitless and the state needs to develop an ongoing campaign to educate its residents, beginning in secondary school, that everyone will likely need long-term care in the future, and that people must plan for how they will pay for that care. Below are some actions that can improve the system.

1. The Division of Aging should give more flexibility to the AAAs to manage the LTC programs at the local level, with appropriate program rules and performance standards.

Currently, the ADRCs do a needs assessment for people seeking LTC services. The AAAs then begin an eligibility determination process for those who appear to qualify for public support. The result is that a person may qualify for a number of programs and services. Questions then arise about which program should be accessed to serve their needs. Once a person is assigned to a specific program, there is only one defined set of services and providers to meet their needs. Although it is important that services be allocated to specific budgets, systems should be developed to give more flexibility to meet people's needs across all programs for which they are eligible. For better customer service and improved outcomes, the Division should work with the AAAs to design a more flexible local system which could include a single allocation for all LTC enrollees, that meets defined standards and outcomes.

2. Indiana should make it clear that CHOICE funds are permitted to be utilized pending Medicaid eligibility.

The Division of Aging has been very clear that it wants the AAAs to utilize federal funds before using the state-funded CHOICE program and has made it a requirement that people cannot receive CHOICE services unless they first apply for Medicaid. While it is understandable why a state may decide to maximize a federally-financed program, it needs to use its state funds to ensure that people can receive appropriate HCBS to avoid unnecessary institutionalization or a decline in their health condition. Since it can take months for Medicaid Waiver approval, people needing services and public support should be able to access needed CHOICE services in the interim. State policy must be clear that this is an appropriate use of state funds.

3. The Self-Directed Attendant Care program should be enhanced to allow spouses and parents to serve as caregivers, with defined limits, provide people with individualized budgets, and deliver education and training programs for participants and caregivers.

While it is very positive that Indiana has established a self-directed attendant care program, it should promote its usage by establishing individualized budgets for people to manage and allowing a broader definition of who can be a caregiver. Most states that have established self-directed programs in recent years have utilized a model of individualized budgets based on assessment of need. The enrollees manage that budget with the assistance of a fiscal intermediary. Indiana already has contracted for fiscal intermediary services and this would not be difficult or expensive to design and implement. States have also delegated authority and responsibility to enrollees to choose their own care providers, including spouses and parents. Indiana could allow for these additional categories of caregivers under limited circumstances and where there is a shortage of qualified in-home workers. In addition, participants and caregivers in these programs need education and training in the principles of self-direction and how this program could benefit them. The results for these programs have demonstrated at least cost neutrality, satisfactory quality and high consumer satisfaction.

4. Indiana should develop and implement a LTC educational campaign targeted to all residents, beginning at the secondary school level and focused on younger working-age adults, that encourages planning for and financing their LTC needs.

This important educational campaign would focus on making people aware of their potential need for long-term care and encourage them to make a plan for how to pay for that care. One state entity should be designated to coordinate this effort. It would certainly involve the education system and also the insurance department, as facilitating the purchase of LTC insurance should be part of this campaign. Building on the work done with the Indiana Long Term Care Partnership Program, this is a long-term effort where Indiana could demonstrate its leadership.

– See page 33 for Successful State Models for Improved Financing –

Providing Needed LTC Services and Supports

Services are a vital component in any balanced long-term care (LTC) system. There must be a sufficient variety of available services offered and enough providers to deliver those services. In analyzing service adequacy, it is important to look at both publicly-funded services and privately-financed services.

Indiana has a broad array of services available under its Medicaid Aged and Disabled Waiver, the federally-funded Social Services Block Grant (SSBG), the federally-funded Older Americans Act and its state-funded CHOICE (Community and Home Options to Institutional Care for the Elderly and Disabled) program. However, it should be noted that there continues to be a significant waiting list for the CHOICE program and as of December 2009, there is now a waiting list for the Aged and Disabled Waiver.

Informal Caregivers

When discussing service providers, one should really start with the “informal” caregiver. This term usually refers to unpaid individuals such as family members, friends and neighbors who pro-

vide care and can live with the person cared for or live separately. There have been many studies over the past number of years which estimate both the number and economic value of family caregivers. AARP research estimates that Indiana had an estimated 1.1 million family caregivers at some time during 2007 at a total economic value of \$7.8 billion.

Most caregivers are employed and many provide care for many years. Not surprisingly, there are numerous studies that demonstrate the impact on caregivers' employment status and physical, mental and emotional health. Approximately two-thirds of working caregivers caring for someone over 65 reported having to rearrange work schedules, decrease their hours or take unpaid leave in order to meet caregiving responsibilities. Caregivers may also have an increased risk of cardiovascular disease among other adverse health outcomes and 40% of caregivers caring for people with dementia report depressive disorders.

It is vital for states to develop ways to support this valuable and much-needed caregiving resource. In Indiana, money is used for counseling support groups to assist caregivers in understanding issues that arise in the areas of health, nutrition, financial literacy, decision-making and problem-solving, and training and education that allows them to provide better care. There is also money for respite (relief) care, home modifications, assistive technologies, emergency response systems, and incontinence supplies.

Many state Medicaid programs are now also compensating family members for providing HCBS. They are utilizing both their Medicaid waivers and their "individualized budget" programs to accomplish this. This has proven a viable method for a number of states to increase the number of reliable in-home caregivers. In Indiana, individuals receiving services under the Medicaid Waiver or the CHOICE program may choose to participate in a Self-Directed Attendant Care program where they have the right to choose their own attendants including family members, but not spouses or parents and do not control an individual budget.

It is difficult to assess whether Indiana has an adequate supply of providers of all types of services. Provider supply was not an issue noted as problematic by Indiana state and local officials or consumer advocates. However, one can assume that there are provider supply issues for certain services in specific areas of the state due to a variety of pay rates and other issues. However, with the overall population aging and the demand for HCBS growing, provider supply is an issue worthy of additional focus in the near term.

Workforce Initiatives

The strategies employed by states to ensure an adequate supply of trained workers are diverse, but can be grouped into broad areas: improving wages and benefits; improving the work environment; reforming the training and credentialing systems; and engaging the public workforce and education systems in recruitment and training. Indiana does not appear to have a comprehensive workforce strategy to support the LTC needs of older adults and adults with physical disabilities.

Housing

Housing is a serious issue for states that seek a balanced LTC system for a variety of reasons. Many individuals who need care and want to remain at home often need their home modified after a fall, stroke or progressive illness, but either do not have the resources to make these modifications or cannot get permission from a landlord to do so. In Indiana, the Medicaid Aged and Disabled Waiver will pay for environmental modifications if necessary to ensure the health, welfare and safety

of the individual and without which the individual would require institutionalization. Maintenance is limited to \$500 a year and there is a \$15,000 lifetime cap on these modifications. The CHOICE program has a similar benefit without a lifetime cap, with similar requirements to avoid institutionalization, and will finance modifications in rental homes or apartments with permission of the landlord.

Many state Medicaid programs also pay for “housing with services” programs such as assisted living and adult foster care. While states vary in how they define these services and what they will pay for, they are all similar in that they have a community-based group housing arrangement where long-term services and supports are delivered to those who need them. Indiana’s Aged and Disabled Waiver covers both adult foster care and assisted living services.

Additionally, state services programs have been working with their state housing counterparts to address these issues in a variety of ways including new construction, rehabilitation, and rent subsidies with preferences for older adults and individuals with disabilities. The Indiana Housing and Community Development Authority, in partnership with the Indiana Division of Aging, implemented a new program called Home Again targeted to people moving out of institutions which makes existing subsidized housing units accessible and even more affordable. This is a good example of a state partnership which should become the basis for other affordable, accessible housing development targeted to older adults and individuals with disabilities.

Opportunities to Improve Indiana’s LTC Services and Supports System

1. Indiana should develop and implement a variety of methods to encourage and sustain family caregivers such as providing more opportunities for respite care, education, training and other forms of health and emotional support.

Indiana has made progress in expanding the amount and type of HCBS. However, the state needs to put caregiver support higher on its priority list. No one denies how vital families are in supporting their loved ones who need long-term services and supports. One of the major reasons individuals are forced to leave their homes to get needed services is because there is not sufficient family support. Those family caregivers need to be encouraged to keep supporting their loved ones and know that their unpaid work is being acknowledged and supported. Education, training and time off from caregiving are all proven methods to accomplish this goal. A number of localities across the country are also focusing on the health and well-being of the caregiver. Indiana should assess caregiver needs and develop programs to address them.

2. Indiana should designate a lead entity to take responsibility for recruiting and training needed LTC workers. AAAs should be charged with identifying gaps in services and be responsible for provider recruitment and retention, but the state must take responsibility to develop a sufficient, quality workforce to meet the state’s LTC needs now and in the future.

Although worker and provider shortages were not major issues identified in this study, there was no clear understanding what entity had responsibility for provider recruitment and retention. While some acknowledged that identifying gaps in services was an AAA responsibility, there was no clear authority or responsibility given for local provider recruitment and retention. The AAAs are in the best position to know about gaps and shortages and, with appropriate resources, should be clearly given responsibility for provider sufficiency. However, the state must have a coordinated LTC workforce strategy, espe-

cially in the recruitment and training of in-home workers, given projected demographic changes. Workforce and education entities must work with human services entities to develop and implement that strategy.

3. Indiana must focus its workforce strategy on recruiting and retaining in-home care providers to meet the need for services where people want them. This must include a focus on increased pay and benefits as well as education and training.

The Indiana Division of Disability and Rehabilitative Services (DDARS) has developed and implemented a solid program to develop the direct support professional workforce that serves its clients and others. While there was no evaluative work discovered on the outcomes of this program, this is exactly the type of program that needs to be considered for other parts of the workforce. Consumers want quality services and are willing to pay reasonable amount for those services. A trained and well-compensated in-home workforce not only supports the individual needing care at home, but also supports family caregiving. Developing and implementing a thoughtful strategy is vital for the sustainability of a LTC system into the future.

4. Affordable, accessible housing for individuals with disabilities and those needing long-term services and supports must be a priority for the state. A lead entity must be designated and given the responsibility of ensuring that a specific number of units are developed.

The Indiana Housing and Community Development Authority, in partnership with the Division of Aging, appears to have developed a solid program of subsidized financing an accessibility modification through its Home Again program. This appears to be a good concept which is being implemented, but much more needs to be done. Whether new units are developed and/or existing ones are modified, there needs to be a coordinated focus on “housing with services” models. There are many ways to develop these models, but they all begin with affordable, accessible housing where people can receive the care services they need. Assisted living is just one model. Indiana needs to research and implement models that work for its state and give one entity responsibility for design and development.

– See page 43 for Successful State Models for Improving Needed Services –

Ensuring Quality LTC Services

Everyone wants to have quality LTC services. However, there are no absolute standards by which all agree on what constitutes quality. The Centers for Medicare and Medicaid Services (CMS) has been focused on quality in nursing homes for decades and has more recently been focused on quality in HCBS. There are clearly-defined federal laws and regulations that states enforce for nursing home quality. However, states continue to have great latitude to design their quality assurance (QA) program for HCBS. CMS has adopted an HCBS “quality framework” for states to follow for the quality management of its quality assurance and improvement program. It also requires that a quality management strategy be defined in a Waiver application.

In reviewing Indiana’s Aged and Disabled Waiver application, Indiana has developed a credible quality management strategy, on paper, for the operation of its Waiver program. It has identified areas that it will monitor, how it will monitor and methods it will utilize to remediate issues.

has assigned specific roles and responsibilities for the Office of Medicaid Policy and Planning, the Division of Aging, the AAAs and its outside contractors. It is less clear how the system improvement process will work, but there are entities assigned to review and analyze data. One could assume that improvements would be made based on those evaluations.

The Division recently reported that it had begun field testing a plan of care review and a consumer outcomes and satisfaction survey for the Aged and Disabled Waiver. These activities should reveal data about whether individuals' plans of care are meeting their identified needs and whether program participants are satisfied with their services. This is part of the QA management strategy outlined in the waiver. In addition, the Division will begin surveying non-licensed providers on a random basis that have not been surveyed in the last three years. Again, this is part of the QA strategy outlined in the waiver.

Nursing Facility Quality

While all states take responsibility, and are funded, to monitor and enforce federal law and regulation applicable to nursing facility quality, it should be noted that Indiana is one of a few, but growing number of states that have worked to structure their payment system to account for quality. The current reimbursement system, which is in the process of being changed, rewards all facilities based on quality from \$1.50-\$3.00 per resident day. The proposed system would eliminate a quality payment for those facilities scoring in the bottom quartile and would increase the payment in the top quartile from \$3.00 to \$5.75. This would clearly make a bigger distinction in paying for quality. The proposed new system would also eliminate the "profit add-on" for facilities in the bottom quartile, maintain the benefit for the top quartile and reward others on a graduated basis. Indiana is planning for further revision to take effect in 2011 based on a series of measures modeled on Minnesota and Iowa's current programs. This will continue its strategy to clarify its expectations for nursing facility quality.

Opportunities to Improve the Quality of Indiana's LTC System

1. Indiana must define specific measures of HCBS quality related to the health, wellness and satisfaction of the program participant.

Indiana has done good work defining a quality assurance management strategy for participants in its Medicaid Waiver program. It clearly defines expectations and roles and responsibilities and is implementing a monitoring system that could ensure quality systems. However, it needs to adopt specific quality measures as they relate to the program participant. First, these need to include standards for consumer satisfaction, especially as it relates to supporting the independence of the individual and the dignity and respect each deserves in how services are delivered. Additionally, certain measures such as avoidable hospitalizations and nursing facility admissions, and emergency room visits ought to be considered.

2. The Division of Aging should ensure that appropriate consumer stakeholders are involved in designing the quality measures and quality incentive program utilized to reward nursing facility quality.

State and local consumer advocacy organizations, AAAs, LTC ombudsman program staff and other consumer advocates have direct experience in assessing quality and advocating for improvements in nursing home care. As such, they should be included in a formal and

ongoing process to monitor nursing facility quality and make recommendations for continued improvements.

CONCLUSION

Indiana has made good progress developing a long-term care system that gives more people choices of services and setting with the passage and implementation of SEA 493 of 2003. However, it still ranks near the bottom of all states in the percentage of public resources it spends on home and community-based services, those services people want the most and are most cost-effective, compared to money spent on nursing facilities. Indiana has developed a good base from which it needs to continue to build in order to meet the current and projected demand for HCBS. As outlined in this paper, there are many steps it could take to improve its ability to deliver the quality, cost-effective home and community-based services that Hoosiers want and deserve.

Indiana needs to make sure that its residents understand their individual and family requirements for future long-term care services and how to plan and pay for them. It needs to ensure that people needing long-term care have comprehensive, understandable and unbiased information at crucial times and places, and counseling when needed, to make proper choices for themselves and their families. Indiana must make rapid decisions on eligibility for public resources so that families have meaningful choices to address their long-term care needs. It should give its AAAs the resources and funding flexibility at the local level to address a growing population of individuals needing counseling and services. Indiana must support family caregiving in new and expanding ways and ensure there are an adequate number of qualified paid caregivers, especially those who deliver services at home. It needs to give clear authority and direction to its AAAs in developing sufficient provider resources and delivering quality, cost-effective services options. It also needs to ensure that services are delivered according to individual needs and desires and that they reach desired consumer and system outcomes. Reaching these goals will take a focused effort, but with the commitment of consumer advocates, individuals and families, providers, government and non-profit organizations, Indiana can meet the needs and preferences of its residents for quality, affordable long-term care services and supports.



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Testimony before the Select Joint Commission for Medicaid Oversight September 21, 2010

Submitted by Robyn Grant
United Senior Action

Exhibit L
Select Joint Commission on
Medicaid Oversight
September 21, 2010

I am Robyn Grant, Long Term Care Policy Director, with United Senior Action of Indiana, a statewide senior citizens advocacy organization. I want to thank Chairman Crawford and members of the Commission for their interest in the issue of nursing home care in Indiana and for this opportunity to speak today about the terrible problem of understaffing in our state's nursing facilities.

I'm sure that you are all aware of the articles in the *Indianapolis Star* that revealed that the staffing levels in our nursing homes are appallingly low. You've probably also seen the articles that highlighted the poor quality of our nursing home care.

It is no surprise that our care is poor and our staffing is low because the two are inextricably linked.

RELATIONSHIP BETWEEN STAFFING LEVELS AND QUALITY OF CARE

Countless studies have shown that staffing levels in nursing homes are linked to quality care. In fact, a major study conducted by the Centers for Medicare and Medicaid Services (CMS) provided strong and compelling evidence of the relationship between staffing ratios and quality of nursing home care and concluded that higher staffing levels improve the quality of care.¹

RECOMMENDED STAFFING MINIMUMS

The federal government study found that without at least 2.8 hours a day of nurse aide care and 1.3 hours of licensed nurse care, including at least .75 hours of care by Registered Nurses (RNs), residents are much more likely to experience poor outcomes. This is a total of 4.1 hours of direct care for long-stay residents.² The study also

¹“Appropriateness of Minimum Staffing Ratios in Nursing Homes: Phase II Final Report,” Centers for Medicare & Medicaid Services, December 2001.

² Nursing Home Staffing: A Guide for Residents, Families, Friends, and Caregivers. The National Consumer Voice for Quality Long-Term Care.

determined that if residents receive less than 2.0 hours of nursing assistant time per day, they are at serious risk.³

In Indiana, the most recently audited cost report data show that nursing homes only provide an average of 2.94 hours of direct care nursing hours per resident per day, and the average amount of certified nursing assistant time per resident is 1.72.⁴

Of course, there are good nursing homes that staff above these levels. But our average number of nursing hours are dangerously below the recommended level of 4.1 nursing hours per resident per day.

THE EFFECTS OF UNDERSTAFFING ON RESIDENTS

The effects of inadequate numbers of nursing staff on residents are physically and emotionally devastating.

1. Residents experience egregious care, neglect and abuse that result in:

- Horrendous and painful pressure sores
- Contractures
- Malnutrition
- Dehydration
- Infections
- Incontinence
- Avoidable declines in functioning
- Loss of mobility
- Abnormal weight loss
- Preventable hospitalizations
- Avoidable pain and suffering
- Injuries – including hip fractures - from falls due to lack of supervision
- Actual harm or immediate jeopardy (a situation in which residents have suffered or are likely to suffer serious injury, impairment, or death). In Indiana, 44.66% of the state's nursing facilities were cited for causing residents actual harm or immediate jeopardy in 2008.⁵
- Death

2. Residents experience avoidable declines and decreased quality of care due to high staff turnover rates. Work overload often forces nursing staff to leave their positions due to stress and an inability to perform their job adequately. Nationally, the turnover rate for nursing assistants is 64%. In Indiana it is an astounding 98.1%.⁶

³ Appropriateness of Minimum Nursing Staff Ratios in Nursing Homes. Phase I Report. Health Care Financing Administration. July 2000.

⁴ Nursing Facility Statistical Report, Section 2. Myers & Stauffer. 7/19/10. Note: direct care nursing staff includes the amount of time from each type of nursing staff, excluding the Director of Nursing whose job is administrative in nature.

⁵ Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2003-2008. Charlene Harington, Ph.D. et al. p.81.

⁶ Study of Turnover and Training in Indiana's Long-term Care Facilities. Prepared by the University of Indianapolis Center on Aging and Community for the Indiana State Department of Health. October, 19, 2009.

Turnover reduces quality of care because:

- Caregiving relationships between staff and residents are disrupted, affecting staff's ability to recognize resident decline and consistently address care needs⁷
- Newer, less experienced workers are brought in
- Residents are cared for in a rushed, unsafe manner
- Opportunities for mistakes increase (over 800,000 preventable medication errors occur in long-term care settings every year⁸)

3. Residents suffer emotionally and psychologically due to:

- Lack of ongoing, trusted and valued relationships stemming from staff turnover
- Unmet emotional needs and sense of isolation because staff don't have time to connect with or even talk to residents
- Dehumanizing and appalling lack of dignity when residents have to sit or lie in their own waste for hours on end

REAL HARM TO REAL PEOPLE

Understaffing results in real harm to real people. The following stories illustrate the impact that lack of staff had on three Hoosiers.

Mrs. C.

Mrs. C. was alert and oriented throughout her nursing home stay. When she entered the nursing home she was able to walk with assistance and was continent, but needed help getting to the bathroom and getting on and off the toilet.

From the very beginning, understaffing was a problem for Mrs. C. Here's what she experienced:

- When Mrs. C. needed help, it would take staff 45 minutes or even an hour to respond when she pressed her call bell. At times no one came at all.
- Instead of replacing underpads soiled with feces and/or urine, staff would put another underpad on top of the old one because it took less time.
- When Mrs. C.'s daughter asked nursing staff to give her mother a shower, she was told, "We don't have time. We'll give it to her later." Later never came. At best Mrs. C. got one shower a week.
- Because there were too few staff on the day shift, certified nursing assistants (CNAs) on the night shift would wake Mrs. C. up at 4:30 am, which was not Mrs. C.'s usual time to wake up. Staff would then dress her and take her to the dining

⁷ "A Case for Consistent Assignment," *Provider Magazine*, June 2006

⁸ National Academies press release, July 20, 2006

room, where she would sit for hours - without as much as a cup of coffee - until breakfast was served around 7:00 am.

- Mrs. C. was not taken to the bathroom when she needed to go. Mrs. C. told her family that when she had to go to the bathroom, nursing staff told her to “go in her brief,” and they would change it later when they had time.
- Mrs. C’s daughter reported that she usually observed only two - three CNAs for approximately 48 residents during the day and one aide at night.

This chronic lack of enough staff had a profound effect on Mrs. C.

- She lost the ability to walk even with assistance because staff didn’t have time to ambulate her on a regular basis. Her family was told that the restorative aides, whose job it was to provide assistance with ambulation, were needed on the floor instead. Mrs. C. became more and more bedfast and chairfast.
- When Mrs. C was in her wheelchair and asked to be put in bed because her back was hurting her or she was tired, staff didn’t have the time to do so. As a result, Mrs. C. would frequently have to spend all day in her wheelchair in pain or discomfort. Often she was in her wheelchair from 5:00 am until 6:00 pm.
- Mrs. C’s family reported that they found her wet from urine almost every time they came to visit. Mrs. C. herself said that she was left wet for long periods of time. The family had been told there would be a toileting program for Mrs. C., but that never materialized. Mrs. C. became incontinent.
- Mrs. C was placed on a pureed diet – not because she had swallowing issues – but because there weren’t enough staff to cut up her food.
- Heartbreakingly, Mrs. C.’s family observed that as she lost her dignity, she lost her spirit.

Mr. G

Mr. G., who had dementia, entered a nursing home after a major stroke left him paralyzed on the left side. Mr. G. was completely dependent on staff for all his needs. He required assistance with dressing, bathing, and eating. He also needed to be kept clean and dry due to incontinence, and to be repositioned regularly and to have his skin inspected on a regular basis because he was identified as being at risk of pressure ulcers.

Because Mr. G. could not communicate his needs to staff, his daughter visited frequently so she could monitor his care. Below are examples of understaffing that she experienced:

- When Mr. G.'s daughter found her father in need of assistance, she would try to find a nurse or an aide to help him. She would look for 30 - 45 minutes without finding anyone who was available to help.
- Because Mr. G. was a big man, it took two staff members to move him. When his daughter came in and discovered him wet, she would go to the nurse's station to ask staff to clean him up and change him. However, the staff person at the nurse's station would often tell her that there weren't two staff people available, so her father couldn't be changed.
- Staff constantly told Mr. G's daughter, "We got behind. We don't have enough people."

This ongoing and constant lack of staff severely affected Mr. G.

- He was left in urine and feces. His daughter said her father stank. On one occasion when she walked onto her father's unit, she could hear him yelling from all the way down the hall. The door to his room had been shut. She found him slouched over in bed, unable to right himself, with both feces and vomit on him. When Mr. G.'s daughter asked why the door had been shut, staff told her it was because they didn't want to hear him scream. His daughter had no idea how long her father had been in that condition prior to her arrival.
- Mr. G was hospitalized for dehydration and acute renal failure.
- The oral care Mr. G. received at the nursing home was so poor that the emergency room nurse noted it in the records at the time of his hospitalization.
- Mr. G., who had been admitted to the nursing home with only one very small Stage 1 pressure ulcer, developed **at least 9 new pressure ulcers**, 6 of which were not even found until they were either Stage 4 - the worst stage possible - or necrotic. One of the nurses actually admitted that nurses and CNAs did not have enough time to do all the turning, repositioning and skin inspections he required.

Mr. S.

Mr. S.' daughter wrote the following account:

"We trusted that Dad's needs would be met in an Alzheimer's unit of a Medicaid-certified nursing home where he could be safe and closely monitored. However, we soon realized during daily visits that the woefully inadequate staffing levels and his dementia made him extremely vulnerable to neglect. My mother, sister and I observed the following situations:

- *CNAs provided the majority of daily hands-on care. During the evening shift, typically only 2 CNAs were assigned to care for a total of 25-30 residents, a ratio of 12-15 residents for each aide..... sometimes only one aide worked the evening shift. Because I was at my job during the day, I cannot comment on the number of staff present during the day shifts. ... Weekend staffing was even worse.*
- *Usually there was only one nurse during each 12-hour shift to dispense medications and respond to medical needs; often a QMA... was on duty instead of a nurse.*
- *There were not enough CNAs to feed everyone at the same time. Therefore a family member helped my father with nearly every noon and evening meal; otherwise his food would become cold, or it would end up on the floor when he fed himself. Often residents waited unsupervised in the dining room for long periods of time before their meals arrived, and as a result, became agitated, disruptive, and tired.*
- *It was not unusual for Dad to wait 30 minutes or more for assistance to the bathroom or to be placed in bed. Because he required two aides to transfer him (he was wheelchair bound and unable to bear his own weight), it could take even longer for two aides to become available. Before admission, we were told that residents receive assistance every two hours; however in reality, that was humanly impossible with the staff-to-resident ratio....*
- *Dad's personal grooming and dental care were not provided on a regular basis. His hands were never washed prior to mealtime. Personal hygiene was compromised, because the CNAs didn't have enough time to cleanse him thoroughly after bathroom visits and incontinence episodes.*
- *He experienced muscles contractures in his arms and legs, because he did not receive restorative therapy on a frequent basis.*
- *He developed painful pressure sores on his buttocks due to lack of movement.*
- *He was not properly monitored and experienced several falls, which required emergency trips to the hospital to examine him for injuries.*
- *Staff did not check on Dad in his room frequently throughout the day. Sometimes he was in acute pain and distress for long periods of time without anyone noticing until I arrived. I wondered if he would have received any medications for his pain if I hadn't been there.*
- *Poorly trained and insufficient CNAs put Dad and the other dementia residents at risk of injury to themselves and others when behavioral problems occurred.*
- *Nurses and CNAs were forced to decide on a daily basis which resident to ignore so that they could attend to another resident's needs....*

This is my father's own story, but it could be anyone's story. All of these problems are a direct or indirect result of understaffing."

Sadly there are many, many more stories like this.

RECOMMENDATIONS

If the state of Indiana wants to improve the quality of its nursing home care, we must increase our staffing levels by requiring minimum staffing standards, and base those standards on what the evidence shows will prevent poor resident outcomes. As stated earlier those evidence-based standards are as follows:

- 2.8 hours of certified nursing assistant time per resident per day
- 1.3 hours of licensed nurse time per resident per day, including at least 0.75 hours of RN time⁹

In addition, nurse experts recommend: 1) staffing at these levels every day (and not averaging over a certain period of time); 2) adjusting staffing levels upward based on resident need and acuity level; and 3) spreading the hours for certified nursing assistants over three shifts so there is a countable ratio of nursing assistants to residents on the day, evening and night shifts.

These staffing levels could be implemented incrementally over a five-year period.

CONCLUSION

Study after study indicates that staffing is a key indicator for nursing home quality. Yet Indiana nursing homes are not required to have minimum staffing levels. As a result, too many nursing home residents – oftentimes our most frail and vulnerable citizens – suffer needlessly, not from the conditions they came in with, or the naturally occurring frailties of old age, but from the poor care they receive in the nursing home when there are not enough staff to attend to even their most basic needs.

Staffing standards are not a silver bullet. There are certainly other factors that play an important role in achieving quality, like sufficient training, good supervision, and consistent assignment, to name just a few. But we can't even begin to provide quality care if there aren't enough CNAs and nurses on the floor to provide that care.

If we are serious about improving nursing home care in our state, we must require minimum staffing levels. Without such a mandate, there will continue to be nursing homes that cut their staffing levels to the point where residents are harmed in order to increase profits. Good nursing homes don't need minimum standards – they always have and always will have levels high enough to provide quality care. Unfortunately, other nursing homes will only do the bare minimum. If we want to protect **all** Indiana nursing

⁹ Licensed nurse time includes only those nurses providing direct care. This would exclude the Director of Nursing, the Assistant Director of Nursing, and any training personnel.

home residents, we must ensure that the bare minimum is enough to prevent poor outcomes, indignity and suffering.

United Senior Action thanks you again for this opportunity to provide testimony on this important issue.



September 21, 2010

FSSA Secretary Anne Murphy

HYBRID UPDATE





Number of Hoosiers Receiving Benefits Increases Since 2002

With the economic downturn, FSSA program enrollment has increased by 39% since 2005.

Enrollees by Program (as of June 30 annually)

	2002	2003	2004	2005	2006	2007	2008	2009	2010
Medicaid*	756,904	777,170	822,344	847,625	857,599	877,933	920,332	1,017,571	1,088,637
Food Stamp Recipients	428,089	487,197	532,402	557,206	575,602	586,156	639,470	721,155	828,604
Food Stamp Households	180,457	205,208	228,218	241,177	249,914	253,443	273,876	306,562	355,626
TANF	151,269	146,783	148,788	141,055	135,206	117,311	122,743	119,912	104,004
Number of Hoosiers enrolled in at least one program**	776,121	810,694	866,103	899,701	922,434	943,343	1,013,429	1,114,950	1,250,774

* Medicaid increase in 2008 & 2009 affected by addition of HIP program (18,903 members in 2008 & 50,115 members in 2009).

** Program totals are comprised of only unique cases, and not a sum of individual program data.

Source: "IN diana Fact" report; ICES



SFY 2010 Enrollment

FSSA saw over a 12% enrollment increase, which compares to a 2% enrollment increase from SFY2006 – SFY2007.

Enrollees by Program (as of the end of the month)			
Month	Medicaid*	Food Stamps Recipients	Hoosiers enrolled in at least one program**
June 2009	1,017,571	721,155	1,114,950
August	1,034,343	751,530	1,170,844
October	1,045,097	766,230	1,101,441
December	1,054,276	796,662	1,206,594
February	1,066,346	805,572	1,220,026
April	1,076,522	811,061	1,232,061
June 2010	1,088,637	828,604	1,250,774

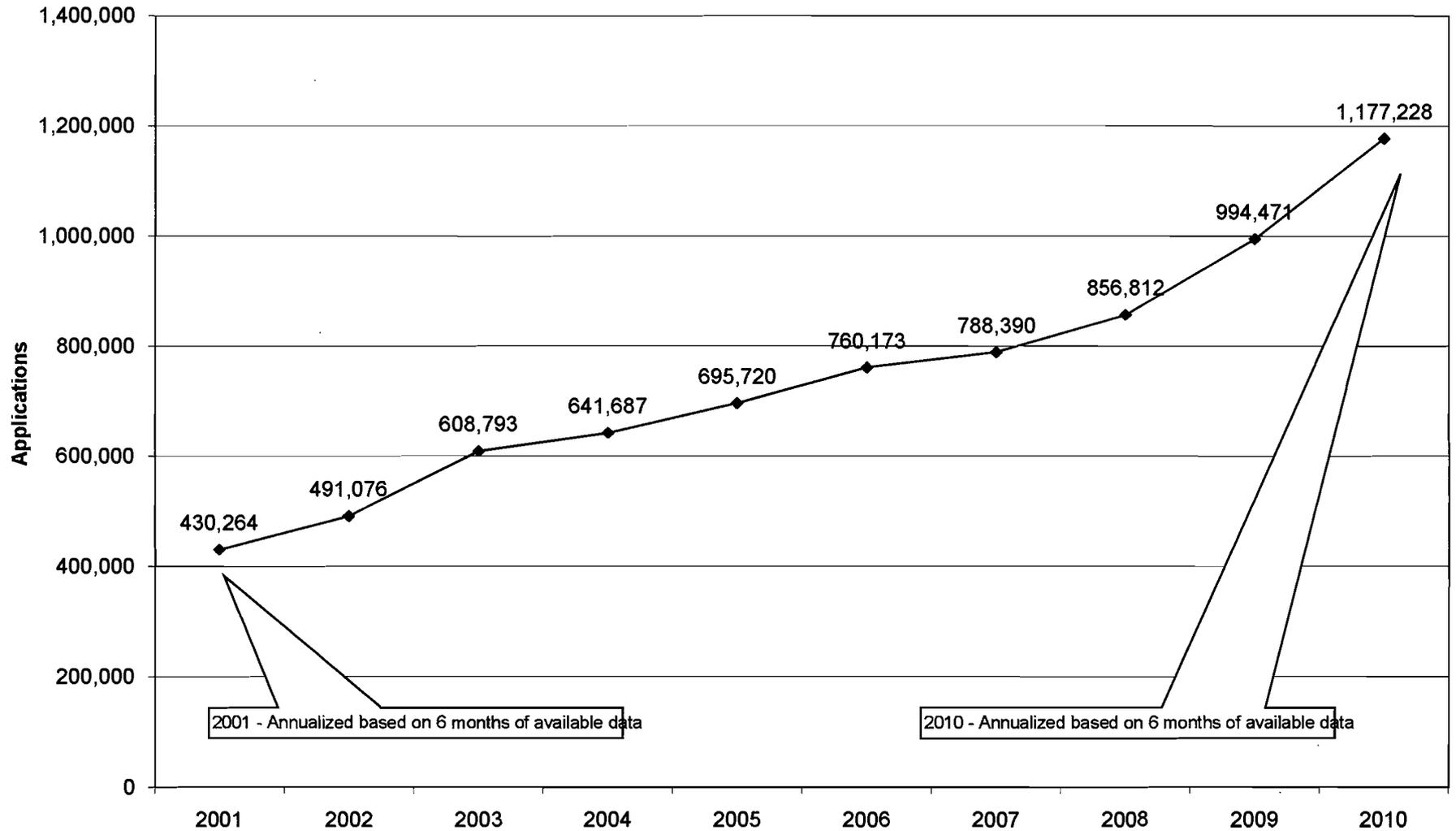
*Medicaid numbers do not include retroactive coverage, as this report is compiled from ICES data at the end of the month. Actual Medicaid enrollment is slightly higher.

** Program totals are comprised of only unique cases, and not a sum of individual program data.

Source: ICES

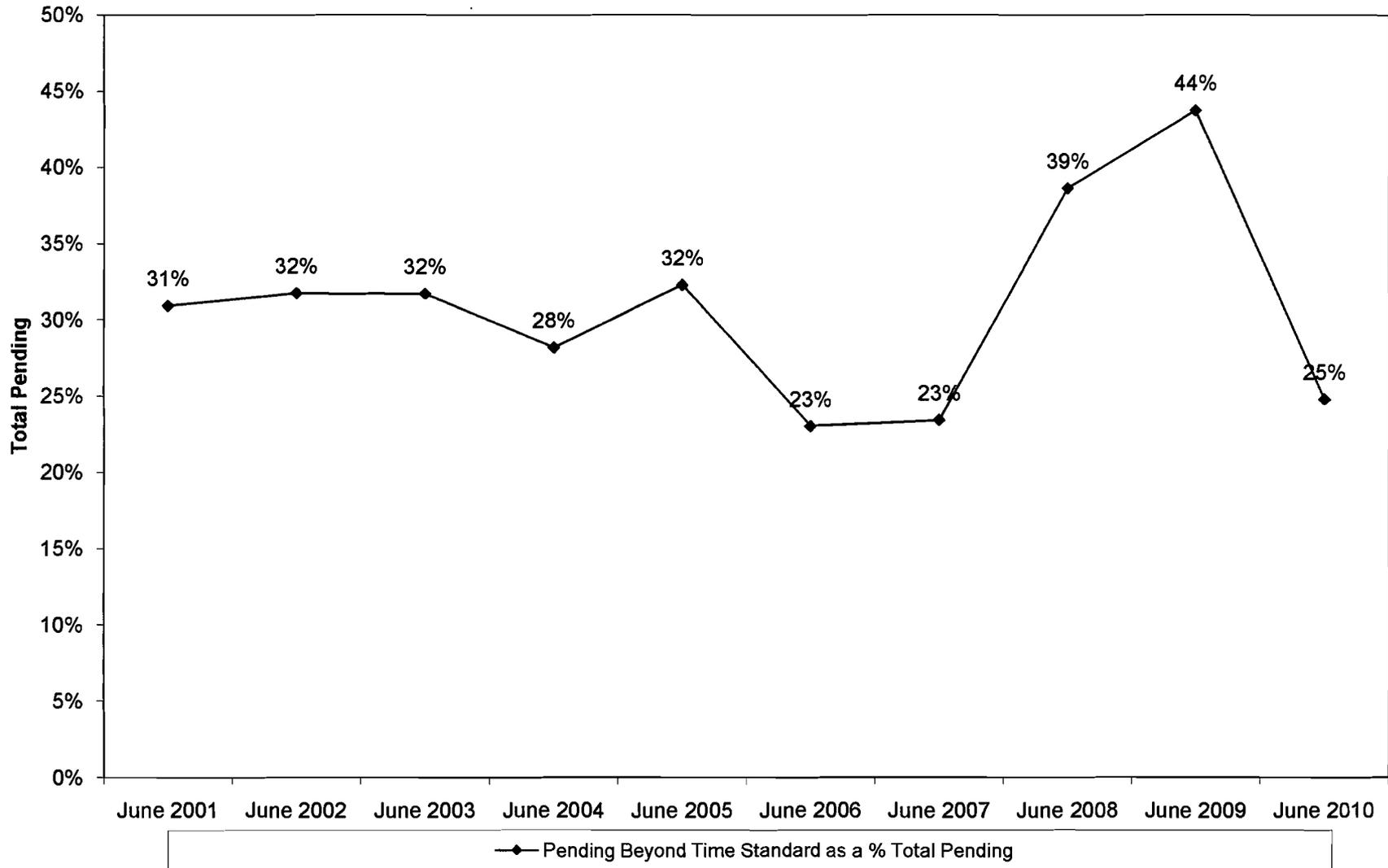


New Applications for Assistance Groups Received in ICES Statewide





Applications Pending Beyond Time Standard as a % Total Pending Applications Statewide





Regional Application Backlog 12/5/09 – 9/18/10

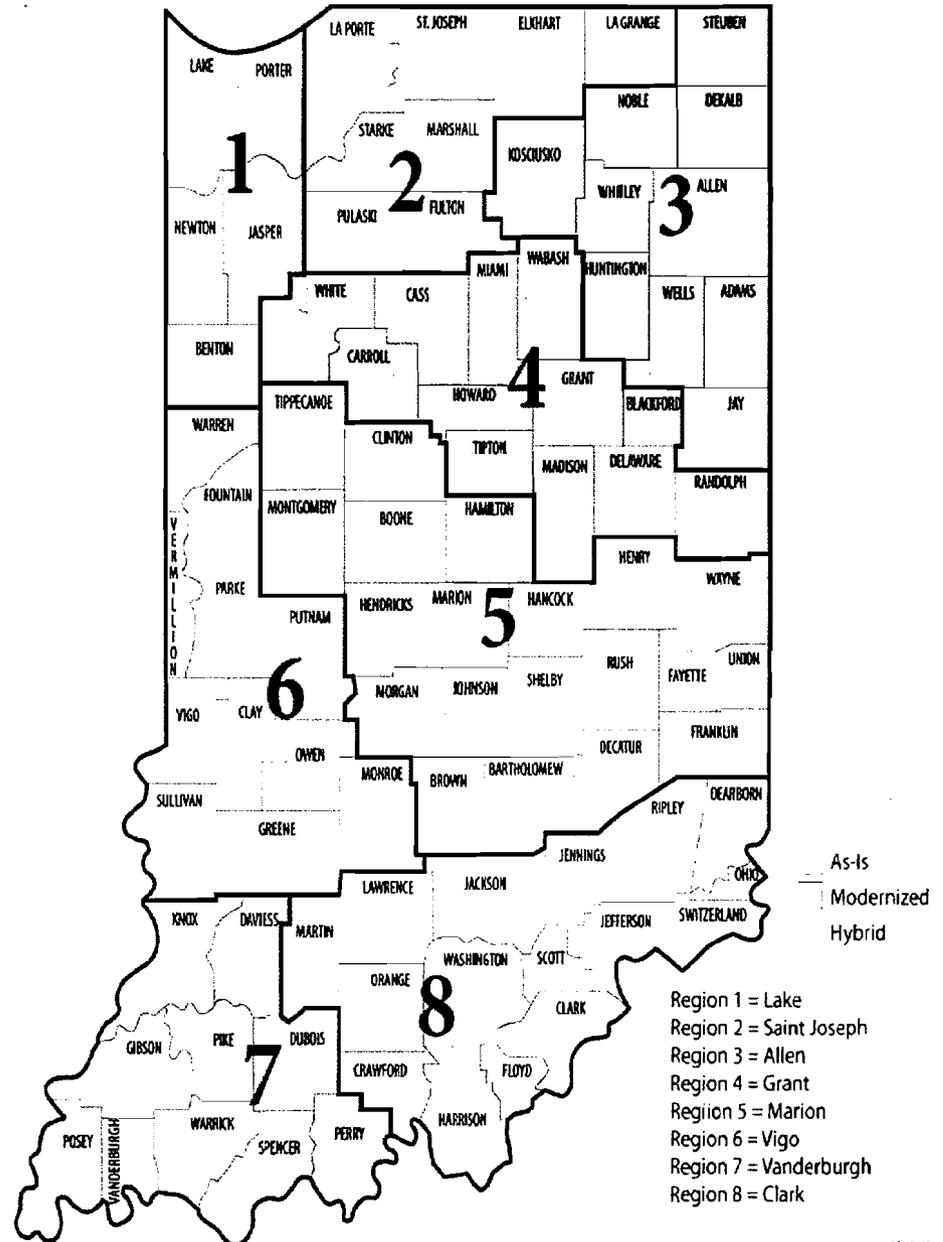
Applications Pending and Late Excluding HIP									
	Lake	St. Joseph	Allen	Grant	Marion	Vigo	Vanderburgh	Clark	State
Week Ending	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Total
12/05/09	1,309	830	3,941	3,468	8,653	2,338	2,427	3,053	26,019
09/17/10	397	204	1,583	2,580	4,544	241	418	341	10,308
Increase/ Decrease	-70%	-75%	-60%	-26%	-47%	-90%	-83%	-89%	-60%



DFR Regions

Hybrid Conversion:
 Vanderburgh – January
 Vigo – June
 Clark – September

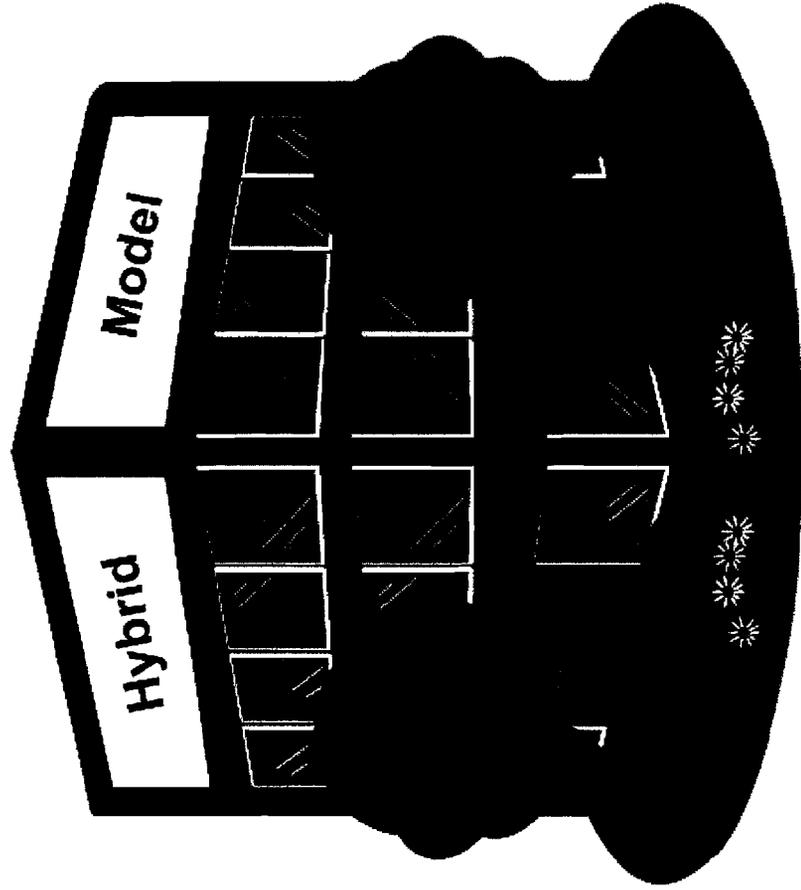
Indiana has been working closely with the Federal government. FNS requires two months of data prior to giving the State approval to expand to another region.



Information

What is a hybrid? The Merriam Webster On-line dictionary defines hybrid as "something that has two different types of components performing essentially the same function" or, in other words, a composite. The Hybrid Model comprises a combination of the best of the A, S and Modernized environments for the delivery of Eligibility Services to our clients.

The Hybrid System will allow for increased face-to-face contact between workers and clients who desire it, while maintaining the electronic advancements of modernization.



Click the FORWARD control to continue.

◀ Back

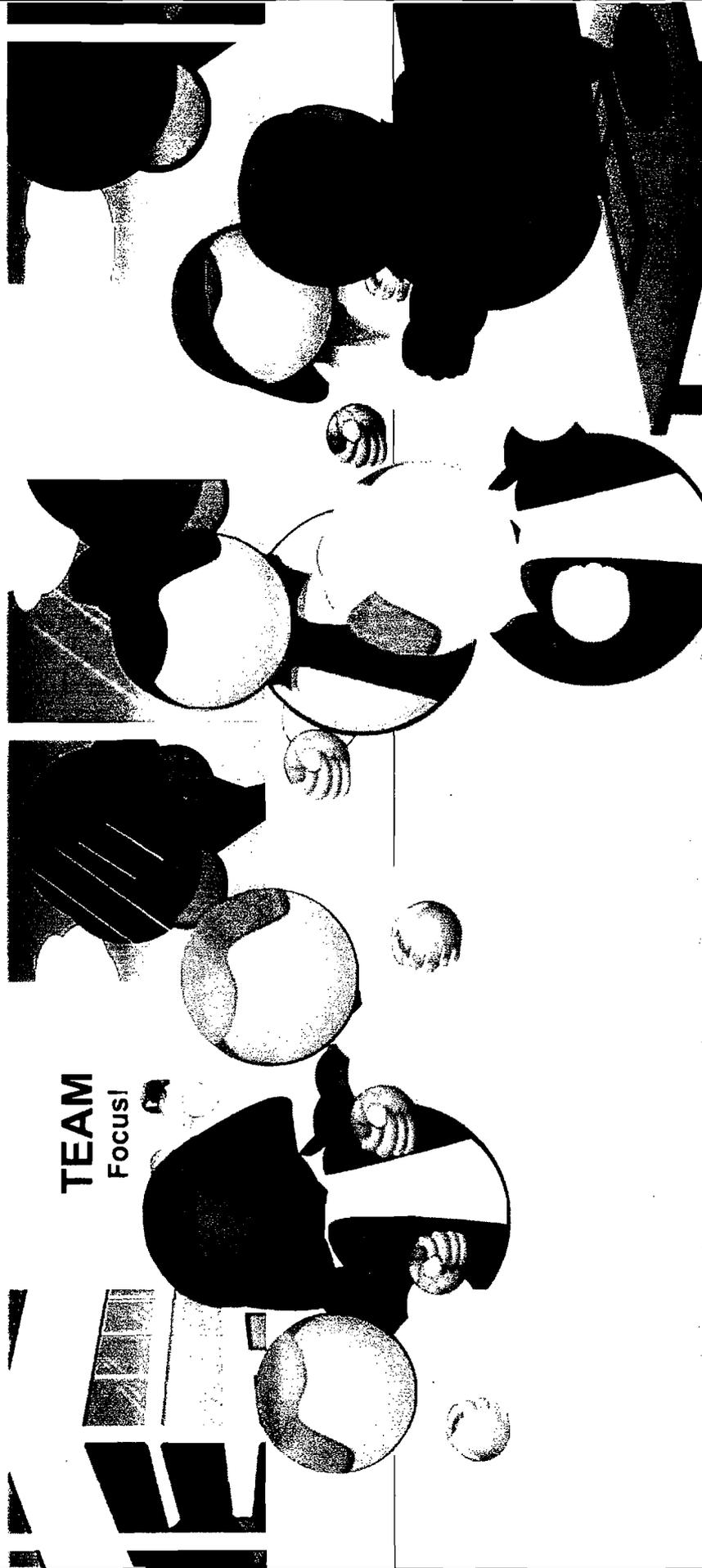
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Information

Local County Office Team Concept:

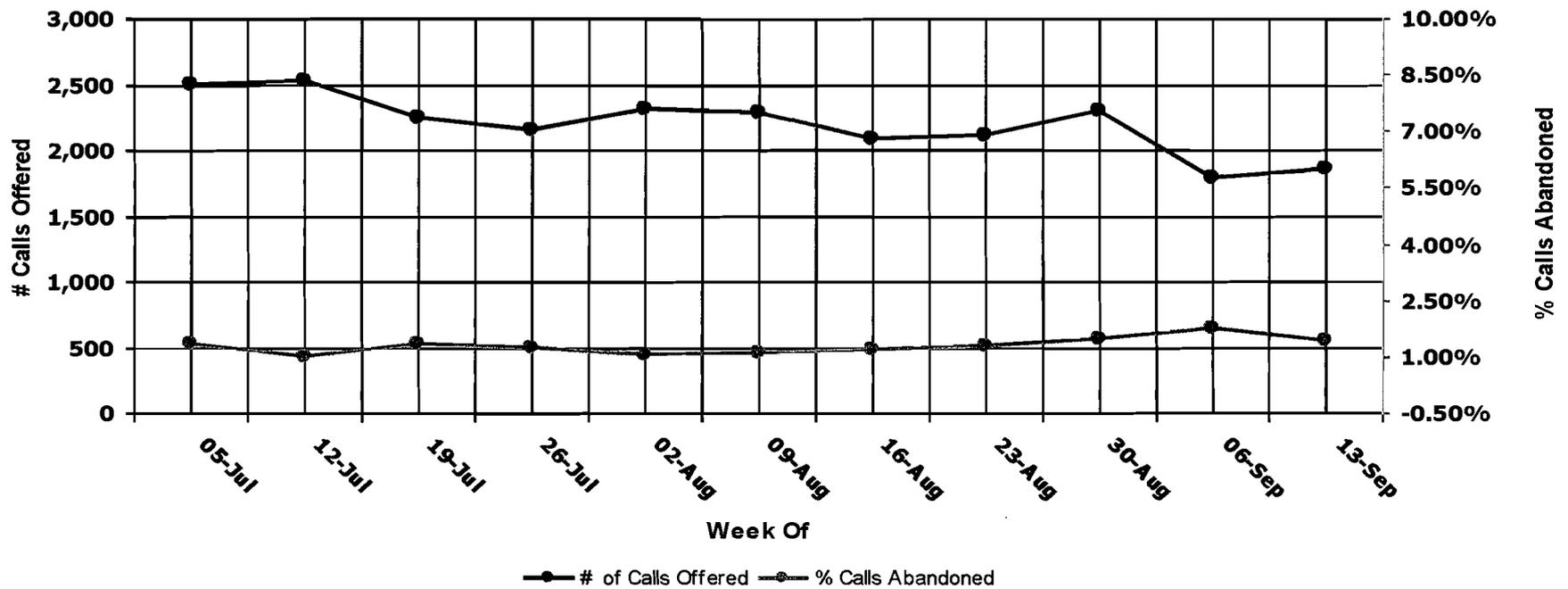
- Clients will be served by a team in their county (as opposed to the modernized system where cases may have been handled by employees from around the state).
- Team members will have the ability to assist and access client's cases in the county.
- Teams will allow newer case workers to work with more experienced case workers and learn from their example.
- Clients who wish to talk to one of their team members will have their calls automatically transferred to their local county office rather than a centralized call center.

Click the FORWARD control to continue.



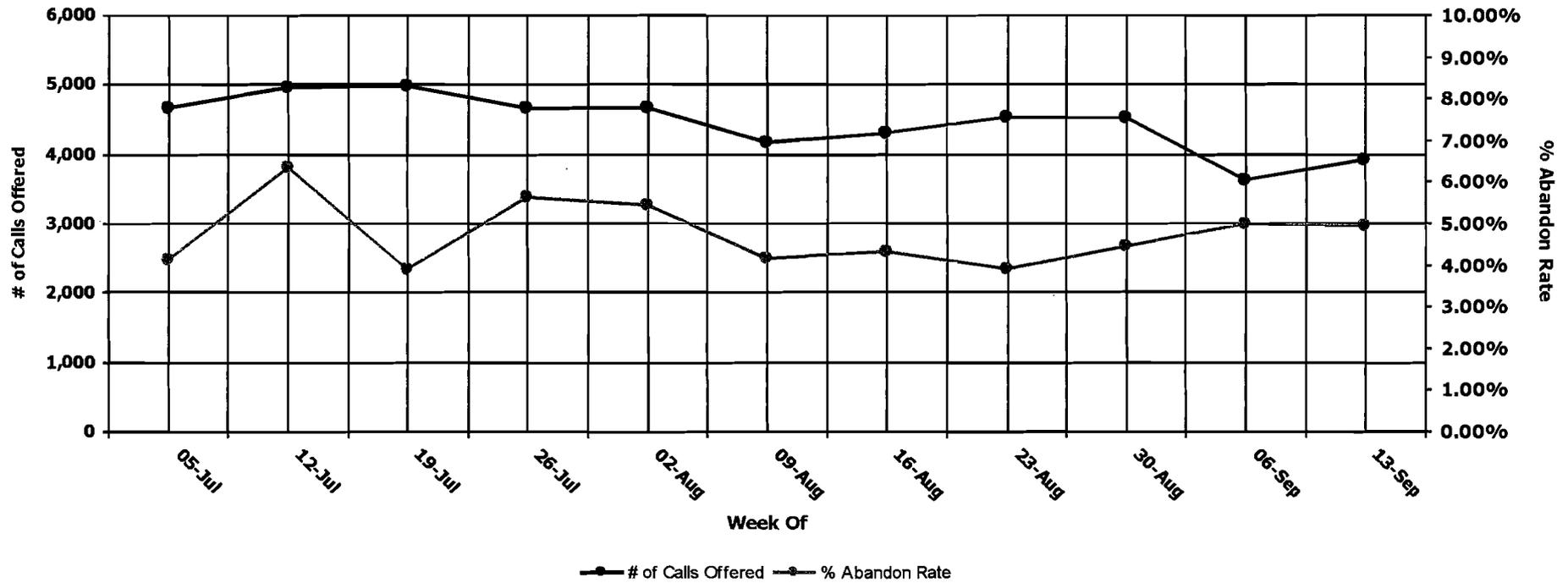


Weekly Local Office Call Statistics



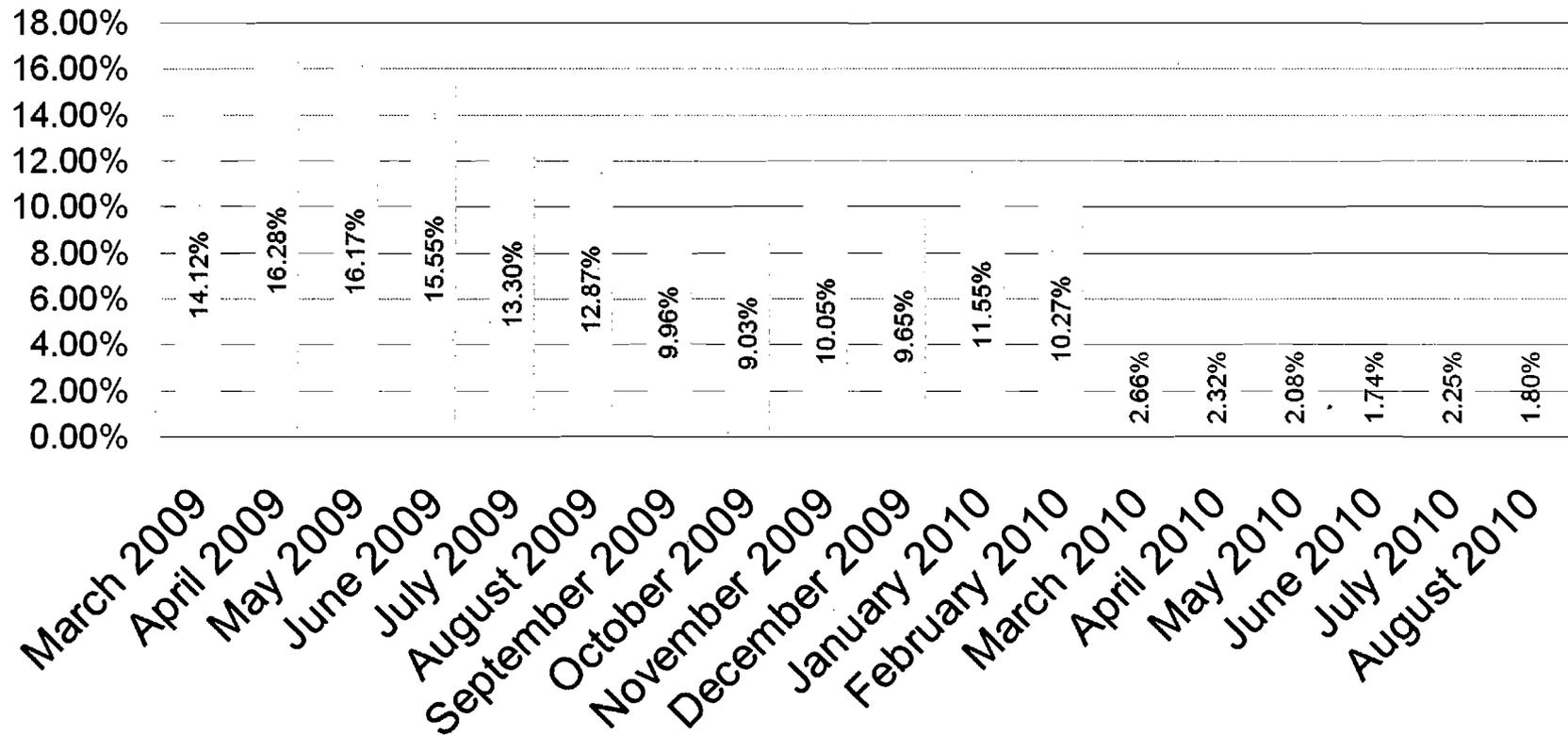


Weekly Regional Change Center Call Statistics





Medicaid Disability Applications Pending Over 90 Days with State Delay



Applications pending over 90 days with State delay

*Thornton Lawsuit requiring the State to progress towards below 1% pending over 90 days with State delay



Hybrid Performance: Key Metrics

FNS Validated, Cumulative Food Stamp Error Rates*

Positive April 2009	9.82%
Positive April 2010	3.44%
Positive April National Average 2010	3.65%
Negative April 2009	14.58%
Negative April 2010	2.61%
Negative April National Average 2010	7.66%

All Programs Timeliness

Modernized Counties August 2009	52.1%
Modernized Counties August 2010	59.9%
As-is Counties August 2010	81.3%
Hybrid Counties August 2010	82.8%

*The most recently available SNAP error rates validated by FNS are for the month of April



Contract Costs to Date

	Total Paid	State share paid	Federal share paid
IBM Disengagement Services	4,388,470	1,949,797	2,438,673
IBM Contract Costs (through termination)	437,550,488	196,938,821	240,611,667
Eligibility Vendor Contract Costs (as of 8/31/10)	58,760,315	26,107,208	32,653,107
TOTAL COSTS	\$500,699,273	\$224,995,826	\$275,703,447



JUN 09 2010

United States Cathy Boggs, Director
Department Division of Family Resources
of Indiana Family and Social Services Administration
Agriculture 402 W. Washington Street, Room W392
Indianapolis, Indiana 46204

Food and
Nutrition
Service

Dear Ms. Boggs:

Midwest Region

77 W. Jackson Blvd.
20th Floor
Chicago, IL
60604-3591

The Food and Nutrition Service (FNS) received your letter dated May 17, 2010 in which the State requested approval to expand the Indiana Eligibility Modernization Project Hybrid service delivery model to the Vigo Region (Region 6) in late June 2010. The letter included the Hybrid Regional Roll-Out Vigo Region Readiness Assessment report and other documents justifying the request to expand.

Based on FNS' recent site visit to the Vanderburgh Region (Region 7) where the hybrid pilot has been operating since late January 2010, and careful review of the documents provided in your letter, FNS is approving the requested hybrid expansion. Approval is contingent upon the Vigo Region and the State completing all of the readiness criteria prior to the June 21 cutover.

Further expansions beyond Region 6 will not be allowed without prior approval from FNS. Please let us know if there are any changes to the go/no-go or readiness criteria. Region 6 must be operating successfully for at least two months before any further areas can be added. We will continue to monitor the Vanderburgh and Vigo hybrid regions and analyze data prior to allowing any additional roll out.

We look forward to working closely with you on this effort. If there are any questions, please contact Tim English at (312) 353-1533 or tim.english@fns.usda.gov.

Sincerely,

OLLICE HOLDEN

Regional Administrator



United States
Department of
Agriculture

Food and
Nutrition
Service

Midwest Region

77W. Jackson Blvd.
20th Floor
Chicago, IL
60604-3591

Anne Waltermann Murphy, Secretary
Indiana Family and Social Services Administration
402 West Washington Street, Room W461
Indianapolis, Indiana 46204-7083

September 3, 2010

Dear Ms. Murphy:

The Food and Nutrition Service (FNS) received your report dated August 23, 2010, in which the State requested approval to expand the Indiana Eligibility Modernization Project Hybrid service delivery model to the Clark Region (Region 8) in late September 2010. The request is included in the Hybrid Regional Roll-Out Clark Region Readiness Assessment report and other documents justifying the request to expand.

Based on FNS' recent site visits to the Vanderburgh Region (Region 7) and Vigo Region (Region 6) where the hybrid model has been operating, meeting State management staff in Indianapolis on August 25th, and careful review of the documents provided by Indiana, FNS is approving the requested hybrid expansion to the Clark Region. Approval is contingent upon the Clark Region and the State completing all of the readiness criteria prior to the September 20, 2010 cutover.

Further expansion beyond Region 8 will not be allowed without prior approval from FNS. Please let us know if there are any changes to the go/no-go or readiness criteria. The two remaining modernized regions, Allen (Region 3) and Grant (Region 4), are tentatively scheduled for a January 2011 roll-out. This will allow Region 8 three months of operating under the hybrid model and should allow for solid data to be gathered and provided to FNS. It will also provide additional time for Indiana to gather and share performance data with FNS from the three hybrid regions to utilize in making decisions regarding future rollouts. We will continue to monitor the Vanderburgh, Vigo and Clark Regions and analyze data prior to allowing any additional roll-out.

We look forward to working closely with you on this effort. If there are any questions, please contact Trish Solis at (312) 353-1533 or patricia.solis@fns.usda.gov.

Sincerely,

A handwritten signature in cursive script that reads "Ollice C. Holden".

OLLICE C. HOLDEN
Regional Administrator

cc: Mike Carr, Interim Director, DFR, IFSSA, Indianapolis, IN

July 2010 All Programs Denials and Appeals			
Region	Applications Received	Denials	Appeals*
Lake	11,017	5,472	287
St. Joseph	12,456	5,370	217
Allen	10,607	4,824	514
Grant	15,066	8,950	471
Marion	32,044	16,446	822
Vigo	7,301	3,703	325
Vanderburgh	6,743	3,853	229
Clark	9,803	3,698	494

*Includes all appeals received and not solely appeals for the denial of an application. This could include appeals regarding changes in benefits, prior authorization, etc.

Daugherty v. Murphy

Court/ Judge: U.S. Dist. Court, S. D. of Indiana, Indpls. Div./ Judge Barker, Magistrate Judge Lynch.

Case number: 1:06-cv-00878

Date filed: June 2006.

Summary: Daugherty is a class action lawsuit filed on June 2, 2006. It involves two classes. Class 1 is the group of persons who applied for Medicaid and did not qualify due to the spend-down policy, which showed their respective spend-down amounts were too high to qualify for Medicaid. Class 2 is an undefined group of Medicaid recipients who received notice of reduction or termination of benefits and appealed before the date of the adverse action but did not have their benefits continued at the same level as before the date of the adverse action.

Perdue (formerly Gibson) v. Murphy

Court/ Judge: Marion County Civil Court 10/ Judge David Dreyer

1

Case number: 49D10-0803-PL-013340

Date filed: March 2008

Summary: This case is related to denials of benefits based upon the use of the failure to cooperate codes.

**Welfare Modernization/Medicaid Issues/Comments from Providers
September 21, 2010**

Emails were sent to St. Mary's Medical Center, Deaconess Health System, Deaconess Women's Hospital and all of the United Way Agencies in the Evansville area. The following comments were made re: Welfare Modernization and/or Medicaid Processes:

From Lynn Kyle – Lampion Center (lkyle@lampioncenter.com):

"I am not hearing anything in particular about privatization anymore. I hope that means things are running relatively smoothly.

Our issues with Medicaid are really still the same as before: The MCOs use different procedures, different forms, different everything – which makes keeping up with them very difficult. Then just when you think you have it all going, an MCO changes their procedures. Or they change their psych services provider which makes all credentialing and procedures start over. Having the state require MCOs to have more consistent timelines and paperwork would be a huge asset.

FYI, Medicaid currently pays about ½ of the cost of each therapy hour, requiring us to fund raise the rest."

From Lynn Hert – Deaconess Health System (Lynn_Hert@deaconess.com):

"Issue 1: Concern again that patients are not getting communication regarding their Medicaid phone interview. If they do not have the date, they cannot be at home to receive the call. The process is then terminated and patient must reapply and begin the process all over again.

Issue 2: Concern regarding MCO assignment after Presumptive Eligibility. Patients who complete the Presumptive Eligibility process are getting reassigned to another MCO when they get their pregnancy Medicaid. Process should be seamless-- they should automatically be assigned to the MCO they were originally linked to. Thank you for the opportunity to provide feedback."

From Cindy Baudendistel – St. Mary's Hospital (CBaudendistel@stmarys.org):

"We have found with the new Hybrid system, the process is more user friendly. The application process is much smoother for the patient and the authorized representative. If a patient has questions we have confidence that the local office can answer the question with correct information. We have also found that the appeals and MRT processes have a much quicker turnaround time.

We do still have a concern with e-mail responses on case inquiries. We do not always receive a response back. If we do get a response it is timely and much appreciated. Authorized representatives are not receiving correspondence on patients. We have been told that this is a manual process and is only happening about 60% of the time."



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

GAIL RIECKEN
200 WEST WASHINGTON STREET
INDIANAPOLIS, IN 46204

COMMITTEES:
FINANCIAL INSTITUTIONS, VICE CHAIR
EDUCATION
FAMILY, CHILDREN AND HUMAN AFFAIRS
VETERANS AFFAIRS AND PUBLIC SAFETY

September 21, 2010

**Exhibit P
Select Joint Commission on
Medicaid Oversight
September 21, 2010**

The Honorable William Crawford
200 West Washington St.
Indianapolis, IN 46236

Re: Select Joint Commission on Medicaid Oversight

Dear Chairman Crawford:

Please accept this letter as a comment about the status of services provided to clients of Family and Social Services Administration in my district, District 77. With the reform of FSSA to include more local decision making in a regional structure, the quality of services constituents receive should have improved over time. I've noted comments relative to improved services from those who contacted my Indianapolis phone number or the Statehouse website.

One main concern exists in the 17 or so complaints we have worked through since April. FSSA answers the constituent's questions, but doesn't seem to address additional issues. In other words, there isn't any intent to look at barriers that may impede a successful relationship with FSSA for the person. This causes the same case to arise many times, before it is finally resolved.

Here is an example: A Medicaid patient with mental health issues failed at being responsible with medication and attending doctor's appointments, yet there were still expectations that FSSA wanted them to adhere to. No requirement that an authorized representative of the patient be added to assist the process, until my office was finally contacted. We made the request, and only then was extra pressure added for the caseworkers to make sure all angles were addressed. This took months of repetitive inquiring, until it was finally granted.

Instead of a policy of case by case where the caseworker looks at the entire picture, the present policy is question by question. This type of policy leads to unresolved issues and multiple contacts between FSSA and the client. Our legislative office still act as caseworkers, asking all of the questions ourselves and not getting all of the answers.

The system failures can be summed up this way; the system is not designed to help the neediest. It is designed to help those who can navigate the system whether they are the neediest or not.

Respectfully,



Gail Riecken
State Representative
House District 77

Cc: 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

**The Privatization of Social Services:
An Examination of Healthcare**

Prepared By:

The Senior Social Policy Class

Under the Supervision of Dr. Matthew Ringenberg

Valparaiso University Social Work Department

Valparaiso, Indiana

In wake of the IBM crisis in Indiana over the privatization in healthcare, it is necessary to examine other states that have been involved in the privatization process and to gauge their level of success and failure. The two states examined were Texas and Louisiana. Texas like Indiana, struggled with the process, whereas Louisiana proved to be more successful in this realm.

Texas' initial intentions in privatizing social services were to efficiently assess thousands of applications for state support (e.g. Medicaid, food stamps, TANF, long-term care, and CHIP), and to save taxpayers' money (Vestal, 2006). In 2005, Texas funded 899 million dollars to the consulting firm, *Accenture* to run the state's food stamp eligibility program (Rahamatulla, 2010). Unfortunately, the pilot program failed almost immediately due to computer malfunctions and procedural issues.

The new contractor left many applicants waiting too long for service or left many without much needed service at all. According to state officials, 27,000 children applying for CHIP (Children's Health Insurance Program) were mistakenly marked "expired". When calling in, applicants such as the poor, elderly, and handicapped were left on hold for over twenty minutes, leading more than half of them to hang up before even speaking to a representative (Rahamatulla, 2010). Even worse, thousands of urgent applicants waited longer than federal rules to be accepted into services. One of the most preventable mistakes involved over one hundred applicants' Social Security numbers and medical information being accidentally faxed to a Seattle Warehouse (Rahamatulla).

Privatizing social services left its most significant dent on food stamp applicants. According to Kevin Concannon, member of the USDA, the application process is in a "five year decline" due to mistakes in the new system (Vestal, 2006). If the application screenings had gone

more effectively with the new system, 650,000 more applicants could be receiving food stamp services. Clearly, these mistakes were proof that the new method of privatization in Texas needed to be changed.

In order to lessen the negative effects of privatization on the Texas welfare system, Texas took steps to work towards a system that allows Texans to choose their method of application towards welfare services. The system is built on modern technology and makes the most of limited state resources.

Improvements on the previous system included decreasing telephone wait times to less than two minutes, reinstating the coverage of the 27,000 kids before they lost their services, and a takeover of processing new applications by state workers.

Mildred Warner a privatization expert at Cornell University explains how privatization makes sense in theory but not in practice. He concludes that the reason for the failure of the majority of projects is a deteriorating quality of service. “In more than half the cases, the projects did not save taxpayer dollars (Vestal, 2006).”

The state of Louisiana, however, may offer a solution that could remedy Texas’s problems with the system as well as our own. The Department of Children & Family Services in the state of Louisiana follows a process known as Continuous Quality Improvement (CQI) or sometimes referred to as Performance and Quality Improvement (PQI). It is a name for a process whereby both management and workers strive to improve quality of service to individual clients. CQI is a theory-based management system, driven by data, that looks at processes/outcomes in order to track the quality of services at agencies such as the Louisiana Department of Children and Family Services. CQI holds agencies accountable through good management, input from all levels of staff, teamwork, and a continuous review of progress. In

Louisiana, there is a state level Continuous Quality Improvement team and a team for each individual region of the state. The teams include staff from all levels within the agency representing all programmatic service areas as well as community stakeholders. Continuous Quality Improvement keeps all people involved in the agency involved in the process, including persons/families served, employees, volunteers, and consultants, members of advisory boards, consumer advocates, and all levels of agency staff. There are six steps to the process of Continuous Quality Improvement.

1. Identify a need/issue/problem and develop a problem statement
2. Define the current situation, break it down into parts
3. Analyze the problem, identify the root cause
4. Develop an action plan
5. Look at the results, confirm that the problem and its root causes have decreased
6. Start over with a new problem

This process could be utilized by an agency as a model. Agencies could use this model to determine if they are meeting their goals and if the policies and practices they are implementing are actually working.

The Council on Accreditation is an international, independent, not-for-profit, child and family service and behavioral healthcare accrediting organization. It was founded in 1977 by the Child Welfare League of America and Family Service (now the Alliance for Children and Families). The council views accreditation as a catalyst for change that builds on an

organization's strengths and helps it achieve better results in all areas. Although COA was originally known as an accrediting body for family and children's agencies, it currently accredits 38 different service areas and over 60 types of programs. Perhaps by utilizing this agency to oversee what is going on at private agencies, it would help the various agencies achieve better results and hold everyone accountable for what goes on (Continuous Quality Improvement).

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